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Better Together

A Mantra for Success Under Value-Based Care

Providers and payers navigate the need to pool and leverage data resources to improve care outcomes, reduce costs

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Helen Keller once said, “Alone we can do so little. Together we can do so much.” The observation, while astute, didn’t carry much weight for payers and providers as they navigated the fee-for-service world. It has become especially relevant, however, to healthcare organizations that are now trying to cope with the new realities of value-based care and reimbursement models. As value-based care takes hold, healthcare payers and providers – who have worked as adversaries, of sorts, for many years – are realizing that they now need to work collaboratively to succeed.

The problem: While the “better together” concept is easy to understand in theory, it is often difficult to implement in the real world. Indeed, the change to a paradigm of cooperation is especially trying for healthcare payers and providers who have spent many years trying to survive under the individualistic rules of the fee-for-service world.

The big question: How will payers and providers not only adapt – but succeed – in this changing world? This whitepaper examines how value-based care differs from previous care models and how payers and providers need to rethink relationships as the move to value-based care accelerates. More specifically, the paper explores how providers and payers can work together toward shared goals and how data analytics can be leveraged to support emerging partnerships.

Dealing with this complexity is no longer an academic exercise but a necessity for healthcare organizations as they move beyond simply envisioning value-based models and begin to implement them.

Value-based care lands

Value-based models are upending the status quo and forcing payers and providers to adapt to new realities. Under value-based arrangements, the metric of care changes from a visit (unit of care) to the patient (or patient population). This concept considers how all aspects of care affect a single patient, rather than looking at each encounter individually. Simple enough in theory, value based care, in practice, has resulted in quite a bit of complexity. Most notably, since value equals quality divided by cost, healthcare organizations need to measure discrete, relevant aspects of quality against the total cost of providing care to accurately assess progress.

Dealing with this complexity is no longer an academic exercise but a necessity for healthcare organizations as they move beyond simply envisioning value-based models and begin to implement them. While the concept of value-based care has been bandied about for quite some time, the model is finally gaining traction and is expected to soon become the prevailing paradigm. Consider the following:

- Half of healthcare systems are receiving some or most of their reimbursement as part of value-based payments that put providers at risk for the cost and quality of care, according to a survey of healthcare payer and provider leaders conducted by KPMG, a global consulting firm.[1]
- Value-based care is expected to transform the healthcare industry over the next decade, with a tipping point in the U.S. reached within the next few years, according to a survey of healthcare leaders conducted by Lazard.[2]

[1] KPMG Survey. https://home.kpmg.com/us/en/home/media/press-releases/2017/01/payers-providers-see-population-health-taking-hold-despite-challenges-kpmg-survey.html?cq_ck=148494028z7938&utm_source=Twitter&utm_medium=social-share-voicestorm&utm_campaign=C-00000000

[2] Lazard. Global Healthcare Leaders Study 2017. https://www.lazard.com/perspective/global-healthcare-leaders-study-2017-executive-summary/

- About one third of hospitals and health systems are participating in voluntary value-based payment models, such as bundled payment for major surgeries or accountable care organizations that offer bonus payments for meeting cost and quality targets, according to a Washington Post BrandStudio/Philips survey of 346 hospital executives.[3]

Discovering a new order

As the industry continues its trek toward value-based models, payers and providers are playing by new rules. Instead of setting their sights on mutually exclusive care delivery and payment objectives, payers and providers now are looking to realize shared goals centered on improved outcomes, enhanced patient experiences and reduced costs – the basic tenets of the industry's much coveted Triple Aim. Reaching such goals will require these healthcare organizations to re-evaluate their relationship to one another, according to Gordon Moore, Senior Medical Director for Clinical Strategy and Value Care, 3M Health Information Systems Inc.

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"If the goal is to reduce unnecessary costs by improving the quality of care delivery, then the past model, which cultivated more of an adversarial relationship between providers and payers, simply won't work," Moore said. "Payers and providers need to come to terms with the fact that they now have to work together."

Getting on the same page, however, is not a simple endeavor. In fact, providers and payers are struggling to appropriately define shared value-based care goals and incentives, according to survey of 452 primary care providers and health plan executives conducted by recent Quest Diagnostics and Inovalon. The survey revealed that just 47% of physicians reported advancement in payer-provider alignment under value-based contracts in the past year.[4]

Coming together

Payers and providers, however, can adopt a variety of strategies that will help them move toward this much-needed alignment. Indeed, to succeed under value based models, payers and providers will need to:

Write a new playbook. Payers and providers should rewrite the rules with contracts that "reward them for improving population health while reducing costs. These contracts should provide clarity around the goals they are trying to achieve and offer a glide path for making a transition from a fee-for service to a value-based payment arrangement," Moore said.

Pool their resources – specifically their data assets. "Both sides have significant resources in terms of data but the data are different and serve different purposes. For instance, health plans have claims data, which provides a broad understanding of the population and costs. The payer needs to share the information about the

[3] Transforming healthcare to a value-based payment system. The Washington Post Brand Studio. http://www.washingtonpost.com/sf/brand-connect/philips/transformin

[4] Quest Diagnostics and Inovalon. Progress on the path to value-based care. http://quanumsuite.questdiagnostics.com/2017study

total cost to treat a population," Moore said, while pointing out that risk adjustment methodologies can be applied to adjudicated claims data to create total cost of care budgets as well as expected rates of key outcomes including hospitalizations, emergency department visits and others. These rates are illustrative of the link between better care delivery and quality and cost outcomes. Providers also bring valuable data to the mix. Providers often have very granular data that offers valuable insights into which patients need help and how they can be treated to achieve the best possible outcomes while reducing healthcare expenditures.

Appreciate each other's strengths. On top of sharing data, payers and providers need to understand the value of each other's resources. For example, providers should realize that payer data can help them to understand relative medical utilization expenditures and then develop interventions that improve quality and cost outcomes. Likewise, payers need to realize that provider data offers insight into the effectiveness of specific care interventions.

The metrics used to measure outcomes should relate directly to what the healthcare organizations are measuring.

Set common outcomes measures. Payers and providers should determine exactly how they will determine if they are meeting clinical care goals. As such, they need to "think carefully about what they are measuring and how they are measuring it," Gordon advised.

This can be accomplished by selecting a core set of metrics that represent critical aspects of quality, such as health or functional status, changes in health risk, mortality, access to preventative care, continuity of care, chronic and follow-up visits, readmission and complication rates, inpatient hospital admission and ED utilization rates, and composite measures.

Ensure that measures tie directly to outlined intent. The metrics used to measure outcomes should relate directly to what the healthcare organizations are measuring. "Sometimes, metrics are used to make sure an organization is passing some sort of quality standard to get access to insurance savings. That's very different from using metrics to support performance improvement. And, then, there's the third use case of trying to differentiate high from low performers," said Katharine Schneider, CEO, Delaware Valley Accountable Care Organization.

Use measures that matter. Most importantly, providers and payers should come to terms on measures that truly make a difference. "You always have to ask: Do these quality measures really matter? That's the elephant in the room. I know of physician organizations that have 150 measures and when looking at what they are doing, I have to wonder if any of it really matters," said Joseph Grennan, Regional Medical Director, University of Pittsburgh Medical Center, during a roundtable hosted by Health Data Management.

For example, measuring some of the "nitty-gritty" activities that occur in a physician's office with a patient might, at first blush, appear to constitute a valuable set of indicators. However, these measures often fall short. "There's a reasonable amount of evidence in the medical literature that shows that process measures don't always predict population health outcomes," Gordon pointed out.

Kimberly Bodine, DNP, RN, Senior Director, Applied Clinical Informatics, Tenet Healthcare, agreed. "Healthcare organizations should only accept such measures if there is data that proves the measures can lead to better outcomes. Organizations are saying that they practice evidence based medicine and they do. And then they turn around in the arena of measures and say payer A wants us to do this quality measure so we'll do it without even looking to see if it ties to outcomes, without any proof, per se. Providers need to insist that this disconnect doesn't exist," Bodin advised.

The challenge is that healthcare organizations can only measure so many things because it's exhausting to look at everything for every clinician all the time.

For example, measuring how often a provider administers blood sugar tests to certain patients does not necessarily provide substantial insight into how effectively the provider is treating diabetic patients. Such measures "don't necessarily translate to total cost-of-care improvements and population health outcomes improvement," Moore said. "The value of reporting on the delivery of an A1C or even an aggregate for the diabetic population doesn't seem as valuable as reporting on more comprehensive outcomes such as the rate of hospitalization."

Take a broad approach to outcomes. Many factors ultimately play a role in determining outcomes. "So, the health plan might want to step back and define outcomes broadly and then the provider can think about all the different things they can do that would lead to improvements in that outcome indicator such as access, care coordination, or post-hospital care," Gordon said.

Choose metrics that provide a holistic view. "The challenge is that healthcare organizations can only measure so many things because it's exhausting to look at everything for every clinician all the time. Therefore, the metrics are often honed down. Then, providers are judged on 12 metrics – and that seems absurd because it doesn't provide a full picture," Moore said. As such, healthcare organizations need to strike a balance between using metrics that are manageable yet still offer a 360-degree view of patient care.

Digging data's value

While it is important for payers and providers to redefine their relationship under emerging value-based care models, a solid data foundation is an absolute mainstay for success. With reliable data, healthcare organizations can assess the current situation, identify opportunities to improve performance, design appropriate programs and track progress.

Producing such a reliable dataset, however, is a complex process that should be approached by providers and payers with care and skill. If data integrity is not high, the result can be poor patient health outcomes and sunk costs. With a solid data foundation, healthcare organizations can reduce variation, introduce value, improve total cost of care and enable sustainability. More specifically, quality data can be used to improve outcomes for chronic condition populations, enhance medication adherence, positively affect patient behavior and identify and define impactable patient populations.

What's more, when payers and providers bring their data resources together, the insights could help to support initiatives that could have a positive impact on outcomes. For example, data analysis might prompt a hospital to establish stronger ties with a skilled nursing facility, so that patients who are discharged after total hip replace surgeries are not readmitted within 30 days. Another healthcare provider might implement a more aggressive cholesterol management program to prevent heart attacks among its patient population.

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Realizing results

The importance of strong data became readily apparent when payer organization Wellmark and provider Wheaton Franciscan Health Care-Iowa joined forces under a value based initiative to improve quality and outcomes while reducing costs. To jumpstart this endeavor, the two healthcare organizations worked jointly under a contract that included an approach for member attribution, a model for shared savings, financial targets and a quality incentive payment based on the 3M Value Index Score (VIS).

Key elements of success included:

- ***Data sharing.*** Wellmark, through 3M's online dashboard, provided the analytic tools and data to the system and physicians, and is helping to train and educate them on how to use the tools. Risk-adjusted data on costs, quality and population health status were made available through the dashboard. This enabled the physicians to drill down to the patient level and generate patient lists for care management and gaps in care.
- ***Comparative analytics.*** Wheaton Iowa provided physicians with detailed, comparative analytics in a "safe" environment that makes physicians comfortable accessing and using the data. To do so, they relied on the 3M Value Index Score (VIS), a single score that represents how well a primary care physician cares for his or her patients, regardless of their health status (i.e., healthy to chronically ill).
- ***Transparency and collaboration.*** Transparency the system built trust within the organization and between the payer and provider, an important contributor to achieving desired results. In fact, the collaboration between physicians and Wellmark has led to a better understanding of the type of data and reports physicians are looking for.

By relying on these strategies to optimally leverage data and work together cooperatively, these healthcare organizations have been able to use data to retrospectively identify individual patients with gaps in care; build health maintenance into the electronic health records (EHR), which provides recalls and reminders on a prospective basis; and create process teams that identify necessary changes to improve results, including the process for scheduling screening mammograms, handling patient no-shows and cancelled appointments, and contacting chronically ill patients to schedule visits with their primary care providers.

As a result, Wellmark and Wheaton and have come together to not only meet but exceed quality goals. After one year, Wheaton exceeded its established quality and financial targets. The healthcare provider appears to be on course to reach the goals that will produce success under value-based models just like other providers who are working with Wellmark have. Indeed, after the first two years, the initial five Wellmark ACOs have improved their quality scores by over 35% and saved more than $12 million.

Using data to implement targeted interventions is certainly emerging as a strategy that can help organizations reach the care and cost goals inherent in value- based systems.

This is just one example illustrating how healthcare organizations can work cooperatively to achieve success under value-based models. A healthcare payer in the South leveraged 3M data analytics solutions to identify high risk members – and then reaching out in collaboration with physician practices to encourage those individuals to better engage with primary care providers. As such, outcomes are dramatically improving. A Midwest payer organization employed data analytics to identify people with extraordinary utilization patterns. The payer then worked with providers to reach out to these patients to more specifically define the needs of these patients – and then provide the services required to keep them healthy.

Using data to implement targeted interventions is certainly emerging as a strategy that can help organizations reach the care and cost goals inherent in value-based systems. For example, the Minnesota Department of Health achieved a 20% reduction in readmissions, which lead to $70 million in savings by using software that analyzes data to determine whether a readmission is clinically related to a prior admission, identifying readmissions that potentially could have been prevented with better discharge planning, care coordination and follow up. Similarly, the Maryland Department of Health achieved a 32% reduction in complications and an estimated $110.9 million in savings by using software that analyzes data to assess more than 60 different types of complications that occur during hospital stays, providing insight into incentives and interventions.

As value-based care becomes the dominant care delivery model, payers and providers are apt to continue to enter into relationships that rely on increased cooperation. While the shift to this new model might prove uncomfortable at first, as these organizations continue to push toward sharing and leveraging data in the name of improved care, they are apt to realize the result that will truly make them believe that together they can truly do so much to improve outcomes, enhance the patient experience and reduce costs to succeed under the auspices of value-based care.