qrcAnalytics

Bringing Clarity to the Complexity of Quality, Risk and Cost

White Paper
Transitioning to Value-Based Care

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Introduction

In 2019, 64 million people were enrolled in Medicare. This number continues to increase as more and more baby boomers reach retirement age. The surge in new Medicare beneficiaries is triggering an additional increase in cost and a high demand for age-related services. Controlling the raising costs and improving the quality of care is a major concern for government funded programs such as Medicare. Because of this, the Center for Medicare and Medicaid Services (CMS) began implementing value-based care models. These models are designed to keep healthcare costs down while improving the quality of care provided. Unlike the traditional fee-for-service (FFS) models used largely in the past, providers were paid based on the quantity of services provided; the value-based payment model measures quality and risk to determine the payments to providers. A study completed by the New England Journal of Medicine*, confirms that the value-based care models are more cost-effective than the traditional FFS model.

As providers and health care organizations begin to negotiate more managed care, they inevitably move from the FFS model to the value-based care models. To remain profitable and compliant in this new model, providers must shift from focusing on the *quantity* of care provided to the *quality* of the care. Successful providers and organizations shifting to the new models should have a clear understanding of the risk adjustment philosophy and its impact on their entire Medicare population, including traditional FFS, Medicare incentive payments, penalties, and how risk adjustment is calculated within their patient population. This shift not only includes changes to the way primary care providers deliver care but has a substantial impact in specialty medicine as well. CMS has implemented several specialty specific value-based programs (Such as Kidney Care Choices (KCC)) significantly impacting specialty medicine. Each of these models encompasses the definition of value-based care as defined by CMS.

Background

In 2001, Health and Human Services (HHS) and CMS began introducing Medicare quality initiatives to ensure quality health care for all Americans. In 2008, the Medicare Improvements for Patients and Providers ACT of 2008 was enacted and is known as MIPPA. One of the requirements under this Act includes a plan to transition to a value-based program for Medicare payments for professional services. The following year, the Health Information Technology for Economic and Clinical Health Act (HITECH) was established. The HITECH program includes incentive payments to healthcare providers for the meaningful use of electronic health records (EHRs). In 2010, the Affordable Care Act (ACA) was implemented. The ACA was designed to focus on quality care and includes several value-based programs rewarding providers for quality rather than quantity. The ACA has provisions for value-based reimbursement and Congress has reinforced the provisions by creating a new payment methodology based solely on the quality of care provided. These programs have caused the healthcare industry to shift from traditional FFS to value-based care. This shift has caused providers to make significant changes to their current processes and workflows. This transition is overwhelming, especially when resources are limited and uncertain. Providers must weigh the risks of FFS vs. value-based reimbursement very carefully.

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Healthcare organizations have spent decades optimizing their business models, maximizing revenue using the traditional FFS model. However, under the value-based care model, healthcare organizations are required to transition (or change) to a new business model. With the change, organizations typically struggle to both understand these models and to sustain their revenue using or implementing new procedures and workflows. qrcAnalytics has successfully provided tools to healthcare organizations to not only survive this shift but prosper in this new environment.

Purpose

Value-based care is a payment model that rewards healthcare providers for providing quality care. Providers seek to achieve Medicare's "Triple Aim" of providing better care for patient populations and reducing the cost of care.

This form of reimbursement is an alternative that potentially replaces FFS reimbursement which pays providers retrospectively for the number of services provided. Value-based care centers on patient outcomes and how well providers improve quality of care on specific measures and at the same time reducing cost.

Medicare's

"TRIPLE AIM"

Providers are incentivized to engage patients and use data analytics to get paid for their services. To learn more about the "Triple Aim" click here:

https://www.qrc-analytics.com/wp-content/uploads/2019/06/qrcAnalytics-Achieving-Success-in-Risk-Adjustment-and-Quality-Incentives.pdf

Are you ready?

Transitioning to value-based care requires a dynamic shift in thinking and implementation of brand-new technologies and workflows. Moving away from maximizing the number of services provided, to ensuring patients get the appropriate care at the right time is a fundamental change. Organizations need to prepare for this change and take advantage of the numerous incentives available. If you are currently participating in a no risk program, now is the perfect time to look at where you are and establish Key Performance Indicators (KPIs) and goals to ensure your success today and in the future.

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Here are questions organizations should be asking prior to taking on risk:

- When is the right time to transition to value-based care?
- How will this change impact care and reimbursement?
- Do we need to change any process or procedure?
- How close are we to implementing HCC (Hierarchical Condition Category), coding and how will we measure success?

ARE YOU RISK READY?

If your organization has been considering taking on risk, or additional risk, to support the value-based model, now is the time to be proactive. The charge is incumbent upon health care to be ready and informed about the future. Consider the questions above and let qrcAnalytics help you to gauge your readiness and progress in this shift.

Barriers in transitioning to value-based care

Value-based care is on the rise in the United States. As of 2011, 48 states have implemented a value-based program. Unfortunately, with changes comes challenges. While working with clients we have established that there are consistent issues that have interfered with the implementation and long-term success of the value-based care model. Knowing what these barriers are and how to overcome will be key in your successful implementation.

- Lack of clearly defined measurements
- Population health data management
- Unpredictable revenue streams
- Lack of resources

Efficiency is a must for any healthcare organization transitioning to value-based care. The new shift in thinking and processes make it virtually impossible to achieve success without analytics. With proper analytics and sustainable solutions these barriers can be addressed before taking the risk. Utilizing the qrcRiskReadiness Assessment™, organizations will be provided solutions for each barrier listed above. Included in some offerings are automated point of care tools for physicians and care managers, administrative and clinical analytical dashboards used to track expenditures and utilization.

What is required in developing an action plan for transitioning to value-based care

The move from FFS reimbursement to a value-based payment model can be a painstaking process. Value-based care models require healthcare providers to take accountability for spending and patient outcomes for a defined population of attributed patients. Organizations that rely on data analytics to manage their populations and utilize patterns is key to success, especially in the risk-based models. Using analytics, you can identify areas that have a significant role in the delivery of care as health care depends more on patient data to drive new strategies and decision making. This often means embracing new workflows and relying heavily on analytic tools. Using analytics to measure, track and analyze your population will enable you to develop specific action plans that have the highest, immediate results most relevant for your organization.

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Questions qrcAnalytics can answer:

Difficult Questions Answered

- Are there gaps in care?
- Do we have clinical opportunities in our patient population?
- Do I know where our dollars are spent and utilization rates?
- What measures should we be using?
- Are we optimizing our coding?
- Do we have the tools to evaluate the impact of our new value-based strategies?

Prior to implementing an action plan supporting the shift to value-based care, the answer to these questions is crucial. There is no cookie cutter solution, each organization has its unique strengths and weaknesses. The qrcRiskReadiness Assessment™ was designed to show the uniqueness of the organization and enables you to focus only the areas that need attention. The qrcRiskReadiness Assessment™ analyzes your data as it looks today and recommends action plans centered around what matters most to you today and your success tomorrow. We have the capability to ingest 3 years' worth of clinical and claims data through the qrcEngine™, we then categorize results into actionable processes, workflows and dashboards. This allows you to repeat the process to ensure your action plans have had the expected outcome. Using this process, you can focus on your specific needs and measure strategic initiatives to see what worked or what did not, allowing for minor adjustments or drastic change. This process saves valuable time and resources and the answers to the difficult questions mentioned above.

Key performance indicators (KPI) for success in value-based care

The new generation of KPIs under value-based payment models is yet another shift caused by the change from volume to value. To be successful, providers, need to change from an FFS mindset to one of value. A proven method for initiating change is by measuring and monitoring specific KPIs. The big question here is, are you measuring the correct markers and data to support sustainable success? The answers to these questions are found in the analysis of your organizations unique data. Here are some questions qrcAnalytics can help answer for you.

- Are you capturing severity and risk accurately?
- Are you seeing your patients at least yearly?
- What clinical conditions NOT identified should be considered for an individual patient or groups of patients?
- How much money are we leaving on the table?
- Is there specific disease that are under or over coded?
- Do we have any compliance concerns?
- What is our HCC (Hierarchical Condition Category) recapture rates today?
- Which providers need additional training and education?

Organizations using data analytics that include KPIs, benchmarks, targets and provider performance have higher success rate than those who do not.

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Why patient prioritization and types of care are key to success

Understanding your patients and patient population is the foundation of value-based care. When looking at populations at risk for hospitalization or over utilization of emergency room visits, you will identify the population that is driving health care cost in your organization. Often, this population suffers from fragmented care. These variations in care often lead to increased cost and lower than expected quality care.

Use of point of care tools can reduce variations and enables providers to choose the best treatment and specific diagnosis most relevant to the individual patient. Having providers engaged and involved is critical for success in value-based care. When analyzing clinical data providers become aware of their specific patterns and can make any needed adjustment to their practice.

- Who are your sickest patients?
- What cluster of diagnosis appear in specific populations?
- Are you seeing the right patient at the right time?
- Are you capturing all conditions effecting care?

Patient Specific Analysis

"We are uniquely qualified to support healthcare in payment reform. The data scientist at qrcAnalytics designed the qrcRiskReadiness Assessment™ using organizational unique data, including quality, utilization, cost and specific patient characteristics. The results of the assessment are presented to the client in a manner that is transparent, trusted, and actionable. This process enables organizations to meet the patient where they're at and achieve Medicare's Triple Aim."

***Gene Rondenet, CEO, CTO and cofounder of qrcAnalytics*.**

Conclusion

Value-based care is on the rise, a report released in 2018 by the Health Care Payment Learning & Action Network confirmed that 34% of payments were tied to value-based-care and have steadily increased over two years.** There are over 40 value-based models created by CMS. Each model is unique, based on type and level of risk assumed. Organizations just beginning to enter the value-based care model should select the model that best fits their diverse patient population.

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qrcAnalytics has been a leader in the movement to value-based care for primary care and specialties since its inception. Our tools are oriented around total population health and improving quality, cost and risk. Using our technology, payors and providers can better understand their episode grouping, risk adjustment and potentially prevent additional events and most importantly, know what actions to take to have the best success with value-based programs. Contact us for a qrcRiskReadiness Assessment™ today.

References

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