Accelerate Success in Value-Based Health Care

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The U.S. health care system is consistently challenged to deliver high-quality care at an affordable cost. Value-based care is widely publicized as the lever that will drive improvement. Virtually every public or private payer has adopted at least one care delivery or payment model to support value-based care, such as Accountable Care Organizations (ACOs), risk-based contracts, gain or surplus sharing, performance-based incentives, or quality rating systems. All these approaches have the same set of goals—provide the right care in the most appropriate setting at an affordable price.

Even with the best of intentions to improve patient care and outcomes, the health care system has become a complex web of technology, rules, operational processes, performance metrics, and reporting requirements that can be inconsistent and confusing for the health care delivery community. Health care providers, especially physician practices, need help to modernize their structures, processes, and technology to deliver care in a way that makes them successful in value-based arrangements.

Health plans have much at stake in this value-based care market, especially in government programs such as Medicare and Medicaid. There are millions of dollars on the table in the form of performance incentives, as well as the avoidance of penalties for health plans. Other motivating factors include reduced costs and improved health outcomes for members, higher CMS Five-Star Quality Rating System and NCQA accreditation rankings, increases in assigned membership, and the ability to offer a competitive price for employers and individual purchasers.

Despite these incentives, health plans find themselves largely dependent on physicians and other health care providers to deliver the results they desire. Forward-thinking health plans aiming to outpace their competitors and reap the rewards of value-based arrangements need to establish an approach that will provide hands-on help to physician practices. This requires relatively small yet targeted investments that will help practices modernize their daily operations and streamline care delivery guaranteed to create a positive return on investment.

Background

All health plans, whether they operate in the commercial or government markets, seek to maximize their performance under value-based arrangements. Health plan performance is dependent on highly functioning physician practices, yet most health plans maintain an “arm’s length distance” from their practices and lack detailed knowledge of the inner workings of a physician practice.

Without a detailed understanding of how physician practices work, health plans can’t provide the support or assistance that practices need to succeed under value-based contracting arrangements. Physician practices need to retool to position themselves in the new value-based care market, but they lack the time, focus, and skills to do it alone. Most practices operate near maximum capacity every day to keep pace with the demands of caring for their patients. Increases in the prevalence of major chronic conditions, proportion of patients on long-term medications, and the need to monitor and counsel on risk factors for disease across the patient population have all dramatically increased the demands on physicians. On top of these increased demands, the burden of getting credit for all the work physicians do to evaluate, assess, monitor, treat, and prevent suboptimal outcomes has been placed largely on the physician practice. Yet, physicians often don’t have in-house expertise in the areas of...
population health, quality metrics, risk adjustment, workflow optimization, or health information technology. Thus, the seemingly small requests from health plans of their providers are impossible demands from the perspective of a physician practice.

As value-based care contracting arrangements continue to expand, health plans and physician practices are becoming increasingly dependent upon each other for survival.

The Problem
The current trend for health plans is to offer value- and risk-based structures that reward physician practices for delivering high-quality, cost-effective care. Most value-based payment programs consist of two core components: 1) a contract that defines the rules; and 2) a combination of technology and reporting requirements that are used to set expectations, measure progress, and document the results that must be attained to earn incentives. Despite their efforts, many health plans are frustrated that these value- and risk-based structures aren’t being implemented fast enough to help move the needle.

In reality, most physician practices don’t understand the details of the value-based programs they’re involved in and many of the tools provided by the health plans aren’t being used. Here’s why:

• **Information Overload.** Practices that participate with multiple payers are inundated with new value-based programs, with different metrics, targets, and tools they are expected to master.

• **Resource Challenges.** Practices have limited resources. Their number one focus is to deliver quality care to patients. It’s challenging for practices to dedicate the time to implement new processes and reimbursement models.

• **Insufficient Training.** Health plans don’t provide the necessary levels of training and guidance for practices to understand the requirements and how to integrate the tools into their workflow.

• **Motivational Issues.** Most practices lack a catalyst to drive them into action. They need an individual who can learn the value-based requirements, determine how they can fit within the practice, and guide the practice through the implementation.

A fresh approach is needed to ensure success in value-based arrangements—an approach that positions health plans and physician practices as partners in care delivery.

Medicaid Withholds—Capitalizing on Missed Opportunities
As part of one state’s Medicaid pay-for-performance program, seven participating health plans can earn up to 1.25 percent of their premium and delivery payments as an incentive for achieving high performance on designated Healthcare Effectiveness Data and Information Set (HEDIS) and customized quality measures. This equates to an annual reward opportunity of more than $140 million for the managed care plans. The payout starts above the NCQA 25th percentile.

At the end of the measurement year, the managed care plans earned only one-third of the available incentive bonus, leaving approximately $94 million on the table. While most managed care plans increased their overall quality performance, they also experienced a decline in at least one HEDIS measure. In some cases, physician practices were unable to report any data for common clinical measures, such as BMI or HbA1c control. For example, for the Diabetes HbA1c control (8.0 percent) HEDIS measure, participating managed care plans in this state’s pay-for-performance program were awarded only $1.4 million of $20.3 million possible, representing only 7 percent of the total incentive available.

Missed opportunities for collecting and reporting patient data can adversely impact managed care plan results. Hands-on support in the practice is needed to uncover the root cause of the issue. Is the practice not providing the services? Does the practice have a process for accurately monitoring gaps in care for its assigned panel? How does the practice document the services? Once the root cause has been identified (and it’s seldom the case that quality care isn’t being rendered), an experienced coach can assist the practice in making the changes needed to move the needle on metrics.

Impacting quality outcomes at the point of care is essential to maintaining overall operational and financial health in a highly competitive market. Well-deployed interventions at the practice level can unlock millions of incentive dollars for the managed care plans and ease the burden of physicians.
Reporting Tools & Provider Portals

Why Some Practices Are Just Saying No!

- Cumbersome to use and not integrated into current practice technology
- Requires manual or duplicate data entry, adding significant time to daily processes
- Lack of staff with data and technology skills needed to use the tools
- Lack of staff with expertise in translating reports into actionable steps the practice needs to take
- Variety of payers with multiple tools—too much work to access reports for all payers

The Opportunity

There are many factors within the health care delivery system that health plans can’t control. However, they do possess a unique opportunity to influence the care delivery process to accelerate the path to their desired value-based outcomes. Physician practices need support in implementing value-based requirements, but they often lack the necessary resources. Health plans can provide the necessary resources in the form of coaches who are focused on teaching the practice how to access, interpret, leverage, and integrate the tools and technology into their practice operations.

The term coach isn’t taken lightly as the necessary hands-on resource. These coaches are more than just experts in the health plan’s specific program or set of programs—they are experts on the daily operations of a physician practice. A coach determines how best to integrate the requirements of the health plan into the practice workflow and ensure it captures and submits the necessary data to the health plan—all with minimal disruption. This hands-on coaching approach drives meaningful improvement in patient care and health outcomes while attaining optimal financial performance for the practice and the health plan. The coach is focused on making the practice and health plan successful in their shared goals.

Execution Roadmap

Success in value-based contracting requires new ways of thinking. Health plan leaders have many competing priorities, just like physician practices. Sometimes it can be difficult to know where to begin. By following these five simple steps, you can build a program that will engage physician practices and generate the results you desire.

Set Priorities

No health plan can afford to fix everything in every physician practice. Likewise, no practice can completely transform the way it operates, from current state to future state, all at once. A data-driven approach is needed to identify the opportunities where change will be most beneficial. A combination of health plan data, electronic health record data, and practice assessment information can be aggregated and analyzed to identify opportunities and develop an effective targeting strategy (Figure 1).

A successful strategy begins with the overall macro-level goals that must be achieved for both the health plan and physician practices to be successful. This strategy is then segmented into smaller, more attainable goals for each practice. This will allow the practices to build momentum. The plan is further refined through a monthly or quarterly review cycle. The overall goals will be achieved as the individual practice efforts come together as a whole.
Recognize Diversity and Unique Needs
While there are many common themes among physician practices as they work through the elements of value-based contracting, there are also unique needs within each practice. An initial assessment of the current state is critical to determine the best approach for each practice. A hands-on coach can help the practice identify its most pressing issues and barriers, such as workload, training, use of technology, or workflow optimization. Change can only be deployed into a practice successfully after the coach has attained an understanding of how the practice works.

Build Trusting Relationships
Establishing trusted relationships with physician practices is an essential step in promoting transformation. Coaches should be introduced as positive change agents, regardless of whether they’re affiliated with the health plan, the value-based program, or an independent consulting organization. Also, it’s important to identify at least one champion within the practice to support the coach’s efforts. Having a plan that creates some early wins for the practice will help solidify trust and create investment in the process.

Leverage Technology
Most physician practices today have a surplus of technology from their internal information technology team, physician groups, partner hospitals, health plans, Health Information Exchanges (HIEs), and vendors. Yet, many practices have a limited understanding of the functionality available to them and how it all works together. A critical step in creating success in value-based contracting is teaching practices how to fully employ the software and tools they already have and helping them to eliminate redundant or unnecessary technology.

Offer a Robust Toolkit
Because we know that no two physician practices are alike, and virtually no two health plans are alike, a robust toolkit is needed to start a practice moving forward from where they are today. A toolkit may include: industry-leading best practice templates, procedures, workflows, evidence-based care and HEDIS educational resources, and billing and coding training that can be leveraged and personalized for the practice. Table 1 shows sample interventions and how they can positively impact the practice.

Results Matter
At Medical Advantage Group, we practice what we preach. Our hands-on approach to improvement consistently creates meaningful change and a positive return on investment for our clients. We’re in a unique market position that allows us to partner effectively with health plans and health care delivery systems. We’ve established a high level of credibility with physician practices, and we’ve proven that—with hands-on support—practices can experience transformation that will enable long-term success (Figures 2 and 3).

Top 5 Most Frequent Complaints from Physicians about Value-Based Contracts
1) Lack of transparency regarding the method, metrics, and data used to assess performance
2) Inability to influence the method and metrics the practice views unfavorably
3) Lack of alignment between the practice and other care providers (i.e., hospitals have no incentive to work with physicians to reduce admissions from the ER)
4) Payers seldom invest in necessary infrastructure to build practice capabilities needed to succeed (i.e., data aggregation, data analytics and reporting, care management, Electronic Medical Record [EMR], etc.)
5) Each payer has a different set of performance metrics and methodologies

Top 5 Health IT Challenges in Practices
1) Data integration projects are custom and expensive due to lack of standard interfaces
2) EMR vendors don’t have reasons to standardize because it would allow practices to easily switch systems
3) Number of EMR/HIE/data integrations is an expense multiplier
4) Payer data and reports aren’t standardized
5) Systems are built by IT-focused teams that don’t have clinical experience
Intervention

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<tr>
<th>Implement a daily team huddle to plan visits</th>
<th>Office Efficiency</th>
<th>Gaps in Care</th>
<th>Patient Engagement</th>
<th>Manage Care/Cost</th>
<th>Accurate Coding</th>
<th>Data Capture/Submission</th>
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| Learn how to use population health software to generate lists of patients with chronic diseases | •                | •           | •                 | •               | •               | •                      |

| Update EHR templates to consolidate the collection of data for value-based contracts in one place | •                | •           | •                 | •               | •               | •                      |

| Integrate the capture of complete and accurate diagnosis coding into an annual visit | •                | •           | •                 | •               | •               | •                      |

| Attach supplemental data to claims to improve HEDIS metrics | •                | •           | •                 | •               | •               | •                      |

| Implement a process to schedule visits with newly assigned members | •                | •           | •                 | •               | •               | •                      |

| Implement a process to keep healthy members coming back | •                | •           | •                 | •               | •               | •                      |

| Teach patients when to use an urgent care facility | •                | •           | •                 | •               | •               | •                      |

| Implement extended access hours | •                | •           | •                 | •               | •               | •                      |

| Schedule follow-up visits with patients after a hospital discharge | •                | •           | •                 | •               | •               | •                      |

Table 1. Potential Practice Interventions
About Medical Advantage Group

Medical Advantage Group, a wholly-owned subsidiary of The Doctors Company, maximizes health plan and physician clinical and financial performance in value-based contracting like no one else in the industry. With 20 plus years of experience working in physician practices managing cost and quality, our hands-on approach consistently creates change and positive returns on investment for our clients. Our unique value proposition allows us to create wins for both health plans and delivery systems. Coupled with a strong level of credibility with practices, we move costs down and quality up with double-digit improvements for both large and small clients. Learn more about our services at medicaladvantagegroup.com or call 800.594.6115.