



The speed of transformation: Preparing for the payment models of tomorrow

The question facing U.S. health care organizations isn't whether to embrace a risk-based care model, but rather how and when to make the change. With reimbursements increasingly linked to patient outcomes, adopting this new business strategy is crucial to every organization's sustainability and success.

Value-based care no longer qualifies as an experiment. It's a movement quickly picking up speed. Accountable care organizations (ACOs) already cover nearly 33 million Americans — about 10% of the population.¹ All but two states have now implemented value-based payment programs.² And even health systems that have elected not to form or join ACOs are opting for alternative payment models (APMs) tied to quality and cost targets. In 2017, more than a third of U.S. health care reimbursements flowed through APMs — a 23% increase from two years earlier.³

Further proof of the accelerating transformation can be found in the Centers for Medicare & Medicaid Services (CMS) plan to launch new direct-contracting global fee models in 2020. That program alone is expected to shift a quarter of the Medicare population away from fee-for-service care.⁴

As the momentum continues, more and more providers are taking serious steps toward value-based care. This white paper will examine how they can prepare to more readily assume the risks — and enjoy the benefits — of this evolving payment paradigm.

The drivers of change

The combination of unsustainable increases in health care costs and the passage of the Affordable Care Act has

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hastened ACO growth and the shift of risk from payers to providers. Since 2011, the number of ACOs has grown from a nationwide total of 64⁵ to more than 1,000.⁶ Much of that growth is due to Medicare ACOs, most of which participate in the Medicare Shared Savings Program.⁷

But government innovation models aren't alone in catalyzing this change. Commercial payers are also participating through managed care contracts.⁴ UnitedHealthcare®, the nation's largest health insurer, currently covers more than 15 million patients through value-based plans, and by the end of 2020 expects to have \$75 billion in reimbursements tied to such arrangements every year.⁸ Other payers — Aetna, Cigna and Humana among them — are on a similar trajectory.⁹ The Blue Cross Blue Shield plans say their value-based care programs now reach 62 million members nationwide.¹⁰

These private contracts account for more than half of the nation's value-based business. What's more, more than half of commercial ACOs are actively taking on risk — meaning they stand to lose reimbursement if they don't meet quality or cost standards.¹¹

Employers are joining the movement as well. The National Business Group on Health reports that more than 20% of them are engaging with high-value networks and ACOs, a number expected to top 50% within a few years.¹²

Cost-shifting to consumers, rising awareness of health care costs and a variety of mobile health applications are also

fueling demand for transparency into prices and quality. Consumers are taking a much more active role in managing the financial implications of their care.¹⁰ Enrollment in high-deductible health plans (HDHPs) has also increased rapidly in recent years, from 4% of covered workers in 2006 to 29% in 2018.¹³ Typically linked to high-deductible personal spending accounts and informative tools about care options, these plans drive value-based care delivery by encouraging consumers to make cost- and quality-conscious decisions.¹¹

“It’s clear that you’re going to see more and more risk models,” said Alan Krumholz, MD, an independent consultant and former medical director at Mayo Clinic Health System’s health plan. “And if you see more and more risk models, then you have to align or incentivize physicians around risk models. We’ve reached the tipping point, and we’re starting to go downhill now.”

Risks vs. rewards: A strategic view of value-based contracting

The health care industry sees the value-based shift as vital strategy to curbing inappropriate care and rewarding high-performing providers. Health systems are standardizing their processes to offer better value for the health dollar, and risk-based payment models that hold them accountable for clinical outcomes are starting to show results.

Early results from Medicare prove the point. In 2016, the CMS Next Generation ACO Model generated net savings to Medicare of approximately \$62 million while maintaining quality of care for beneficiaries.¹⁴ In 2017, ACOs in the much larger Medicare Shared Savings Program (MSSP) held spending \$1.1 billion below their benchmarks, earning \$780 million in shared savings payments and producing net Medicare savings of \$314 million. For that year, about 60% of MSSP ACOs saved compared with their benchmarks and 34% earned shared savings payments — up from 56% and 31%, respectively, in 2016.¹⁵ The experience level of ACOs seems to make a difference: While only about 20% of ACOs qualify for the extra payments in their first year, about half of those around for five years or more earn shared savings.¹⁶

While the evidence for value-based care is promising, health organizations face significant challenges as they seek to transform. Many ACOs are still working to refine core aspects of the accountable care model — from solid partner relationships and advanced IT capabilities to evidence-

based care protocols and robust population management.¹⁷ While the fee-for-service paradigm may ultimately be unsustainable, it’s hard to shake free of a system so deeply ingrained in the operations, systems and cultures of most health care organizations.

“We assume that because this fee-for-value idea has value in it, it’s going to immediately take hold, but there is a huge cultural and educational gap that has to be bridged before we fully realize the benefits,” said Carl Johnson, MD, EdM, MSc, senior physician director at Optum® Analytics. “If we don’t do our due diligence in preparing our organizations for this huge tectonic shift in how we think about clinically, financially and operationally focusing on value in health care, we’re not setting ourselves up for success.”

Moving to fee-for-value poses real financial risk for organizations unprepared to change the way they do business. The shift entails moving from managing operating costs to reducing the cost of improving patient health. Value-based care involves major shifts in revenue sources, profit drivers and profit centers that produce fundamental change in an organization’s operating economics.

“Organizations need to set a goal of being able to do global risk within three to five years,” Dr. Krumholz said. “Within those years, there will be some moderate gains or moderate losses in that process, because no transition is painless. It’s hard. But on the other hand, they don’t really have a choice. The payer reality is changing.”

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Requirements and considerations in value-based contracting

Providers should define the population health requirements of their market segments, and identify the associated care delivery and care management models to ensure they can deliver on risk-based contracts. Understanding the needs of

each market allows an organization to define macro-level strategies and associated micro-level processes. For example, while clinical protocols for chronic obstructive pulmonary disease don't vary with geography, how and where providers engage an individual will be determined by the market.

How do value-based organizations achieve enough savings to cover costs, finance the shift and reward caregivers? For providers, much of the answer lies in carefully coordinating their clinical and financial transformations. The transition can be risky, requiring early investment and a prudently plotted roadmap to maintain fiscal stability. Clinical transformation activities must be carefully paired with risk-based, fee-for-value contract shifts so that patient volumes and care management efforts match current payer mix and provider strategy. Just as important is an upfront investment in IT infrastructure and the personnel needed to support the transformation. Organizations must invest in optimizing care protocols, partner relationships and data management.

OPTIMIZING CARE PROTOCOLS

The move to value-based care involves a switch from practicing "reactive" medicine — which focuses on treating disease — to delivering "proactive" care, which emphasizes keeping people well. Even organizations operating predominantly under fee-for-service contracts can find profitable opportunities to be proactive. Adopting protocols to reduce readmissions can help minimize losses from CMS readmission penalties. Focusing on disease prevention can help physicians increase volume for tests and services even as they educate patients on staying healthy. Stepping up care coordination, reducing care variation and implementing evidence-based care standards are all critical to value-based success.

Optimizing care protocols toward proactivity can also contribute to culture change. It's no accident that independent physician associations (IPAs) are finding early success in fee-for-value scenarios. IPAs typically manage clinical and financial risk for a defined population under a health maintenance organization (HMO) model. They have the protocols and the infrastructure in place to help physicians forge partnerships to deliver value-based care.

OPTIMIZING PARTNER RELATIONSHIPS

While reconfiguring for proactive care internally, organizations should also be working to optimize value-

focused relationships externally. To define a path, providers must assess their market and its patient populations, identify potential delivery partners, and evaluate existing payer relationships with an eye to accepting more risk. The organizations' clinical transformation can succeed only if payers also adopt value-driven initiatives to improve quality and curb costs. Payer initiatives must be synchronized with the clinical transformation to ensure a match between revenue and clinical operating models.

As they create opportunities to be paid for value, provider organizations must make sure that external providers taking part in their new programs can participate successfully. Physician incentives must be structured to engage, drive and reward behavior that optimizes population health performance. The two efforts flow together. It's difficult to incentivize fee-for-value participation by affiliated physicians if the contracts affect only a small percentage of their patient panel. Care-coordination protocols can make all the difference.

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OPTIMIZING INFORMATION TECHNOLOGY

Electronic health record, health information exchange and other current information systems must be optimized for value. Processes and workflows that use these technologies must be updated to promote proactive patient care. Data and analytics are essential technologies that will aid organizations in optimizing for fee-for-value. Analytics can give organizations actionable intelligence to ensure that the work they're doing makes clinical and financial sense, thus ensuring that the updated processes, workflows and technology will result in better outcomes and improved finances.

It's important to implement clinical and financial adjustments in a careful sequence of steps. The financial transformation ensures that physician and care team incentives are based on managing care, not on productivity. It also ensures that payer contracts are executed based on the ability of the organization. Once organizations start down the value-based path, clinical and financial reforms must be aligned to create and capture the value of the investments.

The challenges of value-based contracting

The health care landscape of the 1990s was littered with failed health insurance plans owned by provider organizations. These failures showed providers that managing patient risk isn't for the inexperienced. But it's clear that the market today is moving toward just that. How does a value-based organization make sure it has the ability to manage the clinical and financial risks of providing care? As with all change management efforts, it requires the right combination of people, process and technology.

"Managing risk is not what people think it is," said Dr. Krumholz, who has more than 20 years of experience as a health plan executive. "Managing risk requires working with providers, aligning their incentives, [and] having the data and analytics to know what you're doing right and to clearly understand what you're doing wrong."

One key is updating processes to apply the right resources in the right setting to care for patients. For example, fee-for-service medicine typically uses physicians to care for all patients regardless of medical need. In a risk-managed environment, physicians provide the most value when they work at the top of their licenses, while other trained contributors — nurse practitioners, physician assistants, social workers, pharmacists and even health coaches — take on less complex tasks.

Data is another key for risk-contracting organizations. Knowledge turns risk into opportunity; by contrast, if organizations don't know what they don't know, they are likely to fail.

"Without large data sets, how could you know whether you're providing quality, cost-efficient care?" Dr. Krumholz said. "It's only when you look at large data sets that you notice variations in care quality. And it's only then that you're able to benchmark physicians. Quite frankly, it's only

been in the last five years since EMRs and the data that comes from them have become more ubiquitous that we've had the ability to look at these things with greater certainty."

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Velocity of value-based change depends upon the degree of change management

Over the last five years, value-based care has made its way into the collective consciousness of the health leaders. Change is underway. Reimbursement gatekeepers — commercial and public payers — are moving aggressively toward the new contract model. And as the evidence makes plain, CMS and large commercial insurers are adopting incentives to get providers on board as well. It likely won't be long before these organizations provide disincentives for practicing fee-for-service medicine. While the end of fee-for-service may not yet be in sight, the model almost certainly won't live forever.

Hospitals, physicians and payers must speed up their transformation if they want to remain vital in the future. To ensure a quick and orderly journey toward value-based care, they should focus on three components: their business model/culture, their care delivery model and their model for patient engagement.

Managing business and cultural change

Changing the way your organization does business requires both cultural and financial adjustments. Success depends upon your administrators' and physicians' appetites for innovation and risk. Traditional medical practice rarely entails taking financial risk. There's great safety in the fee-for-service

model, which, simply stated, involves performing a service and getting paid for it. But an appetite for risk can be developed too.

The benefits of value-based care are clear: By focusing on keeping patients healthy, providers earn rewards for providing high-quality care and elevate their own practice of medicine. A consensus is building among physicians who work under value-based care models that it is invigorating.

“[Value-based care] really allows the physicians to practice medicine like they really want to — that really is important for them — so that they’re more involved with the care of their patients,” said Palmer Evans, MD, board chairman of Arizona Connected Care in Tucson, one of the first ACOs in the country. “Physicians themselves are really engaged in doing things right for the patient.”

The move to value-based care requires careful planning and a rigorous examination of market forces. Organizations must research market dynamics, understand financial impacts, conceive a thoughtful provider network strategy and define the population needs of their service area. They must build risk management capabilities. They must also build the right rewards into their business model.

“That which you incentivize, you get more of,” said Dr. Krumholz. “If you incentivize quality, you get more quality. Right now, doctors are getting paid to do widgets, but not being paid to do the fine stuff that goes with quality.”

But the optimal method for incentivizing physicians is still unclear. Monetary carrots and sticks are obvious choices, but will they be enough to make a significant difference in the way physicians practice? Modern behavioral science suggests otherwise. Business author Daniel Pink argues that money isn’t the primary motivator for any professional: “The best use of money as a motivator is to pay people enough to take the issue of money off the table. Pay people enough so that they’re not thinking about money and they’re thinking about the work. Once you do that, it turns out there are three factors that the science shows lead to better performance, not to mention personal satisfaction: autonomy, mastery, and purpose.”¹⁸

Dr. Johnson agrees that money isn’t a likely change agent for physicians. “I don’t think that we’ve tapped into understanding what it really is that physicians want

as incentives and recognition,” Dr. Johnson said. “In the meantime, it’s going to be, ‘Who’s the gold medalist, the silver medalist, the bronze medalist? Who’s going to get the percentages of the shared savings that we just received?’ Those are great, but I actually think physicians might be more interested in improving the quality of the care they provide.”

Managing change with physicians

Provider organizations help physicians focus on quality improvement by informing them about their performance — including how they compare with other physicians. This information shows physicians how their actions impact care quality and financial health, and how they can benefit from producing healthy outcomes.

Ensuring that this information leads to change is tricky. The vast majority of physicians want to do what’s best for their patients. But when someone without an MD or DO credential starts talking to them about quality and cost, they become skeptical. To get physicians on board, providers need on-board physicians — clinical peers who have caught the vision of value-based care and who can effectively make the case that quality varies among physicians and that improving care quality can contain costs.

“This is why I became a physician,” said Jeffrey Selwyn, MD, of the care models within his ACO, Arizona Connected Care. “It took a lot of coaching, convincing and arm-twisting to help me transform and make that change.”

“Where I am now is a place which I wish other physicians that are reluctant to make this change could see,” Dr. Selwyn said.

Getting physicians on board may not take arm-twisting. With large clinical data sets combined with analytics, physician quality executives can help doctors deliver the best combination of high quality and low cost.

“When others say, ‘How can I get better? What am I doing wrong?’ you can say, ‘Go to this other doctor who’s doing it all right. Here’s your data, here’s hers, here’s where the differences are. Talk to her,’” Dr. Krumholz said. “It’s hard as physician leaders to tell people what they need to do. Frankly, it doesn’t work. But pointing out someone who they can learn from in a nonthreatening way, usually it’s much easier to effect a change.”

“If I knew that I was practicing in a way that was significantly inferior to my colleagues, it wouldn’t even matter about the money. I would have my own pride pushing me to change.”

Making this type of quality data available to physicians requires analytics and predictive modeling tools. Such tools are also critical for running physician-led population health management programs. Sophisticated analytics can use large data sets to predict with a high degree of certainty if a patient will become high risk. Analytics can also help determine the most effective interventions for a given population and can provide clinical performance analysis. They equip population health teams with care management technology that presents all information in one interface, enabling them to manage entire populations and to consider actionable opportunities for individual patients.

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“We always wanted to do the right thing for the patient,” Dr. Evans said. “That was something we always felt comfortable with doing, but we didn’t have the information or the tools to do so. And now, with this technology, and this desire to do the right thing, and with the government and the payers saying, ‘Look, we need to go in this direction,’ I think this is just going to be an exciting time.”

Even with the right structure, the right incentives and the right tools, there’s risk involved in value-based care. That’s because the most important element in patient health — the patient — is also the element over which health care providers have the least control.

Managing change among patients

Managing patient behavior starts with gaining a deeper

knowledge of the health of an organization’s populations. This effort requires developing effective care management programs that engage patients in their own care. Payers and providers have invested heavily in patient engagement technology — from patient portals and telemedicine to mobile messaging apps and remote patient monitoring.¹⁹ In the United States alone, the market is expected to exceed more than \$24.5 billion by 2024.²⁰

Engaging patients in their own care often requires more than monetary investment. It also requires an understanding of the patients’ motivations and emotional needs. Care management teams often include social workers and psychologists with the skill to guide patients toward healthier habits and better self-care. Determining what motivates patients and promoting health improvement strategies that respond to those motivations can help organizations change patient behavior.

While statistics from population health management tools are valuable, health care organizations should move beyond the numbers to understand people on an intimate level. By having a deeper understanding of the target audience, organizations will be better equipped to develop solutions that go beyond today’s needs and build long-term, if not lifetime, relationships.

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Accelerate preparations for value-based care

In the journey from providing care to managing health, successful organizations know which levers to pull to manage patient risk, improve physician performance and reduce the total cost of care. They know they must revamp their care protocols to emphasize proactive and preventive care. They recognize as well the need to upgrade their IT capabilities to enable population health management

and data-based decision-making. And they clearly see the importance of creating solid partnerships and aligning incentives to deliver the full promise of this new care model. These organizations understand the question posed by the coming changes in health care: It isn't whether the market is moving toward value-based care, but which organizations will survive the transition.

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