MILLIMAN WHITE PAPER

Is your provider organization maximizing its performance in value-based care programs?

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As the use of value-based reimbursement programs and the associated financial impact increases, it is important for providers to not only be educated on the mechanics of the programs but to understand the analytical, operational, and clinical requirements to ensure success with the programs. The negative financial implications of value-based care programs can be significant, impacting as much as 10% of gross revenue.

Over the past few years, there has been a proliferation of value-based care (VBC) programs offered by health plans and government payers. These programs, including accountable care organizations (ACOs), bundled payment programs, and quality incentive programs, often include a multitude of measures related to costs, quality, patient experience, and outcomes, along with varying methodologies to determine success. The programs may be upside-only but are increasingly likely to involve some level of risk for the provider. The calculations to determine results can be complicated, with complex member attribution methodologies and ever-changing targets. Even the measures themselves may change from year to year. Many programs can offer significant returns based on performance and some providers may be leaving dollars on the table if they are not focused on the operational and clinical workflows related to these programs.

Success with these programs is possible. However, key challenges must be addressed. These challenges include, but are not limited to:

- Member attribution: Inaccurate member attribution methodologies can result in organizations being responsible for members that are not their own.
- Population data and reporting: Reliance on payer-provided data and reporting that is often not timely, not actionable, and may not be accurate.
- EMR and supporting systems: Electronic medical record (EMR) systems may not be fully utilized to capture all of the information to receive credit for certain activities and may not have sufficient connectivity with other EMR systems used by other providers in the network.
- Care guidelines: Care guidelines or clinical best practices may not be established across the provider organization, which can result in inconsistent treatment and handling of patients, leading to an inability to meet quality components.
- Efficient clinical workflows: Clinical workflows may not be in place, which can cause quality performance measures to be missed.
- Provider partnerships: Organizations may not be responsible for or able to impact all care included in the measures for which they are responsible in the value-based program. As such, there may be a need to coordinate care with other area providers.
- Health plan collaboration: Health plans should provide not only data but other forms of support, including program performance feedback and suggestions for improvement.

To address these challenges, there are several actions and initiatives that an organization may take to achieve better results from VBC programs—and many do not require a large financial investment.

Member attribution

Attribution is a cornerstone of most VBC programs; however, most attribution methodologies are imprecise. Obtaining additional data (typically from health plan partners) can help providers understand, manage, and even negotiate better attribution methodologies. The data provided by the health plan partners should include the following:

- A list of all attributed and attribution-eligible members. Attribution-eligible members are patients that triggered at least one attribution criteria—e.g., seen by a primary care physician (PCP) in the physician practice—but failed to be attributed due to some other criteria. Physicians can use this information to clearly see which of their patients are and are not attributed. Furthermore, it allows them to spot-check for patients who should not be attributed because they were not cared for by the practice in question.

- Specific reasons for members being included or not included, understanding the details will vary based on the methodology. This information can be helpful for several reasons.
  - Understanding the patterns of behavior (either by patients or physicians) driving attribution. In addition, providers can better understand the areas of the physician practice driving attribution of patients who are easier or more difficult to manage.
  - Understanding which patients have not been attributed and why. This can allow physicians to craft specific action plans to increase attribution, if that is the desired goal.
- Information on services being provided by the provider group and outside the provider group for both attributed and attribution-eligible patients. This information can be helpful for providers to understand out-of-network leakage and whether that is having a significant impact on overall VBC program performance.

A detailed look at the data will help the provider group manage these issues and negotiate a more equitable contract. Health plans and some management services organizations (MSOs) can typically assist with member attribution issues.

Population data and reporting

Because population data and reporting are such important parts of VBC programs, provider organizations should ensure that the health plan and/or their MSOs, if applicable, are providing complete and timely data in order to perform proactive analysis on patients and physicians who are part of the program. Initially, historical performance information is needed for the attributed population to assist with the selection of the measures and determination of the benchmarks. The members' risk scores should also be included in this data set. A breakdown of medical costs by service line and in-network and out-of-network utilization, along with appropriate benchmarks, should also be obtained and used to identify improvement opportunities. Patients who are high utilizers of services such as emergency room services and pharmacy should also be identified and reviewed for possible interventions. In addition, patients with clinical conditions known to result in high costs (e.g., chronic diseases such as diabetes, asthma, and congestive heart failure) should also be obtained in order to ensure that those patients are receiving the appropriate care and education to manage their conditions effectively. The health plan or MSO may also have predictive analytics capabilities that help identify patients who have early indications of becoming higher utilizers.

EMR and supporting systems

The EMR system is the backbone for VBC success, as it facilitates the provider's effective management of its patients and translates patient interactions into useful data that drives reimbursement and addresses gaps in care. That being the case, knowing your EMR system and documenting the appropriate codes and fields for data tracking is critical. To sync up the EMR system with your VBC contracts, an inventory of all the various quality measures contained in payer contracts should be created. The list of measures can then be used as part of the assessment of the EMR to determine whether the system is able to capture the pertinent information. One way to help improve documentation in the EMR is to develop a worksheet listing all the quality measures along with the applicable Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes used to document the service provided. The worksheet should be distributed to all providers and their clinical staffs to help with proficiency and consistency of documentation across practices.

While not all EMR systems are able to capture the required information related to value-based program measures, they may be able to be reprogrammed to improve data capture. Otherwise, additional software might be needed to allow for better data capture and reporting. An advanced EMR system, though, should offer a number of quality performance monitoring capabilities and should have functionality related to most quality measures. Optimally, the EMR system should also have capabilities to plug and play with other provider partners especially if they do not have the necessary components for documentation.

Care guidelines

Standards of care or care guidelines are another area that should not be overlooked in relation to a VBC program as they will drive consistency in providing care and completeness and accuracy of documentation and will eliminate gaps in care. Workflow documentation, and standards of care or guidelines that are currently being used should be evaluated in relation to VBC contract requirements and specialty-specific guidelines should be provided to all physicians in each practice and followed consistently. There are proven benefits to having all practitioners using the same standards and guidelines in meeting quality measures. Becoming a formal Patient-Centered Medical Home (PCMH) or an ACO is a simple way of standardizing care, as these programs will normally consist of policies, procedures, and care guidelines that are centered on quality patient care and engagement. An example of a care guideline is the development of a diabetic foot check protocol for nursing staff to perform prior to the physician seeing the patient.

Along with the EMR system, care guidelines will also help address gaps in care that will prevent more serious events in the future and, therefore, will have an impact on overall costs of care. These gaps may be annual wellness visits or cancer screenings and can be addressed through the use of data analysis to detect patients who are not adhering to standards and then reaching out to them to encourage them to set up an appointment.

Efficient clinical workflows

Enhanced workflows and efficient usage of staff within a practice can also improve value-based care program performance. Clinical workflows can sometimes be overlooked and simply shifting certain steps to non-clinicians or nursing staff can give physicians more time with patients. For instance, a practice can develop nursing assessments and standardized care plans for nursing staff to follow prior to the physician's engagement with a patient. This can allow the physician to have a more in-depth conversation with the patient to obtain information necessary to impact quality measures and other VBC program components. There may also be opportunities to increase the use of physician extenders to allow physician to focus on patients with more complex diagnoses.

Provider partnerships

Another component of a successful VBC program is the coordination of care across providers, both participating and nonparticipating. This will likely require education regarding the critical success factors for the VBC program, coordination of patient transfers, and ongoing communication on performance. Some organizations may want to formalize their provider networks based on performance assessments using both quantitative and qualitative criteria. This will require performance data to identify outliers regarding quality, outcomes, and/or costs, with follow-up education on how to improve performance as well as feedback from clinical personnel on patient coordination and care.

Preferred providers, including specialists, post-acute facilities, and home health agencies should be selected based on the results of the performance assessment. In addition, performance should be monitored on an ongoing basis to ensure that efficiency and quality expectations are met.

Health plan collaboration

Lastly, provider organizations should engage with their health plan partners to discuss challenges and ensure a full and consistent understanding of the VBC program. They should be ready and willing partners, as it is in their best interest for providers to succeed with a VBC program. As such, they should be forthcoming with the data noted in the sections above and able to provide feedback on how to improve performance. They may also be willing to perform patient outreach and assist with educating physicians and other providers on the VBC program, keys to success, and best practices.

Parting thoughts

As you can see, there are many issues and challenges to manage in order to optimize performance in value-based reimbursement programs, but it is certainly not an impossible task. Communication and coordination across all parties, well-designed systems, timely reporting, and analytics are all keys to success. Working with participating physicians and other related parties—other providers, vendors, and health plans—can help build the capabilities needed to succeed in these programs.

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