HAYES
MANAGEMENT CONSULTING
Optimizing the business of healthcare

WHITE PAPER

The Shift to Value-Based Care:

9 Steps to Readiness

Table of Contents

Overview **1**

Value Based Care – Is it here to stay? **1**

1. Determine your risk tolerance 2
2. Know your cost structure 3
3. Establish your care delivery network 3
4. Evaluate your systems 4
5. Set data governance parameters 5
6. Tighten your process controls 5
7. Assess your payer proposals 6
8. Solidify your relationships 6
9. Get help before you take the first step 7

Summary **7**

About Hayes **7**

Sources **8**

Overview

Death and taxes. These are the two things people refer to when defining absolute certainty. You can now add one more to the list: the shift to value-based health care.

The convergence of clinical, economic, and political drivers ensures that traditional fee-for-service models where providers' revenue is based on how much they charge for a service or how many tests they order is fast becoming a thing of the past. The reimbursement models of the future will inevitably be based on outcomes: quality of care based on still to be refined measurements, reduced hospital admissions, fewer readmissions, lower infections rates, and better patient outcomes.

Some providers who are ahead of the curve have embraced the change and are making progress toward maintaining profitability with the new models. Others are holding back, but resistance is - and will be - futile. Change is coming and your best strategy is to get ready for it now, before mandates from government and private payers force you to take action.

This paper will examine the path and incentives that have led to value-based care, the current trends, and what you can expect in the future. It will then outline nine steps healthcare organizations should consider when moving to value-based care.

Value Based Care – Is it here to stay?

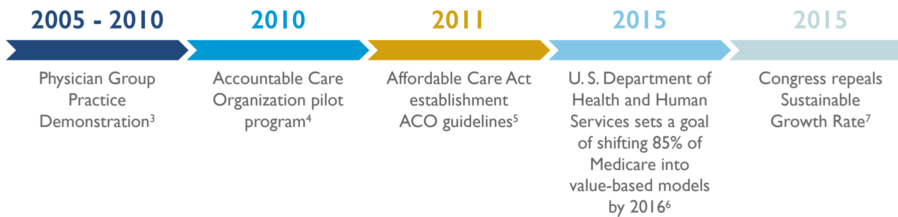
Discussions surrounding shifting reimbursement models from fee-for-service to value-based care have been ongoing for decades. Providers, politicians, and healthcare industry analysts have long recognized the need to align payment methods to patient interests and understand that a model that drives revenue simply by the number of services provided does little to improve care or reduce overall costs.

Thus was born the idea of accountable care – using financial incentives to enhance care through increased focus on patient outcomes, quality, and cost reduction strategies. The Physician Group Practice Demonstration (2005 to 2010) and the Accountable Care Organization pilot program that began in 2010 have significantly moved the industry in the direction of value-based care reimbursement models.[1]

The passage of the Affordable Care Act (ACA) continued the momentum of the shift and established clearer guidelines for ACO's in 2011. In early 2015, the U. S. Department of Health and Human Services (HHS) set a goal of shifting 85% of Medicare fee-for-service reimbursement into value-based models by 2016. Private payers will no doubt follow closely behind.

Congress is seeking to further drive a value-based model by repealing the Sustainable Growth Rate (SGA) formula in 2015 and establishing a merit-based incentive payment system. The legislation also provides a vehicle where physicians can opt into a program that provides higher payments in return for participation in certain Alternative Payment Models (APM's).[2]

EVOLUTION TO VALUE-BASED CARE



The future is clear: value-based care models will inevitably replace fee-for-service reimbursements. You may be able to avoid the shift from fee-for-service in the short term, but ultimately your organization will have to change the way that you practice in order to survive the change in payment mechanism. The smart move is to begin preparing now. Here are nine things to consider when preparing your organization.

1. Determine your risk tolerance

This is perhaps the most important point as you set off into the uncharted waters of value-based care. Participating in these new reimbursement models can provide significant benefits, but there are inherent risks involved. The reality is that there is financial risk to this transition, not a pleasant thought in this era of reduced revenue and shrinking margins. The entire organization, beginning with senior management, needs to fully embrace the risks and make the commitment to mitigate them as much as possible.

However, risks with value-based care can be minimized by executing on issues that promote growth and improve patient care such as better access to providers, efficient clinical workflow, and optimized use of EHRs. Leveraging strong IT systems, developing a long term operational and financial strategy, and fostering a culture of change within the organization can go a long way in minimizing the risks of a value-based care initiative.

2. Know your cost structure

The number one barrier to sustainable cost containment is a lack of data on the true cost of care, according to a report from HealthLeaders Media.[8] Clearly understanding what it costs to deliver a unit of care is crucial as you begin to negotiate with government and private payers on reimbursement agreements. This is also critical knowledge as you develop your service lines and determine how payments are going to be apportioned among providers.

If you are unable to easily determine your costs for providing various services, you may need to enhance your internal cost accounting structure for both the clinical and administrative side of the organization. You need to take into account both direct cost of physicians, nurses, and specialists, as well as general overhead expenses like housekeeping, food, finance, and facility maintenance which can't be tied directly to a specific care delivery event but which must be amortized across all interactions.

Moving to a value-based model means understanding the total medical costs across your entire patient population. You can't rely on payers to report costs. Instead you must have access to payer claims-based data to understand the total cost of care delivered both internally and externally.

3. Establish your care delivery network

As you morph into a value-based model provider, you will need to establish a cost effective, responsive care delivery network. That means working with payers and potential care partners to show them how they can deliver quality care at reasonable prices. You will need to work with primary care physicians and third party providers to determine the best way to provide coordinated care that improves patient outcomes while lowering overall costs.

No organization has all the physicians, specialists, and facilities to deliver the full array of healthcare services needed under risk contracting. . For example, your organization may have enough specialists but a shortage of primary care physicians or you may not have a post-acute skilled rehab facility. You will need to contract with partners to fill these types of care gaps.

You will need to develop an array of payment methods such as fee-for-service, negotiated rates, and capitation rates, as well as

how bonuses will be distributed. You will have to ensure processes are in place to keep patients healthy and out of the hospital. Most organizations do this by hiring additional staff (case managers for example), to monitor the health of their population – and they start well before the patient crosses the threshold of the hospital.

You can also do this by making sure patients get their flu shots to help avoid costly hospital stays should they contract the virus, for example. It could also mean driving proactive initiatives with health club membership reimbursements or patient contact plans to ensure they're conforming to a previously established care plans.

When necessary to refer out these care events, you will need to determine which partners are the most cost effective for each particular service. Each clinical intervention should meet the goal of lowering costs while improving the quality of care and ultimately driving patient satisfaction.

4. Evaluate your systems

Information is power and having the right data at the right time in a user-friendly format is crucial to success in a value-based care model. If you already have an EHR, you will want to optimize it in order to ensure you are collecting, processing, and analyzing all the data related to activity in your organization.

Marshfield Clinic in Wisconsin, a high achiever in the initial ACO program and one of only two of the initial 10 participants to earn shared savings in the first three years, credited the effectiveness of their EHR as a key reason for their success.[9] Their homegrown systems provided ongoing testing and feedback for physicians and administrators as they moved through the program. They were able to aggregate data from all care settings, including third party providers and leveraged a comprehensive data warehouse to report on outcomes, costs, quality, and patient experiences.

Most healthcare organizations already have an EHR in place, but may not be leveraging the system to obtain its optimal benefits. It's crucial to make certain that you have the appropriate infrastructure, hardware, and software in place to obtain the data from your EHR (and other IT systems) to help successfully manage the new payment landscape.

5. Set data governance parameters

It's important not only to have your systems optimized, but you must also ensure that the data you are receiving from them is both timely and reliable. Data governance is the process of ensuring the data you use for your value-based reimbursement programs is clinically accurate. This becomes more difficult when gathering data from multiple, disparate systems - normally the case for most healthcare organizations.

Early stages of data governance usually lie exclusively with the IT department. A truly mature governance program involves all layers of the organization including operations and focuses on using the data to improve efficiencies and minimizing risk. Most healthcare organization are just beginning the journey in regards to data governance so you need to determine where you currently are and where you need to be to support a value-based care model.

Key Goals of Data Governance Program

- Ensuring the right people have the right data at the right time and in a user-friendly format to deliver the best patient-centered care
- Improving productivity by consolidating data from multiple systems
- Enhancing decision-making by transitioning from historical reporting to predictive modeling
- Assigning data governance ownership supported by technology

6. Tighten your process controls

More than half of those responding to the HealthMedia survey identified process redesign as a key for cost containment. Focus on traditional expense reduction strategies like purchasing controls and supply chain efficiency continues to be important, but reviewing and enhancing processes continues to grow in popularity as a way to reduce costs.

Enhancing process controls starts with comprehensive documentation. Only then can you introduce refinements to streamline the process. It is also critical to make sure you are taking full advantage of all the features of your EHR system. Failure to do so can result in the loss of valuable cost reduction opportunities.

Doing things "the way they've always been done" won't work in a value-based care environment where improving care goes hand in hand with cost reduction. Continuous process improvement and revenue cycle optimization are key drivers of profitability and success with the new models.

7. Assess your payer proposals

Once you have a firm handle on your costs and have optimized your processes, your next step is to discuss payment plans with government and private payers. They may offer a global fee structure to cover specific services at pre-determined pricing or a risk-based plan where you are responsible to deliver care for a defined period of time for a fixed price. You will need to evaluate each of these models to calculate your expected costs against the revenue being offered. This will help you determine the volume of services you need to provide to ensure all your costs are covered.

Evaluating these various proposals can lead back to additional process review as you determine how best to deliver quality care while staying within negotiated price points. For example, it may be less expensive to use an external lab than using internal resources even though it may take additional time. You might then have to evaluate the impact of the tradeoff of a four to eight hour delay in getting back test results versus the cost savings.

8. Solidify your relationships

Often times primary care physicians, specialists, and hospital administrators don't see eye to eye when it comes to healthcare. But to achieve the common goals of a value-based care model, those groups need to work closely together. You need to establish a dialogue with all participants within the larger ACO organization to decide how – and how much – payments will be made. It's also crucial to develop standards that everyone in the group can accept.

In many value-based reimbursement models – such as per member/ per month (PMPM) – organizations know the amount that they have to spend. The key is determining how to allocate the funds among the various stakeholders and that's where a spirit of cooperation and understanding the larger issues such as trust are crucial. Making these important payment decisions requires establishing a culture that not only accepts, but also embraces change. To successfully navigate the many nuances of the coming shift you need a commitment from the entire staff to implement the changes that will be necessary.

This culture change involves agreeing on the values that promote effective healthcare, identifying key cultural factors in providing value-based services, reviewing elements of your organizational culture that affects performance and behavior, and developing an action plan to enhance your organizational culture to support value-based care models.

9. Get help before you take the first step

Preparing for value-based care can be stressful and confusing. To make the transition smoother and to overcome some of the challenges, consider working with an established partner.

Tasks commonly outsourced:

- Evaluate your operation on both the clinical and non clinical side to identify cost reduction opportunities
- Set up physician, post acute care, and other networks and contracting with payers
- Review technology systems and vendors to help ensure you are taking full advantage of existing features
- Optimize revenue cycle to improve cash flow and increase margins

Summary

All signs point to an inevitable healthcare shift to value-based care in some form. You can decide to ignore the trend and postpone dealing with it until there's no choice. Or you can proactively try to get in front of it and put your organization in the best position to not only survive, but thrive in this new world.

Taking the necessary steps now may seem daunting, but in the long run, it may be your best alternative. By focusing on the key steps outlined here, you can adequately prepare for success in a value-based care environment.

About Hayes

Hayes Management Consulting is a leading, national healthcare consulting firm and software developer that partners with healthcare organizations to streamline operations, improve revenue and enhance technology to drive success in an evolving landscape. To learn how Hayes can help you, call 617-559-0404 or email *requestconsultant@hayesmanagement.com*.

Sources

[1] *Accountable Care Organizations in Medicare and the Private Sector: A Status Update*, by Robert A. Berenson & Rachel Burton, The Urban Institute, November 2011

[2] *President Obama Signs SGR Repeal Legislation, Shifting Medicare Physician Payment Incentives*, by Mark Hagland, Healthcare Informatics, April 17, 2015

[3] *Accountable Care Organizations in Medicare and the Private Sector: A Status Update*, by Robert A. Berenson & Rachel Burton, The Urban Institute, November 2011

[4] *Accountable Care Organizations in Medicare and the Private Sector: A Status Update*, by Robert A. Berenson & Rachel Burton, The Urban Institute, November 2011

[5] *Accountable Care Organizations in Medicare and the Private Sector: A Status Update*, by Robert A. Berenson & Rachel Burton, The Urban Institute, November 2011

[6] *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, HHS Press Release*, January 26, 2015

[7] *President Obama Signs SGR Repeal Legislation, Shifting Medicare Physician Payment Incentives*, by Mark Hagland, Healthcare Informatics, April 17, 2015

[8] *Strategic Cost Control: True Cost, Process Redesign, and IT Integration, HealthLeaders Media*, June 2015.

[9] *Marshfield Clinic: Demonstrating the Potential of Accountable Care*, by Sarah Klein, Douglas McCarthy, and Alexander Cohen, The Commonwealth Fund, October2014