Whitepaper

Tegria

From Volume to Value: Considerations for a Successful Transition to Value-Based Care

Executive Summary

Over the past decade, value-based care has emerged as a solution to healthcare organizations' (HCOs) rising concerns around cost and quality of care. By linking payment for healthcare to the quality of care provided, value-based care represents a shift in the way healthcare is delivered and reimbursed. Several variations of value-based arrangements—accountable care organizations (ACOs), bundled payments, and CMS programs such as the Medicare Shared Savings Program (MSSP) and Medicare Advantage—have been shown to increase patient and provider satisfaction, reduce costs, and improve patient outcomes.

Per a recent Insights report from Xtelligent Healthcare Media, healthcare leaders are embracing this change: "Across the industry, 43 percent of healthcare leaders agreed or strongly agreed with the statement that the coronavirus pandemic would propel the industry away from fee-for-service... among those, nearly half of all payer respondents agreed or strongly agreed."

The COVID-19 pandemic grew interest in value-based contracts as HCOs sought to mitigate the financial risks created by reliance on fee-for-service models. With a renewed focus on value-based care, many HCOs plan to increase their participation in risk-based contracting in 2021. However, successfully shifting from volume to value is not simple, or swift. With strategic analysis of the organization's culture, analytic capabilities, systems, and workflows, leaders can position their organization for a successful volume-to-value transition.

Ready or Not, Value-Based Care Is Here

The challenge of shifting from volume to value is one many HCOs had started addressing before COVID. Now embarking on the road to pandemic recovery, many organizations must recalibrate their approach to this transition. Compared with the pre-pandemic era, providers are facing more burnout, resources are stretched thin, and HCOs are experiencing the financial fallout brought on by over-reliance on fee-for-service contracts.

These factors underscore why many organizations are engaging in a strategic shift to value-based care and taking on more risk to ensure future financial security. But the decision to move forward with a transition to value-based care at a time when healthcare workers are already overburdened is complex. Before embarking on the value-based journey or expanding involvement in value-based contracts, organizations should weigh several considerations, including:

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Return on Investment

The return on investment for infrastructure and workflow changes required to support value-based care is not always immediately obvious, especially as organizations are experimenting with value-based care while still heavily relying on fee-for-service contracts.

These changes include:

- System infrastructure
- Care management workflows
- Data analytics support including dashboards, actionable reporting, and point of care insights
- Tools to support cost and utilization efforts
- Partnerships with other service providers and community-based organizations

Cultural Readiness

The cultural shift necessary to deliver care that emphasizes value over volume can be difficult for providers and administrators to embrace. These two models can sometimes seem contrary to one another, particularly in terms of:

- Care coordination
- Site of service considerations
- Holistic care vs. episodic visits

As healthcare costs continue to rise, the transition to value-based care is a critical part of any healthcare organization's short and long-term strategy to contain costs and enhance quality.

Preparing for Success in a Value-Based World

Even for experienced healthcare leaders and providers, entering value-based care contracts can seem like stepping into a whole new world. Shifting to value-based care requires changes to well-established operations, tools, workflows, and care delivery models. At the outset of this process, careful strategic planning can help reduce uncertainty and answer the question "Where do we begin?" The following focal areas offer important considerations to address in the planning phase.

System and Workflow Redesign

Shifting from volume to value presents barriers because most systems and workflows were not built with value-based care in mind. Value-based care requires a fundamental shift in how most healthcare providers have practiced medicine for decades under the fee-for-service model.

Compared with fee-for-service contracts, value-based care emphasizes care coordination, outreach, prevention, and data-driven insights to help providers deliver timely care. Value-based care relies on addressing issues such as inappropriate ED use, choosing an appropriate low-cost site of service, and prescription drug costs. To prepare HCOs and providers for the transition, EHR systems should be optimized to present relevant data to the provider at the point of care.

To close gaps and address utilization and patient compliance concerns, providers must be able to easily identify and reach patients who have missed recommended appointments, inappropriately used resources, or are non-compliant with care plans. This requires infrastructure (both inside and outside of the EHR) that supports effortless availability of information and integrates seamlessly into the provider's workflow.

Change Management and Education

Readying providers and staff for the cultural and operational changes involved in the shift from volume to value is critical to the long-term health of the organization. During this transition, the organization must move from a siloed operations model in which organizations are paid for every service provided to a payment model requiring coordinated care, reduced waste, and increased focus on outcomes and value. Integrating appropriate change management and education into the transition helps organizations ensure a smoother, faster shift to value-based care.

Additionally, this shift in mindset, technology, and workflows requires a detailed education plan. Provider and staff education is critical to provide proper training for new tools and workflows, improve adoption, and reduce care team frustration through this transition.

Data Analytics Infrastructure

In addition to change management and education, data analytics infrastructure is foundational to a successful value-based care strategy. Value-based care requires that an organization track costs through utilization controls such as:

- Controlling leakage
- Steering to appropriate sites of services
- Controlling pharmaceutical costs
- Reducing avoidable emergency department use
- Reducing hospital readmissions
- Encouraging preventive measures and holistic care through:
  - Closing care gaps
  - Coordinating care
  - Addressing the social determinants of health

Each component of value-based care requires a strong analytics infrastructure that ensures the capture of appropriate data points. To effectively drive value-based care, analytics tools must also integrate a variety of data sources including claims, clinical, consumer, and community-based organizations to drive care delivery through actionable analytics provided conveniently at the point of care.

To help clarify data analytics needs and capabilities, organizations entering value-based care should consider the following:

1. **Is your IT and Analytics infrastructure modernized** to support storage of large datasets, share datasets and dashboards with payers and community providers, adapt to and report on EHR processes and workflow changes, and pilot new technical solutions to meet evolving requirements? If not, consider creating a population health data analytics infrastructure roadmap with representatives from across your population health services organization.

2. **Do you have a data runway?** In many ways, moving to value-based care is like spinning off a startup from your existing company. Just as fiscal runways are the lifeblood of many startups, data is the lifeblood of successful value-based care. Do you know which payers are sending data? Are they sending all contracts or just a portion? What is the expected frequency of file format changes? Which data should your organization's IT and Analytics team prioritize? Answering these questions will help inform the creation of a data runway that ensures optimal data sharing and collaboration while supporting stronger analysis and interventions.

3. **What is the smallest thing you can do to move your next priority forward, and when are you going to do it?** The first two considerations help organizations prepare for an effective and efficient tomorrow, but what about today? In a world where it seems like we're simultaneously building and flying more than one plane, HCOs need actionable quick wins to help move the performance needle as larger infrastructure activities progress concurrently.

4. **Are you beginning your population health data analytics journey with the end in mind?** Process and outcomes evaluations are essential to creating a culture of continuous improvement. To effectively evaluate process and outcomes, HCOs need strong data architecture and data management tools that can flex to accommodate new and changing queries.

Contracting and Benefit Design

Much of an organization's ability to succeed in value-based care lies in the details and design of contracts and benefits offered. The ability to negotiate favorable contracts depends on an organization's capacity to make decisions about what they can accomplish with the population in question.

Questions that must be addressed include:

- Is there ample opportunity to reduce cost and utilization in this population?
- What is the risk of this population?
- What social determinants of health factor into working with this population?
- What are the current behaviors of this population in terms of how they receive or seek out their healthcare?
- Does the organization have the resources to serve this population?

Answering each of these questions requires robust analytics infrastructure, intuitive reporting, and the availability of relevant data. Contract terms should make sense not only for the organization, but also for the population being served.

In addition to the actual contract, benefit design is something organizations should also consider in their journey into value-based care. It is important to understand the benefit design of the patients included in the value-based contract and ensure the patients' incentives to seek out care, including their co-pays/co-insurance or employer incentives, align with objectives of the contract. For example, if lowering avoidable or inappropriate use of the emergency department is identified as an area of opportunity, organizations should consider benefit design to ensure patients are not incentivized to go to the emergency department with lower co-pays or barriers to other types of care.

Best Practices for Common Value-Based Contracts

Successfully adopting value-based care requires skillfully applying the model to different types of contracts, payments, and payer relationships. Here are three of the most common contract types along with some data analytics priorities that can drive success as you begin your value-based care journey.

Commercial Accountable Care Organizations (ACO)

Commercial ACO contracts can be designed with varying levels of risk: upside risk only, downside risk, and full risk. Variations include how attribution is determined, shared savings percentage, specific quality measures included, quality gate requirements, and how financial targets are set for the measurement period. Regardless of the specifics of the ACO arrangement, organizations must address a few universal considerations:

- **Cost and Utilization:** Since commercial ACO arrangements often focus on shared savings, achieving this is one of the keys to success. Savings can be attained in several ways, and some of the most common involve reducing cost and utilization with initiatives aimed at decreasing unnecessary care or care at inappropriate sites of service. Real-time reporting that can identify patients at risk of utilizing inappropriate sites of service, or those who may be candidates for lower-cost therapies including prescription drugs, is essential to containing costs.

- **Quality Measures:** Most commercial ACO arrangements require providers to meet a quality gate before they become eligible for any shared savings or bonus payments. The quality gate is usually measured through various thresholds set for a combination of HEDIS measures. Establishing detailed, real-time analytics around care gaps and a frictionless strategy for closing those gaps —which may include point of care reminders and proactive patient outreach—is essential to success.
- **Population Segmentation and Care Management Strategies:** Most successful ACOs have population segmentation strategies that are highly coordinated with their care management teams. Outreach to patients is one of the pillars of care coordination, and many organizations focus their (often limited) resources on addressing the needs of their high utilizers and highest risk patients, and rightfully so. However, the organizations that are most successful have found ways to also spend time with their lower risk patients, allowing care management teams to shift their focus to prevention. In addition, regardless of whether you have a centralized or decentralized care management strategy, close alignment between care management teams and primary care offices is a reliable best practice.

Bundled Payments

Although bundled payment contracts can vary depending on the type of bundled payment—CMS's Bundled Payments for Care Improvement (BPCI) and Direct-to-Employer Centers of Excellence contracts are examples—they all require data analytics infrastructure that supports:

- **Baseline Costs:** Because bundled payments reimburse at a set price, it is important for HCOs to not only understand the baseline costs for the bundled services, but to understand points of variation, opportunities to improve costs, and how their bottom line will be affected as they enter into these agreements.
- **Standardized Best Practices and Real-Time Feedback:** In addition to understanding baseline costs, maximizing performance in bundled payment contracts require real-time feedback to identify deviations from expected expenditures as well as additional opportunities to improve costs. Implementation of standardized best practices for services involved such Enhanced Recovery After Surgery (ERAS) protocols and standards for implant usage can help identify deviations and stabilize costs for bundled payments.
- **Patient Expectations:** The patient's role in terms of their expectations, participation, and actions through the process is crucial for success. Consistent patient education to manage expectations around process, pain levels, mobility, how to prepare their home, when and whom to call for help, and follow-up care plans should be carefully coordinated.

Medicare Shared Savings Program (MSSP)/Medicare Advantage

Medicare programs such as MSSP and Medicare Advantage are heavily based in quality measures as well as risk adjustment to determine reimbursement and other bonus payments. Ensuring that risk is accurately documented and care gaps are closed is vital to maintain both compliance and care quality.

- **Condition Coding Management:** Accurate condition coding management ensures quality of care by confirming patients' conditions and is crucial in maximizing payment in contracts that depend on accurate patient risk profiles.
- **Quality Measures:** In addition to the bonus payments HCOs often receive for meeting certain quality thresholds, focusing on quality measures helps organizations engage their patients and keep them healthy. As with other value-based care programs, it is important to have a strong data analytics infrastructure to provide actionable insights to assist in engaging this population.
- **Annual Wellness Visits:** Accurately documenting patient conditions is critical for risk adjustment and closing gaps in care and essential for managing population health. This makes annual wellness visits and other forms of preventative care crucial to success. Data analytics, system tools, and workflows that empower healthcare organizations to ensure every patient has at least one annual visit are the foundation of successful participation in Medicare programs.

Conclusion

The shift from volume to value is here. Regardless of your organization's position on value-based care prior to the pandemic, now is the time to prepare for coordinated care directed through data-driven workflows to lower cost and utilization. For every step—from initial assessment and strategic planning to the development and implementation of sophisticated data-driven analytics and integrated tools—finding a partner is paramount to maximizing your performance during and after your transition to value-based care.

It's time to begin your transition from volume-to-value.