How Data and Analytics Can Improve Negotiations for Outcomes-Based Contracts

While it may seem the transition to outcomes-based contracting is moving more slowly than desired at times, there is little disagreement among payers and providers that they represent the future.

In 2012, there were just 100 Medicare Shared Savings Plan (MSSP) accountable care organizations (ACOs): in 2017 there were 480. Medicare Advantage plan enrollment increased from 10.9 million members in 2009 to 19 million members in 2017 as well, which means one in three Medicare beneficiaries now has outcomes-based coverage. It is expected these upward trends will grow in the future.

What becomes abundantly clear is that hospitals and health systems must be prepared to negotiate outcomes-based contracts. Not just with the Centers for Medicare and Medicaid Services (CMS) but commercial payers as well. Which means they must be prepared to demonstrate the value/quality of the care they are delivering, especially in terms of how the intervention is impacting overall quality outcomes across patients and populations.

With pristine data and advanced analytics, providers can gain true understanding of the risks of all the populations they serve and negotiate value-based contracts based on a comprehensive understanding of their population risk and performance.

Obtaining quality data

The most critical element of a strong data strategy that supports value-based success is ensuring access to the right data, and that the data used is in pristine condition. The data must support providers in closing care gaps, reducing/managing population risk and ensuring resources are focused in areas that will deliver the greatest value. All data will be looked at closely by providers so ensuring the data is highly credible is top priority.

Typically, providers have access to electronic health records (EHR) data. While the data is valuable, it is often incomplete since it lacks a record of care delivered outside the hospital or practice group. Claims data could be used to fill many of the gaps, although at present it is mostly used for reimbursement so it would take some work to make it accessible to clinicians.

Another growing area of importance is socioeconomic data because it provides more information about how patients live and what their potential barriers are to following a prescribed care plan. These social determinants of health, such as where someone lives (especially Zip+4 data), education, income level, ethnicity, etc. offer many clues that can have a huge impact in determining how to best engage with patients and ultimately drive better outcomes. For example, a patient with a low income level is unlikely to be able

to afford medications that cost $100 per month. If physicians know this upfront, they can look into alternatives that are less costly, which means the patient will be more likely fill the prescribed medication.

Additional data to be considered include laboratory, fitness (from personal devices), medical device/remote patient monitoring, prescription, and more. Each of these data sources contributes to gaining a 360-degree picture of not just the patients' conditions or medical treatment but who they are, how they live, and what their personal challenges and goals are.

All of this information is extremely valuable when negotiating an outcomes-based contract because it tells provider organizations how much work will be required to reduce risk and improve outcomes. In other words, the contract for well-educated patients living in affluent areas will undoubtedly be very different than for those living in low-income areas with a higher number of dependents.

Using advanced analytics to predict risk

Once the healthcare organization has the right data, advanced analytics can help create much stronger negotiating platforms with payers – and create incentives for behavior changes among both physicians and patients.

These analytics take all the different types of data and use them to create risk scores for every member of a particular population. Providers can then use this information to determine the best places to dedicate their limited resources to drive better quality and financial outcomes. They can also use it to ensure the contacts they're negotiating focus on these areas of greatest impact.

Here's an example: The patient population with end-stage renal disease is an obvious target to manage actively because if they have a stroke, heart attack, or other problems they end up in the emergency department (ED) or hospital – the two most expensive sites of care. If care managers ensure these patients take care of themselves by going to dialysis three times per week, managing their blood pressure, getting bladder infections treated immediately, and so on, significant impact on both clinical and financial outcomes can be achieved.

But if those same resources are dedicated to an outreach program to the organization's diabetic population, which represents 5 percent of the entire patient panel, that is an expensive intervention that is unlikely to yield much of an ROI.

The goal with risk scoring is to understand first the amount of risk that exists across your population, which opportunities offer the highest value, such as keeping patients out of the ED or hospital and how or if the risk is changing over time.

Writing the contract

Once the organization knows who the highest impactability patients are, and which ones of those have the highest risk, it can write that information into the contract. For example, if 12 percent of diabetic patients are in the highest impactability group, and 10 percent of those are in the highest risk group, the organization knows it needs to target one percent of its total population for that disease most heavily with interventions (12 percent x 10 percent = 1 percent).

The organization must then determine how to inform and motivate physicians to deliver the care required for that population, as well as how to change patient behaviors. Impacting these small segments to identify where greatest organizations should look across high, medium, and low-risk segments to identify where greatest opportunities exist. The resources dedicated and incentives will change based on how much ROI can be achieved, as will the timeline for execution. Ultimately, however, the goals is to affect the entire patient population to drive the best possible outcomes throughout the organization.

A priority can also be given to determining the conditions that can be most impacted with the least complex interventions. Advanced analytics display clear visualizations to illustrate complexity versus impact. The ones that yield the greatest clinical and financial benefits with the smallest level of complication can be written in the contract first.

An effective strategy might be to create easy-to-understand, easy-to-execute programs to generate success and demonstrate the effectiveness of these efforts. As support grows among physicians and patients, the program can be expanded to tackle more complex areas.

Negotiate smarter

It's clear that outcomes-based contracts are the future, so it's important for healthcare organizations to put themselves in a stronger negotiating position. Data that delivers a 360-degree view of patient populations, along with advanced analytics that can derive meaning from the data, will give providers a tremendous edge that helps drive long-term success.

Kevin Keck, MD, Chief Medical Officer of SCIO Health Analytics

Kevin Keck, MD, is chief medical officer of SCIO Health Analytics, an EXL company, and an eminent physician with about 25 years of experience filled with numerous achievements and milestones. He was previously a palliative care physician at The Permanente Medical Group. One of his greatest achievements include the creation of value-based benefit design for Providence Health Plan where he held the position of a CMO.

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