Prepare for change: Align with the needs of the market to benefit from value-based reimbursement
Health care in the United States is undergoing a fundamental change, altering the provider payment structure from one that rewards volume of services performed to one that rewards value of care delivered. Forward-looking physician organizations, hospitals and payers are exploring innovative ways to reform the way they deliver care and the business models under which they operate.

In this dynamic environment, health care providers are being challenged to take on more clinical and financial risk even as they continue to find ways to maximize the fee-for-service payment structure. Providers are at different points along this journey, requiring a carefully crafted balancing act of strategic priorities. But their end-goal is the same: to transform their business model through innovation, partnerships and transparency to ensure long-term financial viability.

As providers try to determine what their transition from fee-for-service to fee-for-value should look like, there are certain aspects for which they need to plan. This white paper will examine how, by taking a structured approach to transforming their provider networks and care delivery models, providers can achieve not only the Triple Aim goals of better health, controlled costs and satisfied patients, but also truly advance from providing care to managing population health.
Create the blueprint for a new care delivery model

How do you maximize the fee-for-service payment structure while planning for fee-for-value?

Most organizations start with optimizing their performance within clinical and revenue cycle workflows to the point where they can reduce costs and leverage the incremental gains to invest in value-based strategies. By redesigning clinical operations and revenue workflows, they have the enhanced ability to adhere to public and private mandates, maximize performance under DRG payments and capitalize on performance-based incentives.

Once they’re well into optimizing their performance process, providers can begin their blueprint of a care delivery model that matches the needs of fee-for-value, taking into consideration external market forces, financial impacts, provider networks and internal care delivery and infrastructure capabilities. By creating such a blueprint, providers exert greater control over how their patient care and business evolves.

“Large fee-for-service-based provider organizations can’t just flip on a light switch and all of sudden become efficient at population health management,” said Daniel Rosenthal, president of UnitedHealthcare Networks. “They have infrastructure to maintain and they use fee-for-service-based operating metrics that are hardwired into their system. It takes time to transform from a fee-for-service system to a population management-based system, which is why providers need a solid plan and a partner that will collaborate and support their transition to a value-based care delivery and payment model.”

Organizations should examine their current and future position in the market in terms of physician alignment, payer contracting and population care needs.

The following planning framework can help organizations focus their efforts on critical workstreams:

<table>
<thead>
<tr>
<th>Identify Market Dynamics</th>
<th>Conduct A Financial Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess The Organization’s Provider Network</td>
<td>Define The Needs of the Attributed Population</td>
</tr>
</tbody>
</table>
Determine your market dynamics

The first step in preparing for change is to understand the external and internal market dynamics that impact an organization’s pace of change. Ted Schwab, a partner at Strategy&, a member of the PwC network of consulting firms, said organizations should tailor their value-based care delivery model based on the key market driver. Schwab suggests leveraging the market drivers as key input into modeling scenarios that take a market-wide, population-centric view.

The external market factors that impact the pace of change include:

The speed at which the market will change.

A key factor in market speed is who is driving the change. Is it an insurance company, a hospital system or a physician group? What percentage of their business are they driving to value-based care, what kind of clinical models are they using to manage risk, and what kind of partnerships are they looking to create?

The growth changes in populations.

Examining the shifts in populations will significantly impact the provider networks and care models in which organizations’ invest. A population needs to be evaluated to determine shifts in demographics, including age, gender and socioeconomic status.

Health coverage shifts.

The Affordable Care Act provisions that became effective in 2014 are impacting both the private and public markets. The private markets are impacting how individuals and small groups buy health insurance, as well as the kind of health plans companies offer. A growing number of high-deductible health plans are becoming available to individuals looking for low-cost products. Subsidies offered through the public market are shifting the uninsured and underinsured to public exchanges. Meanwhile, Medicare is driving populations to accountable care organizations and Medicare Advantage plans to manage costs.

Population and market care needs.

Because of the Affordable Care Act, organizations’ risk pools have also changed, with a larger number of sicker, higher-risk individuals among the mix. “Expect to see a proliferation of population health management programs in the next five years,” Schwab said.

“In Denver, Colorado, where the population is younger and healthier, you’ve got wellness programs everywhere. You’ve got broad networks everywhere,” Schwab said. “In the Northeast, where there is a growing Medicare population, you have extensivist programs, you have polychronic management programs — and they’re targeting specific demographics.”

In addition to examining external market factors, organizations also need to look inward and examine their internal capabilities, including whether they have the three most important in place: data analytics capability, care management infrastructure and a system for internal compensation.

“[Providers] still think they can get a claims report that is at best 90 days old and make real-time decisions — and obviously, you cannot,” Schwab said. Real-time evaluation of risk, utilization and outcomes instead requires capturing clinical information from the
electronic health record (EHR) and continually stratifying the population’s risk.

Once data analytics are in place, he said, the next step is to understand the organization’s current care management infrastructure to provide insights into investment needs. Many organizations reallocate clinical staff to perform care management capabilities — but the skills that make a discharge planner successful may not translate to effective population management. In addition, many organizations are shocked to realize that the EHR is not a care management system, but rather a static health record.

Organizations also need to reevaluate their current provider network and compensation structure. A value-based provider network focuses on population management through the use of primary care physicians, while a fee-for-service network management model focuses on maximizing high-cost specialty services.

As part of evaluating the provider network, organizations need to develop a system for rewarding providers who deliver not on productivity, but rather clinical outcomes. “If you’re going to go to a value-based contract and you’re going to continue to reward hospitals and doctors on a fee-for-service arrangement, you’re going to lose your shirt on the value-based contract,” he said. “You’ve got to reward yourself internally just like the market is rewarding you externally.”

**Conduct a financial impact assessment**

As the industry demands change and the market dynamics shift, the current fee-for-service business model is driven to fee-for-value care delivery and reimbursement models. Moving to fee-for-value creates significant financial risk for organizations if they are not prepared to systematically change the way they do business. Value-based care is derived from reducing the total cost of delivery for the patient and the population through patient attribution and risk adoption. The financial implications of shifting to value-based care affects revenue sources, profit drivers and profit centers that catalyze fundamental change in the operating economics.

Conducting a financial impact assessment in the context of internal and external market drivers will help organizations determine the pace of change and impact to their bottom lines. These changes will have significant financial and economic implications that providers will need to better understand, forecast and manage.

**This assessment should determine:**

- The effect of converting commercial, Medicare and Medicaid contracts to bonus structures or risk, as well as the appropriate timing.
- How and when to implement care management programs to reduce unnecessary utilization.
- The investment required for population health management, including infrastructure and resources.
As organizations evaluate the financial impact of moving from volume to value, they will need to determine how to make up the revenue differences during their delivery model transformation. The emergence of population health management will lead to an emphasis on preventive-focused primary care. Utilization of higher-cost acute facilities and specialist physicians will be de-emphasized, leading to lower revenues and compressed profitability. Organizations will need to increase their market share or capture a greater share of services for the attributed patients to compensate for the utilization decrease.

Through the use of the defined internal and external market forces, organizations need to develop financial scenarios that balance and sequence changes. “A large percentage of the provider community understands that fee-for-service is moving to fee-for-value and that they have to manage their patient population more efficiently to be successful,” UnitedHealthcare’s Rosenthal said. “They also know that they need to make the transition strategically, bridging their current operations to a point where they are comfortable and efficient at managing population health. The changeover does not happen overnight.”

“However, providers must all keep in mind that the competitive market place is not going to sit still while health care transformation unfolds,” he said. While some providers may be focused on a fee-for-service-based market share strategy, other more nimble population health-based provider groups may choose the specialties and facilities with which they’ll work, giving them a competitive advantage as the industry transforms.

Define the needs of your population

Organizations need to define the population health needs of their market segments, and identify the associated care delivery and care management models to ensure they deliver on the value-based contracts. Understanding the needs of each market allows an organization to define macro level strategies and associated micro level processes. For example, while chronic obstructive pulmonary disease (COPD) clinical protocols are the same, how and where providers engage an individual will be different based on the market.

Joan Kim, managing director of health care services for L.E.K. Consulting, said that data analytics play an important role in stratifying populations by risk and helping organizations identify their needs from a resource perspective. At the same time, however, there is no substitute for the clinical judgment of the “eyes and ears” of providers and support staff.

“Even if your analytics are right, and your stratification is actually pretty sound, the execution on what you do with them matters more than any of that,” she said. “I think the pendulum is sort of swinging back to, ‘How do we get the eyes and ears more involved?’ At the end of the day, your best claims analytics are only going to tell you about the train wrecks after they’ve already wrecked and the claims have come through.”

Good care coordination is dependent on real-time detection of a patient’s health issues before they become more serious and lead to a hospital stay. But providers can face a number of structural barriers to being able to have a holistic view of populations, including a lack of care management and administrative support. “Accommodating these new, more holistic integrated approaches will continue to be a challenge,” Kim said.
UnitedHealthcare’s Rosenthal said provider groups that are the most successful in value-based contracts have data systems that allow them to see the full scope of the populations’ health care.

“They do outreach into the community that goes beyond traditional delivery systems and includes senior centers, community centers, and other community-based organizations,” he said. “So they’re satisfying more of the whole person using proactive population health management compared to the traditional fee-for-service-based health care provider model where patients seek care for individual health incidents.”

John Iacuone, chief clinical officer for Vantage Cancer Care Network, said anticipating and addressing cancer patients’ needs is a high priority. Over the next 20 years, the number of new cancer cases diagnosed annually in the United States will increase by 45 percent, from 1.6 million in 2010 to 2.3 million in 2030. This includes an anticipated dramatic spike in incidence among the elderly and minority populations, according to research from The University of Texas M.D. Anderson Cancer Center.

“Cancer is no different than what you have with COPD, diabetes, congestive heart failure (CHF) — the data is out there that if you have a chronic disease like that, the odds of you having comorbid depression is significantly high,” he said. “One of the big areas that has to do with cost is patient management of pain, depression, fatigue — things like that. Clearly from a care management standpoint, it would be high priority to do those types of assessments to manage the global cancer care program.”

Assess your provider network and care management resources

Armed with a better understanding of the financial impact of the transition to value-based care and their populations’ health needs, organizations will need to assess their provider network and the care management resources needed to ensure they have the optimal mix of primary care providers and specialists.

New physician business structures need to be evaluated, including clinically integrated networks (CIN), independent practice associations (IPA), and the employed versus non-employed model. Organizations that already have a large provider network may need to distinguish between their high- and low-performing physicians.

For Vantage Cancer Care Network, for example, this has meant approaching clinical integration through the creation of specialty IPA-type arrangements that include not only medical and radiation oncology, but also urology, thoracic, OB-GYN and other specialties involved in the different kinds of cancers being treated. “We will employ doctors when it makes sense in certain market places,” said Ben Slocum, president of Vantage Cancer Care Network. The IPA-type arrangements, he noted, have the greatest chance of success when there are enough independent oncologists in the market place to create a robust network.

“A key feature of the Vantage Cancer Care Network is a quality committee that continually reviews value-based utilization from medical oncology, radiation oncology and palliative care perspectives, for example, and assesses whether its network members are providing the best care at the lowest cost,” Iacuone said.
“This is not just a federation of groups doing their own thing, or this won’t work,” he said. “This is as disciplined as any university or large health system, if not more because these people are going to be incentivized to work on quality metrics because that’s how they’re paid.”

A clinically integrated network like Vantage Cancer Care Network is attractive to providers because it allows them to have access to more resources while still maintaining their independence.

“That’s the secret sauce that I think VCCN brings,” Iacuone said. “It allows these community doctors to have the financial backing and tools to be able to stay independent. Otherwise, they have to go into a large hospital system to be able to get the software and tools they need.”

The assessment should evaluate the recruitment of primary care providers, nurse practitioners and other care extenders — such as social workers, care managers, pharmacists and dieticians — who are needed to support the new value-based business model.

Marty Manning, president of Cadence Medical Partners, said his network development has been centered on developing resources around patient volume.

“If you only have so many hours in the day, you want to get the large volume and influence leaders to sign first, and then there is network adequacy to consider,” he said. “My approach is to get a sizeable portion of them — get the physicians who represent 70 to 80 percent of the volume — and start to work with them. The others will join with you so as not to be left behind.”

Once the network is in place, Manning said, the next step is to work on driving performance. But measuring performance is not done in a vacuum. Manning created a physician-led quality and performance governance team to define and evaluate performance measures, identify the interventions required and create the revenue models. As part of the process, the governance group identifies the lower-performing physicians and provides them with the tools and resources they need to improve.

Manning said providers need to be not only in the business of caring, but also of change management. In making the transition to value-based care, cultural change can be one of the biggest challenges, but it can also be one of the greatest drivers of success.

**Staging the transformation**

Carefully sequencing the clinical transformation with the financial transformation is key to capturing the most value in your volume-to-value journey. Value transformation can be risky, requiring early investment and a carefully plotted roadmap to maintain fiscal stability. An up-front investment in transformation capabilities build-out and the necessary support personnel to transform the organization will be required. In addition, clinical transformation activities must be carefully sequenced with risk-based fee-for-value contract shifts to avoid passing all the value created on to the payer.
Clinical transformation focuses on defining the appropriate structures, care delivery models and care management models that will redefine how care is delivered in a patient-centric way.

The goal of clinical transformation should include:

- Development of a system-wide population health management organization model that standardizes roles, responsibilities, measurements and incentives for all employees to support population health.

- Identification of population risk and the associated opportunity assessment. As populations and individuals are risk-stratified, different care models can be applied to ensure improved outcomes, improved patient satisfaction and lower utilization.

- Development of clinical models to manage population risk, including patient-centered medical home (PCMH) to improve care and manage population segments.

- Operationalize clinical models across physician practices and hospitals to drive clinical integration and population health management.

Once an organization has identified its specific clinical integration model, involving physicians in every level of the care delivery transformation process is key. This includes creating a governance structure that both engages physicians in various leadership roles and educates the physician community about population-focused care delivery models.

“It’s one thing to say you’re a physician-led organization, it’s another that you create an infrastructure where you’re readying those people to lead,” said Kathleen Exline, system director of performance at Norton Healthcare.

“We’re being very intentional about not only who we’re selecting and the model we’re selecting them in, but also what are the things we’re going to do to support them in their practice,” she said. “If we expect them to lead, how are we going to drive that versus just giving someone a medical directorship fee and saying, ‘We need you to come to a few meetings.’?”

Manning, of Cadence Medical Partners, a physician himself, said his group has been successful employing physicians because “this is a trusted source for them to come to hang their hats versus one of the other options out there. They trust the Cadence system, they trust the management team. They trust that the physician governance model will give them a voice as opposed to just being a cog in the wheel in some other larger system. And that’s kind of unique.”
Financial transformation, meanwhile, is centered on structuring physician incentives to engage, drive and reward behavior that optimizes population health performance. Once an organization develops the strategies and steps required to move from a productivity-based model to a population-health incentives model, it will need to provide physicians with information on their performance — including comparisons with other physicians. This information shows physicians how their actions impact care quality and financial health, and how they benefit from managing toward healthy outcomes.

Organizations will also need to define a path toward converting existing payer contracts to value-based models based on their ability to accept risk. The organizations’ clinical transformation will be self-defeating without a corresponding set of payer contracting initiatives that drive value from increases in quality and reductions in cost of care. These initiatives must be carefully coordinated with clinical transformation to ensure the revenue model matches its clinical operating model.

It is important for an organization's clinical and financial transformation to occur sequentially, as the financial transformation ensures that physician and care team incentives are based on managing care, not productivity. It also ensures payer contracts are executed based on the ability of the organization. Once organizations start down the path of value-based transformation, these two areas must be aligned to create and capture the value of the investments.

If clinical alignment moves faster than financial alignment, the value created by the organization is accrued by the payer, not the provider. If financial alignment moves faster than clinical alignment, the organization will fail to meet its savings targets, resulting in lower-than-expected returns on risk contracts.

**Guiding the clinical transformation**

Because of the scope of change, executing on clinical transformation is the most challenging part of the journey to value-based care. Clinical transformation must happen across all systems of care, all functions and departments, and all organizations.

Exline, of Norton Healthcare, said her system distinguishes between hospital practice and outpatient care, and the approach to clinical transformation in each area is different.

“I think in the hospital what I’ve seen is really striving to be centers of excellence and saying, ‘What are really high quality programs?’” she said. “So whether that’s a certification program, or whether that is us participating in measures within our payer world that says we have to hit certain objectives in the hospital environment, I think that’s really how I see us structuring that transformation. I think it’s very rigorous, and in cases where it’s not rigorous, that poses challenges for us.”

In the area of outpatient care, Exline said there is a strong emphasis on restructuring medical practices around the patient centered medical home concept. Whereas in the fee-for-service environment physicians were focused on patient volumes, the focus is now on managing population health as a team.
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Organizations that have been successful use four guiding principles to facilitate the clinical transformation:

| IDENTIFY | Take a structured approach to identifying, stratifying and prioritizing clinical interventions that meet the Triple Aim of better care, better health and lower costs. |
| ENSURE   | As they transform, organizations need to take a multi-disciplinary team approach that delivers care from a vertical (best practice within the care delivery) and horizontal (integration across the system of care) perspective of care delivery. |
| REDESIGN | A one-size-fits-all approach to care delivery doesn’t work. Organizations must understand the needs of the population and stratify the population to define and implement care delivery models that address the needs of the local market and their segment. |
| PLAN     | Organizations that take a structured approach and plan the transformation from care delivery, physician engagement and capabilities enhancement are successful in clinical transformation. |

The end result of taking a structured approach is that the organization is aligned from a decision-making and execution perspective.

**Position your organization for success**

Your organization can maximize the value of the fee-for-service world of today at the same time it transitions to the fee-for-value world of tomorrow. By taking a structured approach to the transformation of your care delivery model, your organization will be well positioned to thrive as it makes the journey from providing care to managing health.
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