

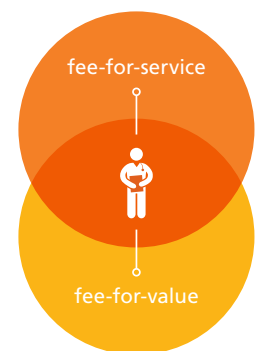
Mapping the journey to value-based care



Success in today's ever-changing health care market requires providers to have a foot in two worlds: the fee-for-service world of today and the fee-for-value world of tomorrow. By strategically positioning themselves to take on more clinical and financial risk — even as they continue to find ways to maximize the fee-for-service payment structure — providers will be able to better control the ways in which their organization transforms.

This paper will examine how providers can map the right strategy for making the journey to value-based care by:

- **Optimizing performance** to align clinical and revenue cycle workflows for faster and more accurate payment
- **Preparing for change** by redesigning care delivery models to benefit from outcomes-based reimbursement
- **Investing new capital** to transform the quality and effectiveness of the care provided to patients



Success in today's ever-changing health care market requires providers to have a foot in two worlds: the fee-for-service world of today and the fee-for-value world of tomorrow.

Optimize performance

For decades, patients have been shielded from the true cost of care. But as patients are being required to shoulder more of the health care cost burden, they are also behaving more like consumers: shopping for the best deal, questioning advice and haggling over prices.¹ The average patient is no longer a passive object; rather, she is becoming an active participant in her care. As value is promoted in health care and cost pressures mount, providers must become more streamlined and efficient if they are to remain profitable.

In addition to the challenges of consumerism, health care providers today face challenges as they work to maintain financial sustainability. Costs continue to increase, reimbursements continue to drop and the government continues to add regulations on top of regulations.

As providers navigate the journey from providing care to managing health, provider leaders are exploring creative ways to optimize performance across patient access, coding and documentation, and reimbursement.

Administrative inefficiencies are a major strain on the health care system. Today, hospitals and physician practices spend \$24 billion on technology and labor to manage their revenue cycle.² Analysts anticipate higher growth in such spending due to changes in reimbursement models and government mandates such as ICD-10.

With consumers seeking greater value and a better care experience, these new cost pressures are moving providers to implement tools that will better manage their administrative processes and reduce inefficiencies. The end goal: to allow their clinicians to focus more on providing quality, patient-centered care.

ICD-10 coding and documentation requirements

In 2015, the transition to ICD-10 is projected to increase denials as providers struggle to adopt a new, more specific set of diagnosis and procedure codes. These codes will have an impact on every component of the revenue cycle. Physicians will need to change the way they document to support admission and level-of-care decisions. Health information management (HIM) professionals will need to change the way they select codes to align with the clinical intent of care providers. Patient financial services will need to ensure that claims reconcile to a patient's episode of care and to payer-specific requirements.

But the new codes will also pave the way for value-based care by providing richer, more comprehensive classification data.³ In addition, Optum research has shown that better coding leads to healthier outcomes,⁴ which is a must for value-based success.

Financial/clinical convergence

The transition to value-based care means assuming increased financial risk for quality outcomes. At the nexus of payer and provider processes, revenue cycle management will need to develop the appropriate tools to support quality alignment initiatives, harnessing the power of clinical and financial data to drive meaningful changes in reimbursement.

Payer scrutiny/audits

Faced with more stringent medical loss ratio (MLR) requirements and declining margins, payer organizations are giving increased attention to driving fraud, waste and abuse from the system. Medicare's Recovery Audit Contractor (RAC) program processed more than \$2.4 billion in reimbursement adjustments in 2012, and costs of medical record requests exceeded \$1 million in the second quarter of 2013, up from only \$720,000 in the fourth quarter 2012.⁵

JOURNEY TO VALUE-BASED CARE

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As the volume and specificity of information continues to increase, patients and payers will hold provider organizations accountable for their role in managing health. Providers who can manage this increasing system complexity are in a position to thrive.

Patients are taking a much more active role in managing the financial implications of their care. Enrollment in consumer-directed health plans (CDHP) continues to grow at a rate of 19 percent annually, with more than 39 million Americans now enrolled in consumer-directed plans.⁶

Cost-shifting to consumers, rising awareness of health care costs, and a variety of mobile and web-based health applications are fueling consumers' demands for transparency into prices and quality. Providers who develop strategies that acknowledge the trend toward increased transparency and consumer-driven choice will succeed.

The challenges posed by lagging efficiency, increased complexity and growing consumerism require a new financial approach. Leading providers are shifting to the next generation of revenue cycle management, which combines world-class technology and patient-centered service delivery and requires a deep expertise in health care operations.

The next generation of revenue cycle management is patient-focused. Patients and their families are primarily concerned about diagnosis, treatment and the recovery process. But financial concerns about the cost of health care can also weigh heavily. The experience that they have with health care organizations doesn't begin and end when they enter and exit the facility. For them, an episode of care begins when they decide to schedule an appointment, visit an emergency department or have outpatient surgery. It ends when they pay their final bill.

The transition to value-based care will require greater alignment between strategy, operations and service excellence initiatives. The next-generation revenue cycle is designed around this framework and includes comprehensive services coupled with next-generation technologies and analytics, all with a patient-centric vision. Adopting such an approach gives providers appropriate technology, process tools and services so the focus, at every touchpoint, is on the patient.

Next-generation revenue cycle technologies remove system complexity and boost staff productivity by enhancing legacy systems with limited data capabilities in a flexible, cost-effective manner. Next-generation revenue cycle services support and link patient-centeredness, physician workflows, hospital administration and payer transactions. Analytic tools such as natural language processing leverage data as an enabler to improve clinical and financial intelligence and drive better decision making.

Prepare for value-based care

Consumers are the ultimate reason why value-based care is taking shape the way that it is. Making patient-focused enhancements to revenue cycle management (RCM) is critical for laying a value-based foundation. Streamlining operations, optimizing technology and improving patient communication allow organizations to focus on making the clinical changes necessary to transform the way they provide care.

This transition will take careful and comprehensive consideration. Organizations can utilize the following process to help them balance the need for financial viability under fee-for-service and create a detailed roadmap to fee-for-value:

- Identify market dynamics
- Conduct a financial impact study
- Define the needs of the population
- Assess provider network

Strategic alignment around financial optimization



GOVERNANCE

RCM needs to be strategic and visible to the executive leadership team and quality leaders.



PHYSICIAN ENGAGEMENT

Value-based care requires greater integration between clinical and administrative workflows.



TECHNOLOGY ENABLEMENT

Advanced RCM technologies improve staff productivity and make revenue cycle data more useful.



PROCESS ALIGNMENT

Modern process improvement and performance-based incentives result in higher quality.



PATIENT COMMUNICATION

Communication from scheduling to payment posting builds rapport with and empowers patients.

Identify 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 key market drivers. Schwab suggests leveraging market drivers as key inputs into modeling scenarios that take a population-centric view.

"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."

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

The speed at which the market will change. A major factor in market speed is the key player that 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 kinds of clinical models are they using to manage risk, and what kinds of partnerships are they looking to create?

The growth changes in populations. Examining 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.

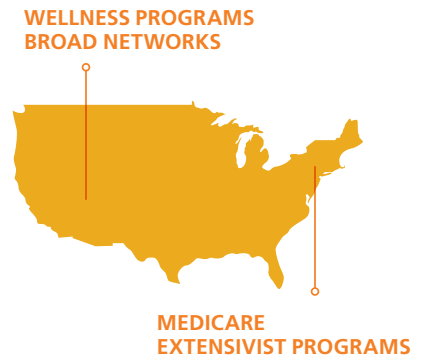
Health coverage shifts. The Affordable Care Act provisions that became effective in 2014 are impacting both the private and public markets. The private markets are impacting how individuals and small groups buy health insurance, as well as the kind of health plans companies offer. A growing number of 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 addition to examining external market factors, organizations need to look inward and examine their internal capabilities, including whether they have the three most important capabilities in place: data analytics, care management infrastructure and a system for internal compensation.

"[Some 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 and continually stratifying the population's risk.

Once comprehensive data and advanced 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, for example, a discharge planner successful may not translate to effective population management.



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Conduct a financial impact assessment

As consumers, employers and governments demand change and market dynamics shift, the current fee-for-service business model continues to yield to fee-for-value care delivery and reimbursement models. Moving to fee-for-value creates significant financial risk for organizations that are not prepared to systematically change the way they do business. Value-based care is achieved by aligning incentives among payers and providers to reduce the total cost of care delivery and capture value from patient attribution and risk adoption. The financial implications of value-based care affect 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 how it will impact 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

An important consideration in evaluating the financial impact of moving from volume to value is determining how to make up the revenue differences during delivery model transformation.

Through understanding defined internal and external market forces, organizations need to develop financial scenarios that balance and sequence changes.

“A very large percentage of this sophisticated provider community knows that the end game is going to be they have to manage the population more efficiently — they know that,” said Daniel Rosenthal, president of UnitedHealthcare Networks. “But if you’re a large provider that is transitioning into that world, you have to have a strategy that allows you to survive until you become efficient.”

To be sure, the competitive marketplace isn’t going to sit still while health care transformation unfolds, he said. While larger providers may be focused on a market share strategy, smaller, more nimble provider groups may more quickly choose the specialties and facilities with which they can align incentives and values, giving them a competitive advantage.

“If you were one of those groups right now and you were in a market where you could pick and choose, you could be very disruptive,” Rosenthal said.

Strategic alignment around delivery model change



GOVERNANCE

Clinical transformation must be governed by clinical experts.



PHYSICIAN ENGAGEMENT

Physicians will engage when incentives are aligned and quality improvement goals are shared.



PROCESS ALIGNMENT

The process of shifting from volume to value should go no faster or slower than the market dictates.

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 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.

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 — senior centers, community centers, things like that," he said. "So they're satisfying more of the whole person than the traditional health care provider who waits for people to show up at their door and manage an incident as opposed to a population."



Assess your provider network

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 (CINs), independent practice associations (IPAs) 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.

Dr. Martin 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 good chunk of them — get the physicians who represent 80 percent of the volume — and start to work with them. The others will join with you so as not to be left behind."

Such a collaboration should be based not only on volume but also on aligned goals, which will lead to properly incentivized care quality standards and will lay the foundation for a natural feedback loop. Organizations will want to measure and manage improvements as they find the right long-term balance between the needs of payers, employers and patients while promoting provider innovation around creating value.

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 revenue models. As part of the process, the governance group identifies lower-performing physicians and provides them with tools and resources they need to improve.

In addition, organizations need to re-evaluate their current provider network 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 that balances the current need for rewarding providers who deliver on productivity with the future need of rewarding providers for excellent clinical outcomes.

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— Daniel Rosenthal, President, UnitedHealthcare Networks

Stage the transformation

With a roadmap that accounts for market needs, financial impacts and provider network strategies, organizations are ready to program the milestones around which they will convert to value-based care. Carefully sequencing clinical transformation with 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 upfront 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 excessive volume/revenue cannibalization.

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 homes (PCMHs) and extensivists to improve care and manage population segments
- Operationalization of 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.

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.



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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.

Invest in managing risk

At this point in the journey from providing care to managing health, it's time to put planning into action. With capital secured, impacts assessed, market forces analyzed and transformation orchestrated, the next step is to invest. Organizations need to invest capital in the new functionality needed for financial and clinical analytics, as well as population health management.

With these capabilities, organizations can not only gain the knowledge they need to predict future risk and costs but also turn that knowledge into action and identify and engage every individual within an identified population.

Most organizations have electronic medical records (EMRs), which can provide strong capabilities around monitoring and reporting. Providers can record and keep information on a patient such as vital signs, diagnoses and lab results. It is, at its most basic level, an electronic filing cabinet for medical records. EMRs can also provide lists for reporting purposes, such as which patients with diabetes haven't had their annual foot examination.

But EMRs don't provide insights. To be able to move from a transactional model of care to answering the questions necessary for population health, additional capabilities are needed to truly turn risk into opportunity.

This requires enabling technology that adds value to both a fee-for-service and a fee-for-value world — technology that is capable of analysis, stratification and prediction.

- **Analysis:** Take a population or a subset of a population and provide longitudinal analysis of cost and utilization trends by diagnosis; drill into or stratify the cost, utilization and diagnosis analysis for opportunities to engage
- **Stratification:** See if high utilizers or high cost drivers coalesce by some demographic to find opportunities to engage that segment to improve cost, quality and/or satisfaction
- **Prediction:** Take a stratification and add an element of prediction, finding the high-cost patients over the next six, 12 or 18 months; for example, who are the congestive heart failure patients who are on a trend to visit the ER?

Having the ability to analyze, stratify and predict gives providers the insights they need at the point of care to actually manage populations. But without the right type of data, these capabilities won't uncover all the opportunities for improving population health.

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Actionable information begins with the right data. While an EMR is an important first step toward capturing clinical data, it is just one piece of the puzzle. Providers should combine predictive and comparative analytics with the right types of data that drive them toward the answers they need. This includes:

- **Claims data:** Most often obtained from payers or medical or pharmacy benefit managers
- **Clinical data:** Found within EMRs, biometric feeds, lab feeds, pharmacy feeds or health assessments
- **Socio-demographic and care management data:** May come from hospital notice of discharge, admission, ER visit or skilled nursing facility transfer

By having all three types of data, providers will have more powerful information to which they can apply analytics, and from which they can glean a more effective basis for prediction of future medical outcomes and costs.

Layering predictive analytics over the best data provides organizations with the most comprehensive knowledge at a population level. The next step is to take action on that knowledge to make a difference in patient health through population health management.

Population health management platforms are knowledge platforms that allow providers to apply analytic knowledge to the populations and patients they have identified. There are four basic steps to applying that knowledge and achieving population health management.

1. **Optimize the provider network.** In value-based environments, providers are incentivized to refer patients to specialists who not only provide great service and quality care but also use proven treatments and cost-effective care. Provider organizations need to ensure that their referral network is clinically effective and financially efficient.
2. **Manage care transitions.** Focusing on seamless transitions when patients move in and out of inpatient, emergency and skilled nursing facilities is critical to value-based success. Proactive, post-discharge outreach through readmission prevention or chronic and complex case management programs for patients can drive down future costs and penalties.
3. **Invest in interventions in the high-acuity, post-acute population.** Provider organizations can reduce average admissions through in-home care management by nurse practitioners. Using predictive modeling along with claims and clinical data (including lab and pharmacy data), providers can identify patients with a high likelihood of an admission or a readmission.
4. **Expand disease management to the full, attributable population.** Providers can make a difference by expanding disease management into appropriate interventions for patients before they become acutely ill.

By applying valuable data to expert-level predictions, organizations have the insight to predict at a population level and pinpoint opportunities to prevent at a patient level.

Strategic alignment around investing in value



GOVERNANCE

Investment must line up with overall strategy and leverage current systems.



PHYSICIAN ENGAGEMENT

When physicians trust data and related proof points, they become motivated to improve.



TECHNOLOGY ENABLEMENT

Data and analytic tools enable population health management and value-based care delivery.



PROCESS ALIGNMENT

Data-based analysis needs to be integrated into as many clinical and financial processes as possible.



PATIENT COMMUNICATION

Focus patient communication efforts around clinical and predictive analytics.

Financial, clinical and resource preparation is the key to fee-for-value success

It may be tempting to consider the shift to fee-for-value to be a partisan effort. Some may wonder if shifts in political power will change the direction in which the industry is headed. But while the Affordable Care Act of 2010 certainly increased the momentum toward risk contracting,⁷ private risk contracting programs have been in place for decades.⁸ Consumers and employers are demanding that quality improve and that costs decline, and most stakeholders agree that these aims can be accomplished by incentivizing quality. Regardless of who is in power in Washington, the industry is moving toward value-based care.

Providers must be prepared. When providers optimize financial performance by aggressive cost take-away and revenue cycle optimization, they prepare themselves economically. When they carefully plan for fee-for-value by accounting for all market forces, population health needs, financial impacts and provider network complexities, they will have a custom roadmap to guide their particular value-based journey. And when they invest in advanced clinical and financial analytics and population health capabilities, they will have the tools they need for long-term success in value-based care.

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Contact us:

Call: 1-800-765-6619

Email: discover@optum.com

www.optum.com



11000 Optum Circle, Eden Prairie, MN 55344

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