helping value-based care delivery pay for itself
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Although many commercial health plan payments now focus on value rather than volume, the bulk of physician income is still derived from fee-for-service payments—or, for employed physicians, salary plus production incentives.a

Pioneers of value-based payment arrangements must navigate this reality if they are going to safely steer their fiscal ships through the choppy waters of healthcare reform. While investing in population health management, these healthcare organizations should seek revenue streams to cover the cost of new infrastructure requirements and to bolster provider income until all or most payments are value-based. To this end, investing in care managers and health IT may generate additional fee-for-service income.

We have put these approaches into practice at Bon Secours Virginia Medical Group (BSVMG), a 600-physician, hospital-affiliated, multispecialty group based in Richmond, Va. To support our patient centered medical homes (PCMHs) and our accountable care organization (ACO), we hired nurse care managers to improve care coordination for our high-risk patients and also expanded our health IT infrastructure. Several new revenue streams—some of them volume-based—have generated nearly twice the amount of money we have spent on care managers.

Preparing for Value-Based Payments

In 2010, BSVMG decided to redesign its care delivery infrastructure with PCMHs as the centerpiece. The columnist David Nash offers the following definition:

“[A PCMH] is essentially delivery of holistic primary care based on ongoing, stable relationships between patients and their personal physicians. It is characterized by physician-directed integrated care teams, coordinated care, improved quality through the use of disease registries and health information technology, and enhanced access to care.b

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Today, 27 BSVMG sites have achieved PCMH recognition by the National Committee for Quality Assurance (NCQA), and seven more offices have applied for recognition. These sites represent 80 percent of our primary care locations.

Our medical homes form the nucleus of an ACO that participates in the Medicare Shared Savings Program (MSSP). In addition, we have ACO or ACO-like contracts with several commercial payers, including Anthem, CIGNA, Coventry, Humana, and UnitedHealthcare. ACO-like contracts with Medicare Advantage plans form a rapidly growing part of our business.

To prepare for these contracts, we revamped our care delivery process to focus on preventive and chronic care. We emphasized care teams and delegation of care duties, and implemented specific IT elements, including registries and population health management tools. The care redesign included the addition of 60 nurse care managers, most of whom are embedded in the primary care sites. Each care manager—also known as a nurse navigator—is assigned about 150 high-risk patients with whom they maintain contact both telephonically and in person. Automation tools help the nurse navigators and care teams work even more effectively.

### Improvements in Care

Our original goal was to double the size of our providers’ patient panels without overburdening the care teams or sacrificing quality. Although we have not yet achieved that number, our patients are receiving about 25 percent more care for needed services than they were previously, including recommended preventive, chronic, and post-discharge care that contributes to improved health. As a result, our patients are less likely to visit the emergency department (ED) or be hospitalized than in the past.

Our post-discharge care, in particular, has improved significantly. For the past three years, the 30-day readmission rate at BSVMG has averaged about 2 percent of all discharges—far below the national rates reported by the NCQA of 8 percent for commercial health plans, 14 percent for Medicare Advantage plans, and nearly 20 percent for the Medicare fee-for-service program. The NCQA points to studies that show a direct correlation between lower readmissions and higher quality of care for discharged patients.

Our care teams help prevent readmissions and post-discharge complications partly through improved medication management. Nearly half the patients discharged from hospitals nationally are confused about their medications, and our PCMH care teams excel at medication reconciliation and explaining drug regimens to patients. Moreover, as our medical homes have grown, our capacity has increased to 2,000 discharged patients a month—10 times as many as we could see at the start of our care delivery redesign project.

ED visits also are dropping because high-risk patients have a lifeline at their PCMH in the form of the nurse navigators, who offer extended hours and coordinate home visits when appropriate.

With the help of an expanded IT infrastructure, care has also improved for the rest of BSVMG’s patient population both during and between office visits. Automation tools have played a key role in this upgrade. Using a populationwide registry fed by administrative and clinical data, a population health management application identifies not only high-risk patients, but also patients who have gaps in preventive or chronic care. When this software recognizes that a patient is overdue for a particular type of care, it can send an automated email, text, or phone alert to the patient.

The office visits that result from this proactive patient outreach do more than ensure that patients receive the care they may urgently need. The encounters also serve to build trust between patients and their physicians, which is key to changing poor health behavior.

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In addition, we use the registry and automated messaging software to identify Medicare patients who are eligible for annual wellness visits and encourage them to take advantage of those care opportunities. When patients come in for wellness exams, we ensure that they receive appropriate lab tests and screenings and that they help develop a patient-centered care plan with their physicians.

**A Worthwhile ROI**

This approach to patient outreach is a prime example of how we have used our new capabilities to increase fee-for-service revenue, while also raising the quality of care and increasing value-based payment amounts.

During a 12-month period ending in August, the outbound messaging to patients who had care gaps resulted in about 31,000 additional visits to BSVMG. Those encounters generated $4.4 million in incremental fee-for-service revenue. The ROI in the registry and automation software is about 6 to 1.

Meanwhile, we also have been able to take advantage of new Medicare revenue streams. Pursuant to the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) now pays providers for transitional care management. Office visits by high-risk Medicare patients within seven days of discharge and follow-up visits at 14 days are paid at a significantly higher rate than are typical office visits. These new codes require follow-up calls to patients within 24 hours of discharge, and CMS stipulates that it will not pay for a transitional care visit if the patient is readmitted within 30 days. Because of our care redesign, we are well-positioned to satisfy those conditions.

CMS now pays for annual wellness visits. Automated messaging can prompt Medicare patients to make appointments for these visits, which nurse navigators usually handle under a physician’s supervision. Such an arrangement not only provides opportunities for additional revenue, but also enables physicians to see their usual volume of patients instead of spending 30 to 60 minutes on these visits.

Between the annual wellness visits and the transitional care management follow-ups, each nurse navigator may see two or three patients a day. Although the revenue from those visits alone more than covers their salaries, the nurses still have time for a variety of duties related to the care management of other patients.

Our care redesign also has paid off in terms of value-based payment. While we have not yet received any revenue from Medicare shared savings, our value-based contracts with commercial health plans are starting to yield dividends. The incentive bonuses for meeting quality goals, plus the monthly care coordination fees that our medical homes receive from all our ACO-like commercial contracts, have added more than $3 million in revenue to date.

Medicare Advantage plans offer another way to capitalize on our new care management capabilities. Because CMS risk-adjusts the plan payments, it is helpful to perform annual health-risk assessments of Medicare Advantage patients. When we accurately document a specific diagnosis and provide supportive data such as pertinent labs, consult reports, and other tests in our electronic health record (EHR), we discover that many of these patients are, in fact, due for an office visit. Consequently, two-thirds of these risk assessments generate appropriate patient visits.

In all, the additional annual revenue from the incremental increase in patient volume, coordination of care, and quality incentives exceeds $6.8 million. By comparison, annual expenses for nurse navigators are about half that amount. The ROI on this program will continue to improve as CMS plans to provide a per member, per month care management fee of $42 for Medicare patients with two or more chronic conditions.

**Other Benefits**

Engaging patients in preventive and chronic care also helps physicians see the potential value in care redesign and in practicing at a medical home. Aside from helping advance their patient relationships, these additional visits increase physician performance incentives. BSVMG also offers bonuses to physicians who meet certain quality-of-care outcomes. These incentives, which are distinct from performance incentives, are intended to equitably distribute the cost savings to those performing the “hands on” care.
The same automation tools that aid in population health management also save money on appointment reminder and outreach calls. If we had not adopted these tools, we would have had to devote staff to making about 500,000 calls a year, a prohibitively expensive endeavor. Appointment reminders alone required front-office clerks to spend many hours calling all patients a couple of days before appointments. Now these staff have time for other tasks that are more specific to patient care.

It also is worth noting that, although we use one of the leading EHRs, that system in its current configuration would not be sufficient to support population health management activities. Its registry is far more manual than the outside registry we adopted because it requires users to identify criteria for all types of preventive and chronic care when running registry reports. In addition, the EHR does not generate outbound telephonic messaging, which must be performed manually. In contrast, the outside registry runs quietly in the background, automatically identifying patients with care gaps and alerting physicians and their care teams.

Better Than Expected
When we started redesigning our care processes, we thought the value-based revenue gains would be enough to justify the investment. But those payments have not grown as quickly as we had hoped, leading us to look for new sources of fee-for-service revenue to augment value-based payment and support our new approach to care delivery. Fortunately, some of the infrastructure we added helps generate that extra revenue.

Two lessons stand out from this experience. First, when you improve the quality of care, the revenue follows. Second, automation is essential to ensure that you do not spend too much to provide high-quality, comprehensive care to all of your patients. By redesigning work processes intelligently, healthcare organizations can make a successful transition to value-based payment.

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