Prove You're a Top Tier Health Care Provider: Six Essentials for Your Value-Based Purchasing Game Plan

written by Theresa Hush | May 13, 2015

You know you need to shift your organization toward Value-Based Health Care. It's a trend that's here to stay, and you're deep into planning your strategy. Question is, what's the right game plan that will enable you to reap financial benefits by proving you're a top-tier provider that offers quality, cost-effective health care?

All too often, providers focus on adopting a reimbursement and delivery model that assumes risk without addressing fundamentals. Remember, this is not just about reorganizing to manage risk without engineering for improvement. While you must take steps to participate in the new Value-Based Health Care models, you need a strong foundation to succeed. Here are three current programs that necessitate a solid foundation; without it, your good intentions—and your investment—can run into trouble:

Medicare Shared Savings ACO or Commercial ACO. Unfortunately, the majority of Medicare Shared Savings Program (MSSP) ACOs have not able to demonstrate that better care has been provided for less cost. The kicker: for many of these ACOs, a significant amount of time and resources were invested, meaning that they didn't generate enough savings to cover the overhead.

CMS Value-Based Payment Modifier Incentive (VBPM), which will be at least 4 percent, and possibly more, depending on the budget neutrality formula. The VBPM now affects all providers, and can even apply to those already in an ACO. The VBPM formula, however, is a win-lose game—you have to do better than your peers to make an incentive. Only 2.4 percent of all groups achieved that in 2013, the first recorded year.

Health Plan or Employer Pay for Performance/Narrow Network Participation. Like the

VBPM, this is a competitive game. You have to be both very desirable for employees plus meet quality and cost standards in order to succeed. And, it's very hard to tell what "winning" means, if you are discounting rates for patient volume that might not materialize, and still have to capitalize your quality efforts.

You might also be considering a better network affiliation, purchasing practices (if you're a hospital or health system), or consolidating or selling (if you're a practice). Maybe you think there's more promise in bigger numbers of providers.

But there's a missing link in these strategies. They're all end games, not the way to win the game. There's a big difference between participating in "Pay for Performance" and being *paid* for your performance. The latter requires demonstrating better outcomes than others as well as lower cost for your patient care.

Six Essential Components of a Successful Value Strategy

So let's back up. If you want your revenues to rise because of your value as a health care provider, your strategy must include the best tools and tactics to achieve that end game, regardless of who is picking the players. Here are key components:

Measure yourself. You need to establish a baseline of both cost and quality, and get the basic information you need to start improving performance.

Analyze your performance via a PQRS Registry. If you've been using a claims-based method to meet PQRS, you may have deprived yourself of the most valuable measurement information you can use to determine your quality status. That is also true if you use an EMR-direct reporting method that does not give you detailed analytics. Consider using a PQRS Registry instead, for its ability to provide you with granular detail on both providers and patients. Just make sure that your Registry vendor provides consultation services to help you choose measures to optimize your VBPM results;

Apply quality measures to all patients, not just Medicare. You need to know how your other covered patients appear to the employer or health plan before you try to negotiate agreements.

Make sure your measurement includes all elements of both Medicare and commercial programs. For example, since Medicare is tracking readmissions and ambulatory care sensitive admissions, you should be doing that too, using a Registry that displays activity by attributed provider and by diagnosis.

Base your actions on your CMS Quality and Resource Use Reports. Your QRUR should serve as your bible for how you compare to others, lacking more specific

data. These reports will show you how you fare against other groups as well as the CMS mean. Along with your performance measures, the QRUR provides the basis for your improvement plan to meet quality.

On the cost side, examine where your QRUR spending exceeds your peers' and the CMS mean, and understand why. These statistics are reported per beneficiary and by the four core chronic diseases, and within categories of spending.

Evaluate the experience of your "attributed" patients. In both Medicare and commercial environments, patients attributed to you could be receiving care from other groups/other hospitals, and so on. Medicare tracks cost using spending per beneficiary—are you providing care that they've already received? If your group provides comparable services, understand why those patients are going elsewhere. It's tough to manage care if you're out of the loop.

Examine your quality and costs in all settings of care: ambulatory, outpatient, ER and hospital. Global costs and quality are now coming onto the forefront, and Medicare's VBPM calculations are one indication.

Engage providers positively in a collaborative venture. If your physicians sense a punitive approach, they will not be easy partners in the effort.

Providing a method for physician education and feedback in performance measures is helpful.

Attribution is a particularly touchy area, especially regarding inpatient services. Enabling providers to change attribution will facilitate better cooperation.

Solicit feedback from your providers on admissions and re-admissions—there may be more to a hospitalization than a physician decision.

In ambulatory care sensitive conditions, determine if some providers are attributed more frequently than others. If specialists, that may mean that no one is managing the patient in an ongoing fashion. If primary, is this person's population more challenging? Could resources be directed here that are not as necessary elsewhere?

What went right? Don't close the case after a demonstrable improvement—learn from success, too. Positive results and improved outcomes are an opportunity to engage providers and patients.

Implement a plan to fill the gaps in care and to improve outcomes. These require different levels of sophistication.

Filling gaps in care is easy to do by using your performance measurement results to establish a patient outreach program, accompanied by initiatives to reach out to patients who have not been in.

Improving outcomes requires a detailed population health program that associates multiple outcomes with patients and tracks the results of your initiatives to improve.

Track what works—spending money on outreach/care or coordinators/education does not equal success. Consider testing various approaches and which works best for which sub-populations, so that you can spend your resources where they will have benefit.

Invest in technology. You may think that your substantial EMR investment should be enough, but that is rarely the case. Your EMR provides the vehicle for your clinicians to fulfill quality services at the point of care, plus the data you require. But you'll get better direction for your Value-Based Health Care strategy if your technology is customized to meet market- and population-driven needs in addition to assisting in the direct provision of care. You wouldn't manage your financial performance with only your billing software, right? You also need financial analytics, contract analysis and investment technology. Each serves a different purpose, but all must work together to give you a complete picture. For your Value-Based Health Care needs, you have to establish an analogous technology strategy:

Performance measurement, with continual feedback to providers, including all areas under quality and cost goals, that also allows input or feedback from providers. Your performance measurement technology should be capable of covering all payers and, in the best case, cross-settings of care. For Medicare, ideally, both VBPM and PQRS are included.

Population Health with the ability to conduct and test different approaches to improving outcomes, as well as filling gaps in care. This means that Population Health should be project-based and capable of performing much more than analytics or patient outreach. It should be accessible to both providers and central staff.

Value-Based Health Care is a long-term trend that will evolve many times in the market. We are at the beginning of that trend, with much emphasis on reimbursement or new delivery models, but little evidence of what really will produce results. It's easy to get mired in scenarios and forget that success depends on providing the basics: better care and efficiency. Your best strategy is to stay on a path to meet those goals and remain vigilant for what comes next.

Download your free copy of the ICLOPS *Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment.*

Founded in 2002, ICLOPS has pioneered data registry solutions for improving population health. Our industry experts provide comprehensive Population Health with Grand Rounds, ACO Reporting and Population Health and PQRS Reporting with VBPM Consultation Solutions that help you both report and improve your performance. ICLOPS is a CMS Qualified Clinical Data

Registry.

Contact ICLOPS for a Discovery Session.

Photo Credit: “Spiral” by Tom Godber