



Digital Operations

How Providers Can Reshape their Operations to Master Value-Based Reimbursements

Healthcare providers must make sweeping system, process and operational changes to thrive under the inevitable move to value-based payments. Here are our recommendations on how to get started.

Executive Summary

The healthcare industry's transition to value-based payments has been slow but steady; inevitably, this new compensation approach will supplant existing fee-for-service models. The Centers for Medicare & Medicaid Services (CMS) has set a target of making 50% of its reimbursements through value-based care programs by the end of 2018.¹

The transition is being hastened by the entry of new healthcare players and increased consumer financial

accountability, both of which are serving to disrupt and compress the healthcare value chain, and pressuring providers to adopt value-based reimbursement.

Yet adopting value-based payments is challenging for providers because their clinical and financial systems, processes and quality metrics were built to support the industry's traditional fee-for-service model. Providers moving to a value-based world must retool systems and gain new skills and capabilities, as industry players and

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regulators settle on universally acceptable quality metrics that are consumer-driven. Accomplishing these formidable tasks will reshape not just how providers deliver care but also how the entire industry determines the value of patient outcomes.

Providers must start investing in value-based care capabilities to remain relevant as industry disruption continues. Simultaneously, they must continue optimizing revenue cycle management,

enhancing quality of care and enabling greater patient accountability for success as the industry mixes fee-for-service and value-based care.

This white paper discusses the forces making the shift to value-based payments inevitable, the challenges providers must overcome and how they can realistically improve their readiness to operate in a value-driven health industry.

Value-based reimbursements: ready or not, they're coming

Most of healthcare is still delivered on a fee-for-service basis, with every provider, lab, specialist and clinical service appearing as a separate line item on the insurer's explanation of benefits. Underlying provider-payer contracts determine actual reimbursements for services rendered, making it difficult-to-impossible for patients to get clear answers upfront about their ultimate financial responsibility, let alone comparison-shop for services.

Yet the industry is steadily moving toward a consumer-driven value chain, one in which technological advances, ubiquitous smart devices, wearables and the Internet of Things (IoT) enable

more care to be delivered directly to consumers via on-demand healthcare platforms that enable patients to pick and choose their medical providers based on price and value.²

In a consumer-centric industry, pricing transparency is critical,³ and quality will be measured in outcomes – specifically, outcomes important to consumers and patients. Our recent study, conducted with our partner ReD Associates, shows that consumers and patients use different approaches to measuring provider quality from the clinical numbers and procedural measures that drive typical provider quality metrics (see Quick Take, see next page).⁴

Quick Take

Quality outcomes from the patient's perspective

Under value-based care, patients will have louder voices on whether a provider has delivered quality care and an outcome that meets their expectations and needs. While meaningful clinical metrics, rigorously followed protocols and high adherence rates are standard quality metrics for providers, these are not likely to be of greatest concern to patients.

That's a key finding of our recent study, conducted with our partner ReD Associates.⁵ This ethnographic field study, supported by a large quantitative phone survey, indicates that more than 85% of patients don't find quantifiable clinical numbers to be very relevant to their healing journeys. Further, many respondents said that even while they closely follow a treatment plan, they don't feel as though they're healing.

The leading indicator that patients use to evaluate their healing experience is whether they can do what's important to them. Our research showed patients judge the quality of their healing by how well they can carry out their life goals, from playing soccer to visiting their grandchildren. We also found that patients go to great lengths to manage their care, in their own way, to achieve these personal goals. Patients experiment with medication dosages and timings, seek advice from peers, and generally work to fit their care into their existing lifestyles.

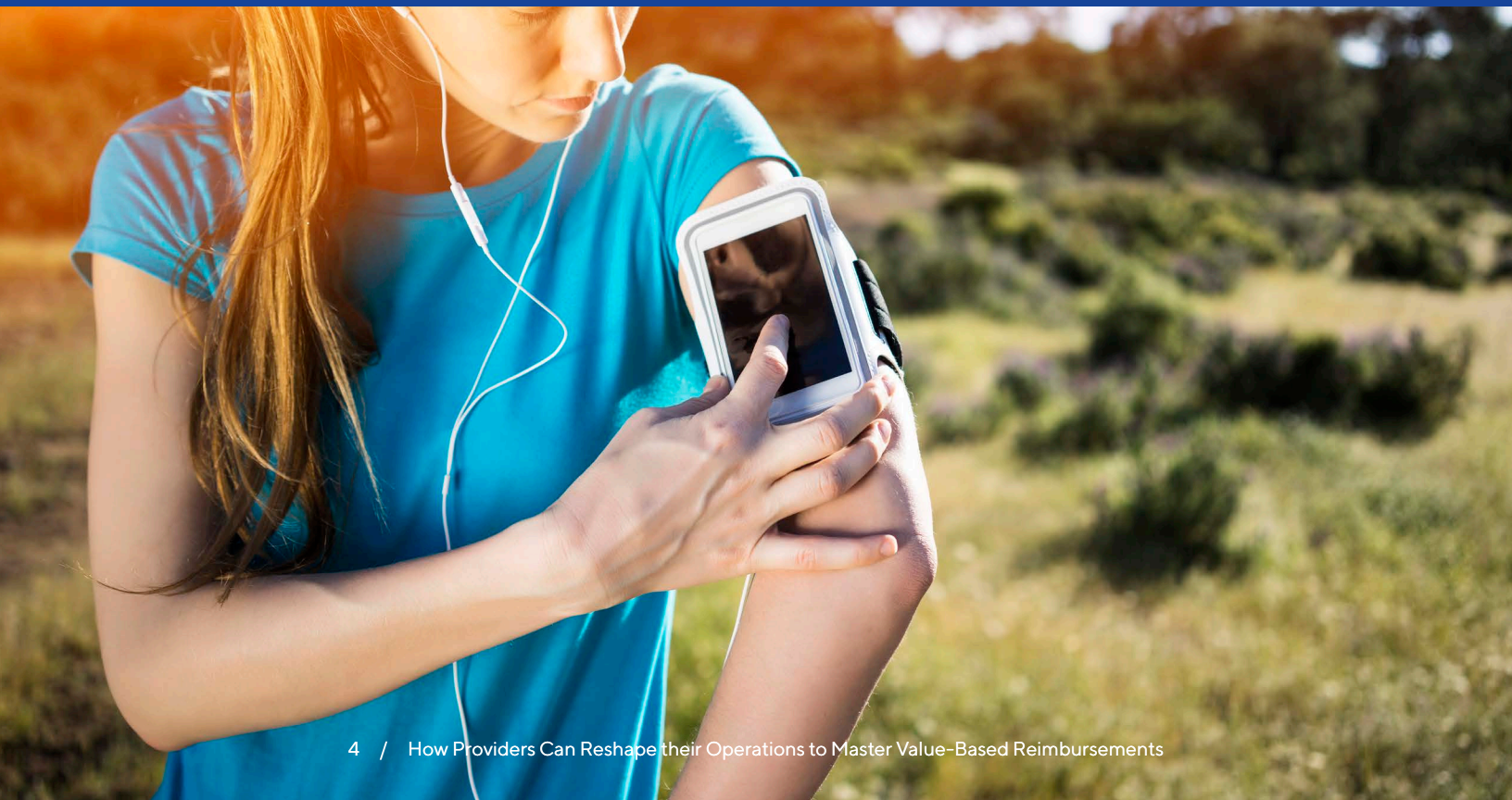
To earn high marks under this patient-centric quality measure, providers must:

- I **Help patients establish and track meaningful life goals.** By correlating patient goals with underlying clinical metrics, providers gather useful data while supporting patient efforts.

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- I **Guide patients through their treatment protocols.** Providers must help patients adapt therapies to their needs rather than promoting one-size-fits-all patient treatment journeys.
- I **Provide personalized, context-based follow-up care.** Such care must empower patients to make their own decisions based on their lifestyles, support systems, goals and resources.

Aligning value-based care with patient-defined metrics is a win for all. Our study indicates that patients who feel they are at the center of their care are more likely to adopt healthier behaviors. When properly designed, digital tools can “warm up” healthcare delivery by giving patients real choices and more personal control. These qualities should encourage behaviors that can lead to better outcomes – the key goal of value-based care.



CMS: driving value-based payment programs

Federal legislation has been prodding the industry to move toward value-based programs for nearly a decade. These regulatory efforts are laying the groundwork for wider adoption of value-based reimbursements by private payers.

	2008	2010	2012	2014	2015	2018	2019
LEGISLATION PASSED	MIPPA	ACA		PAMA	MACRA		
PROGRAMS IMPLEMENTED			ESRD-QIP HVBP HRRP	HACRP	VM	SNF-VBP	*APMs *MIPS

LEGISLATION & PROGRAM

- MIPPA:** Medicare Improvements for Patients & Providers Act
- ESRD-QIP:** End-Stage Renal Disease Quality Incentive Program
- ACA:** Affordable Care Act
- HVBP:** Hospital Value-Based Purchasing Program
- HRRP:** Hospital Readmission Reduction Program
- HACRP:** Hospital-Acquired Condition Reduction Program
- VM:** Value Modifier or Physician Value Based Modifier (PVBM)

LEGISLATION & PROGRAM

- PAMA:** Protecting Access to Medicare Act
- SNF-VBP:** Skilled Nursing Facility Value-Based Purchasing Program
- MACRA:** Medicare Access & CHIP Reauthorization Act of 2015
- APMs:** Alternative Payment Methods
- MIPS:** Merit-Based Incentive Payment System

*Data collection for APM and MIPS began in 2018.

Source: CMS, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html>.

Figure 1

Basing reimbursements on outcomes will require providers – and the industry – to adopt new definitions of quality and ways of measuring it; new financial systems and techniques that support value-based financial modeling; and a new approach to care delivery that is based on wellness, continuous monitoring and preventive, proactive interventions for an entire population vs. managing only those chronically at risk.

The grand vision is clear, and the federal government has adopted legislation and regulations to create incentives for providers to shift toward value-based payments (see Figure 1). Yet progress has generally been slow.

In a nationwide survey of 346 hospital executives, only 14.1% of respondents said their payments were currently tied to value as defined by CMS and that just under 7% of their revenue was truly at risk. Participation in value-based payment

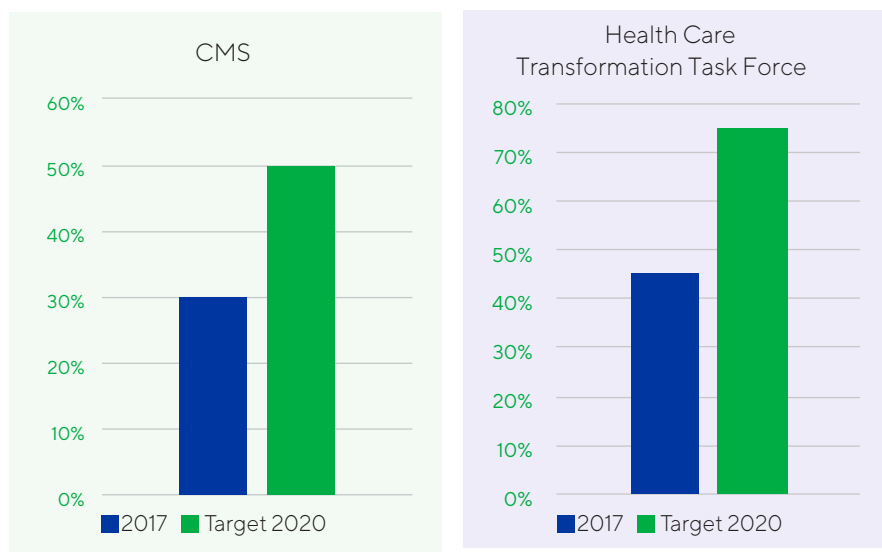
programs was highest in the largest hospitals (200-plus beds).⁶

Regardless of provider participation, market forces are steadily pushing value-based care adoption (see Figure 2, next page). That's reflected in value-based care reimbursement percentages reported by two of the nation's largest private payers in 2017: United Healthcare Group, with 45%, and Aetna, with 40%.⁷

Further, new entrants like the proposed Amazon-Berkshire Hathaway-Chase healthcare entity,⁸ the planned acquisition of Express Scripts by Cigna⁹ and the partnership talks between Walmart and Humana¹⁰ are ultimately about gaining control of the care delivery process, driving down costs and improving the customer experience. Providers that want to remain competitive in the rapidly evolving healthcare economy must deal now with the demands of adopting value-based care.

Public and private payers vow to increase adoption of value-based programs

CMS and the Health Care Transformation Task Force (made up of payers, providers and other industry stakeholders) plan to increase payments through value-based programs.



Sources: CMS.gov (<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html>) and Healthcare Transformation Task Force (<https://hcttf.org/about-us/>).

Figure 2

A challenging transition

Value-based payments can't simply be overlaid on existing operational infrastructure and business processes. Successful adoption that captures real value will require providers to restructure their business, operating and technology models. This raises four primary challenges:¹¹

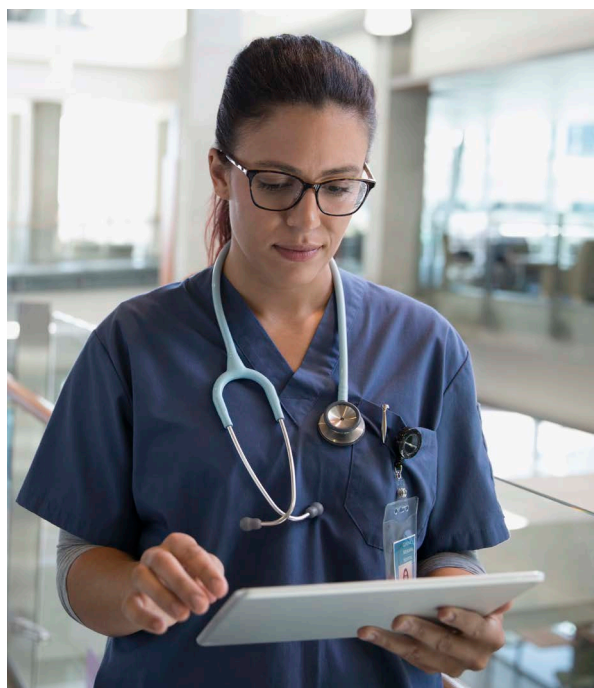
- I **Infrastructure and technology.** Electronic health record (EHR) rollouts have consumed a large share of investment resources so far; investments must now be redirected to new system-wide patient care and financial capabilities rather than restricted, uncoordinated, departmental implementations. Providers must expedite their efforts to fill care management roles despite the difficulty of finding people experienced in value-based care delivery.
- I **Business operations and personnel.** Population health management under value-based care requires a significant investment in workforce and tools; the challenge here is that payer metrics and incentives are not uniform across the industry, making it difficult for providers to know where to focus their resources for the greatest gain. In addition, while value-based care is all about quality metrics, many physicians find quality reporting to be burdensome. Providers need to adopt new and seamless reporting experiences for clinicians to ensure they capture critical data at the point-of-care that enable the reporting and analytics required for value-based reimbursement.
- I **Performance measurement.** In part because of the lack of industry consensus, providers

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are finding it difficult to define quality metrics. Most providers are also not yet adept at crunching claims and operational data to better model and understand the financial risk they would assume under value-based care. In addition, current hospital cost accounting capabilities can't accurately determine actual costs of care (vs. reimbursable amounts), a key variable in succeeding with value-based contracts. Finally, only 5% to 10% of physician pay is tied to value;¹² it is possible physicians will take on more risk if rewards are bigger.

Market forces. Payer contracting varies by market and payer type, i.e., commercial, federal or state. The inconsistencies make it difficult for providers to develop an overarching value-based strategy and achieve a critical mass of patients in each of the value-based programs.

Internally, most providers encounter cultural as well as process difficulties when trying to better coordinate care across a variety of



provider settings. Extensive training and change management programs are needed to address these issues.

Current hospital cost accounting capabilities can't accurately determine actual costs of care (vs. reimbursable amounts), a key variable in succeeding with value-based contracts.

The roadmap to value-based payment

Despite these challenges, three key levers will increase providers' ability to deliver quality (as desired by patients), reduce costs and improve performance.

I **New lower-cost, higher-tech medical**

interventions: Patient monitoring will shift from impersonal, episodic and chronic condition-based to a personalized, continuous and noninvasive paradigm through wearables, apps, smart devices, in-home equipment and AI and intelligent machines that predict issues. Examples include alerting a patient and physician to the conditions that signal a pre-diabetic state, or markers indicating rising cholesterol levels before that shows up on a blood test. Individuals will confer with physicians and multidisciplinary teams about interventions via telemedicine and interactive apps. Such capabilities will help providers build and manage long-term relationships with a much larger population while keeping patients out of high-cost care settings.

I **Future measures of quality performance:** We expect the healthcare industry to establish at least 60% of its measures on clinical data and patient-reported outcomes within the next decade. CMS is again an industry driver: It recently announced its Meaningful Measures program, one focus of which is to measure more outcomes defined by patients.¹³ An industry move toward commonly defined outcomes will help providers know which data to capture and should enable standard solutions and tools to do so.

Capturing this data will require scalable and robust reporting frameworks and enterprise-wide analytics to proactively identify opportunities and close reporting and satisfaction gaps. To align clinical and outcome measures with payment, providers will need to integrate electronic health records with billing, cost accounting, administrative and vendor applications – a largely untested area. Paying physicians and other clinical service providers not directly employed by the provider under a value-based model could create administrative bottlenecks if systems for automated disbursement to the concerned providers (based on their individual contracts) are not aligned.

I **Future healthcare regulatory framework:**

With Medicare and Medicaid under constant financial pressure, it is likely CMS and the federal government will develop policies and programs requiring providers to take on more risk-sharing and performance penalties.¹⁴

To prepare, providers must track payer contracts and government healthcare mandates that affect their volumes and revenues, monitor their direct competitors' performance, and assess their own performance against industry benchmarks for operating margins, current ratio, best practices, etc.

To align clinical and outcome measures with payment, providers will need to integrate electronic health records with billing, cost accounting, administrative and vendor applications.

Finally, while fee-for-service business models drive consolidation among providers, value-based care models will open the door to providers partnering with – and potentially receiving investments from – nontraditional industry players.

Additional steps to prepare for future value-based participation include:

- » Embracing consumerism, through pricing transparency, publishing clear prices for cash-pay individuals and participating in emerging on-demand health platforms.
- » Tracking physician performance and effectiveness.
- » Monitoring current and projected clinical performance measures and their impact on financial performance.

Structure and investments will change as value-based payments become the preferred industry business model. Investments in electronic health

records implementations will evolve toward implementation of population health management tools. Revenue cycle management designed for fee-for-service payments will give way to pricing transparency, mobile health platforms, patient engagement and greater consumer empowerment. Data analytics and reporting will move out of departmental silos and drive greater efficiency through leveraging cost accounting and automation.

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Next steps toward value-based payments

Providers must begin the journey toward value-based payments by extensively evaluating the maturity of their operational areas that are essential to the successful delivery of value-based care (see Figure 3, next page, and Quick Take, page 11). Providers should evaluate their capabilities and practices across these four dimensions:

Care Provision

Care provision involves population health management, patient engagement and coordination of clinical care delivery. Key assessment questions include:

- When managing a patient's care, is it a top priority to consider socioeconomic criteria and collaboration with community-based resources, such as housing organizations and social workers?
- Does easy and secure messaging exist between providers and patients?
- Is there a care transition plan with clear next steps for patients being discharged?
- Are patient education resources tailored for specific diagnoses and/or symptoms?

Evaluating maturity for value-based reimbursement

Successfully adopting value-based care requires providers to fundamentally restructure information technology, financial management and care delivery. Comprehensive change management efforts and internal leadership must support these efforts and build acceptance of new measures of success.

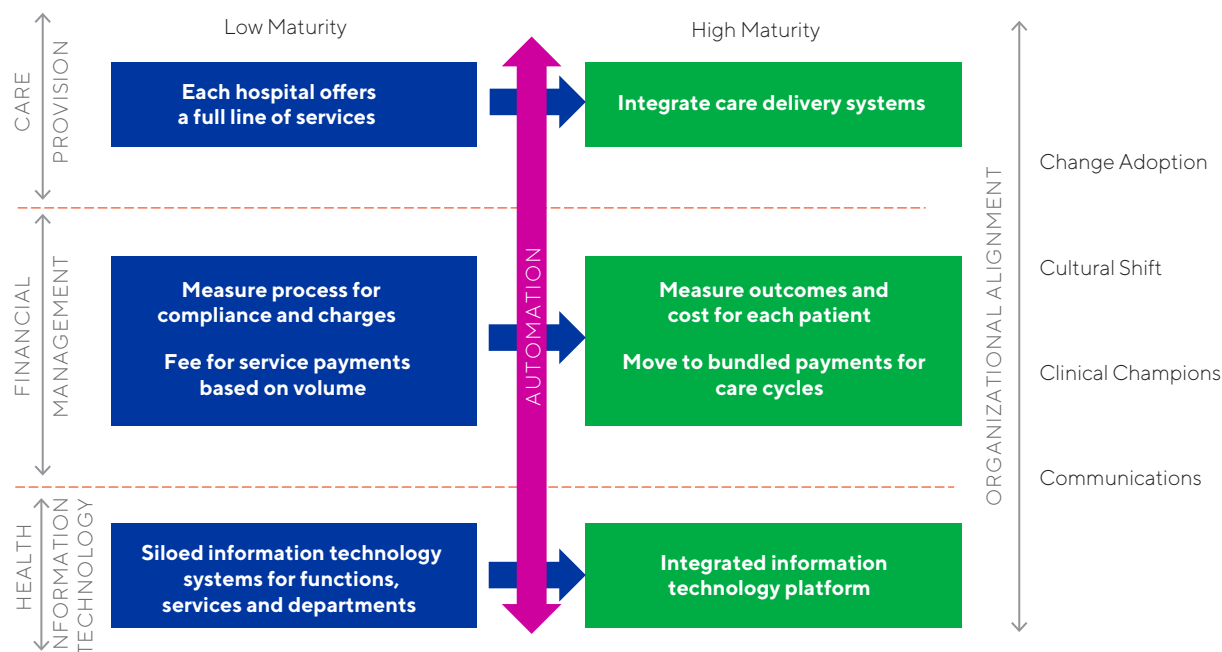


Figure 3

Financial management

Tracking and managing the cost of care is critical in a value-based model. Key evaluation priorities include:

- Comfort with risk-based contracting models.
- Internal processes to identify and manage the costs of services and procedures.
- Clarity on physician performance measurements.

Health information technology

Sound health information technology systems document and share data among a caregiving team. They deliver levels of care based on population risk stratification. Key questions here include:

- Can our primary care and behavioral health staff document observations and treatments in a shared medical health record to coordinate care delivery?
- Does our care plan platform integrate details from claims and other operational systems?
- Do we use tools to perform predictive or comparative analytics using clinical and/or claims data?

Quick Take

Taking a multidimensional approach to assessing readiness for value-based payments

Adopting value-based payments will require more than a next-generation financial system, as this shift affects nearly every operational function of a healthcare system. Organizations must understand the extent of its impact across multiple dimensions and how these changes will help or hinder their adoption of outcome-based reimbursements. These insights are critical to developing a realistic roadmap and actions necessary to create the required future state.

Our value-based payments maturity evaluation methodology assesses these key areas:

- I Strategy: How value-based payments and an organization's short- and long-term business objectives and strategies may complement each other or create obstacles.
- I Operations: The state and maturity of business operations as they relate to processing value-based reimbursements, including data gathering, workflows, care delivery, etc.
- I Technology: The existing infrastructure's flexibility and the application portfolio capabilities.
- I Organizational culture: The cultural impact of value-based payments and the required change management initiatives.

We then utilize a dedicated team of subject matter experts and custom methodology to conduct an assessment, which encompasses:

Quick Take

- I Responses from a customized survey using a bank of curated questions.
- I One-on-one interviews with management team members.
- I Shadowing and ethnographic studies with operation team members.

The maturity score is based on the quantitative analysis from the survey and operational metrics, combined with the qualitative input from the interviews.

In addition to determining the current maturity of the organization with respect to value-based payments, the evaluation also does the following:

- I **Helps organizations identify their strengths and weaknesses** across the 30 categories evaluated.
- I **Establishes synergies** that are advantageous in both a fee-for-service model and value-based payments model and prioritizes them during the transitional phase (e.g., implementing care services that are critical for value-based payments that also generate better outcomes under the fee-for-service model).
- I **Acts as a beacon to reassess implementation programs** in light of their effects on the value-based payments maturity score.

Organizational alignment

Adopting value-based reimbursements requires a huge organizational shift that must be fully scoped and well managed, with a clear roadmap and realistic milestones. Key questions to gauge change readiness include:

- I Do we have the necessary change management capabilities to carry out the necessary enterprise transformation?
- I Do we have leadership support for the cultural changes that will be necessary to make the transition to value-based payments?
- I Have we identified physician, nursing and clinician champions for value-based payment initiatives?

- I Are we doing our best to communicate our value-based payments vision to our staff and its importance to our future?

These are just a sampling of the capabilities providers must assess to evaluate their cultural and structural readiness for value-based payments. With these insights, providers can define what operational maturity looks like in their unique settings. That definition becomes the lodestone for cost-benefit analyses that determine whether to improve current programs and/or implement new initiatives and set priorities and timeframes for doing so.



What's critical is to get started right away. Providers now compete with Amazon and Walmart, not just the healthcare systems across town. Taking the necessary steps to transition to value-based payments will equip providers with streamlined, consumer-focused systems, processes and

capabilities. With that foundation, providers will be positioned to adopt disruptive new business models of their own, as well as participate in healthcare on-demand platforms and new partnerships that are reshaping the industry.

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Endnotes

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Acknowledgments

The authors would like to acknowledge Rachelle Alpern, Senior Innovation Consultant, Center for Innovation, UNC Healthcare, for her valuable insights and contributions to this white paper.

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