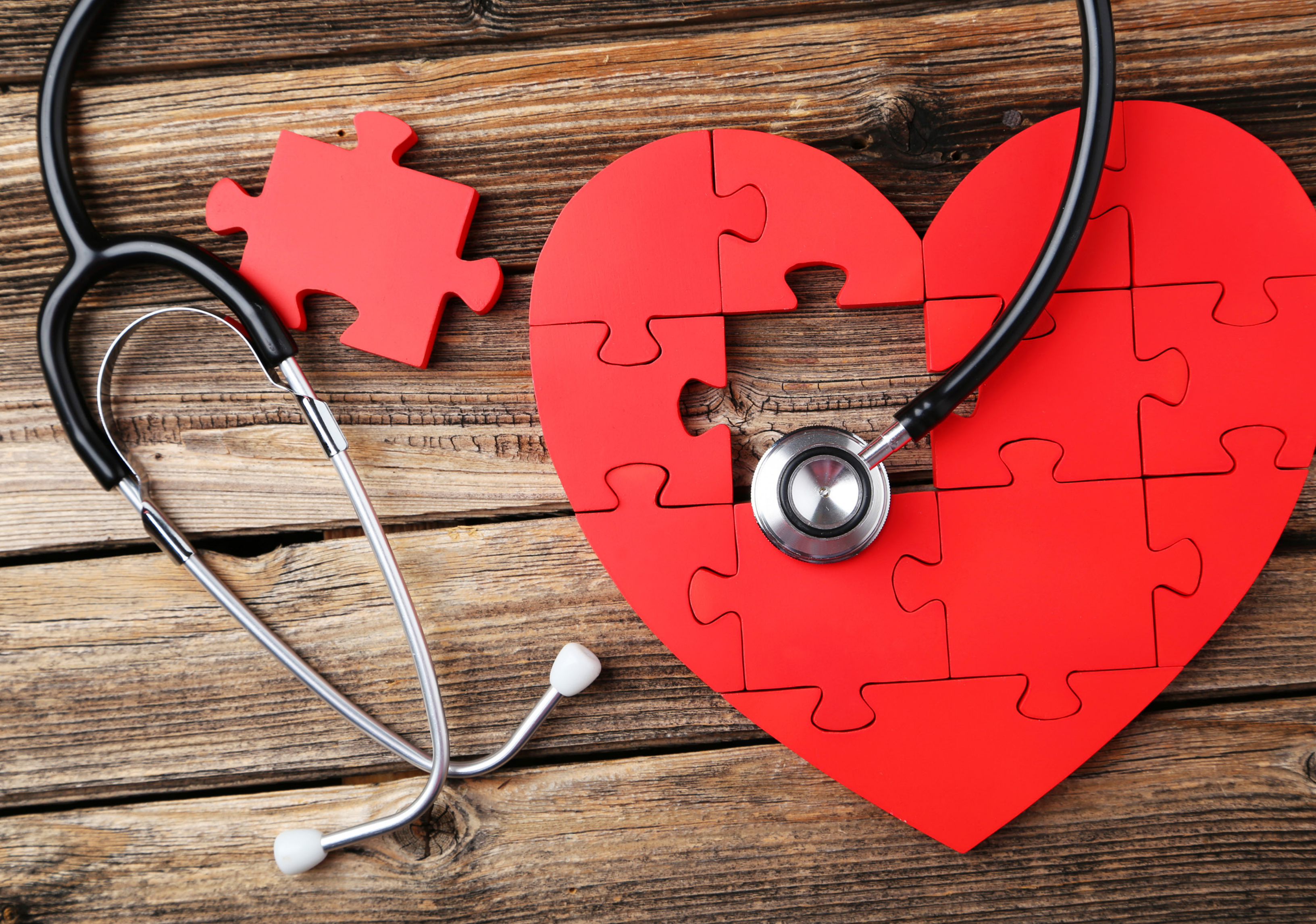


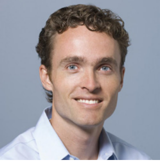
Unraveling the **Quality and Cost Conundrum** in Value-Based Models

healthcare informatics
CUSTOM MEDIA

PROVIDED BY

OPTUM®

Contributing Executives



Alejandro Reti, M.D., M.B.A.
Chief Medical Officer
Optum Analytics

Derek Pederson
Vice President – Medical Informatics Advisory
Optum

Sam VanNorman
Vice President and General Manager
Optum Managed Analytics

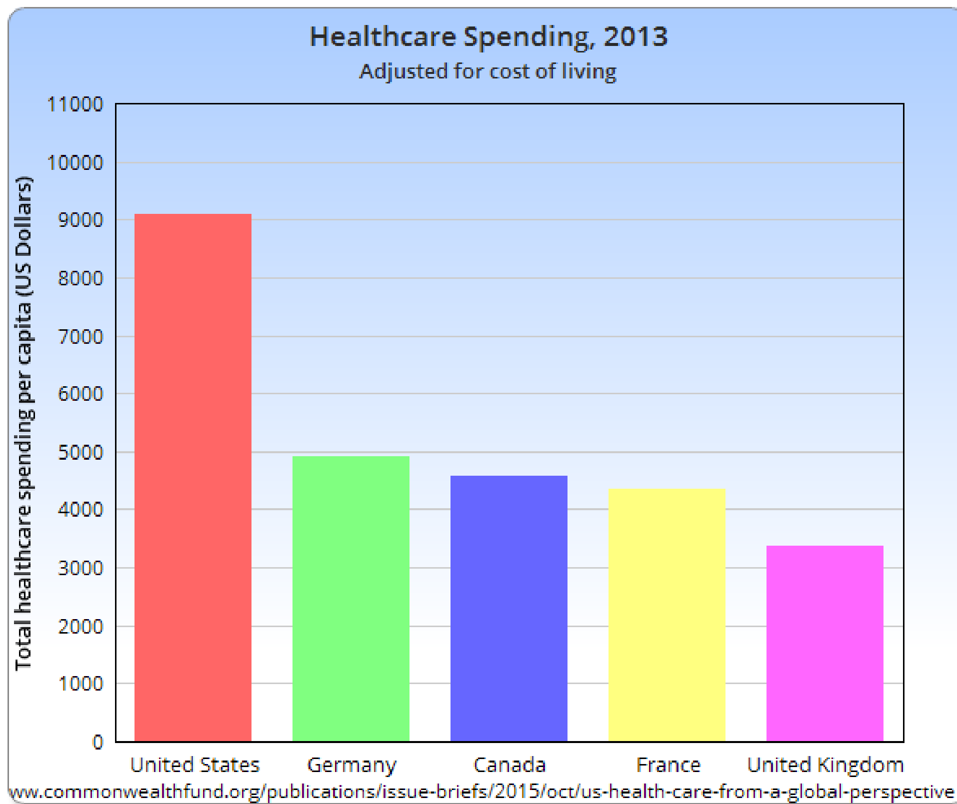
Zahoor Elahi
Senior Vice President – Product
Optum

Ernie Valente, Ph.D.
Vice President – Network and Population Health
Optum

Introduction

The face of health care is changing.

In response to the unfettered rise of health care costs in the United States—a recent Commonwealth Fund report noted that the U.S. spends nearly 50% more than France, the next highest spender, yet somehow still shows poorer outcomes despite it—many organizations are pushing for significant change.[1] And that change involves a new focus: one that pushes for value-based payments over fee-for-service.



Health care is shifting into a new era of value-based care payment models. It is a shift that requires organizations to make some serious changes. They will need to make changes to how they provide care to their patients, changes to how patients interact with the system, and changes to the technology required to manage the flow of information. Because value doesn't just involve providing the highest quality care to patients—it also requires the management of costs so that organizations can improve their financial margins and sustain long term growth.

"This is a profound shift that changes the unit of what's paid for in health care," says Ernie Valente, Ph.D., Vice President of Network and Population Health at Optum. "Historically, health care was paid for piece by piece. As a patient moved through an episode of care, the provider was often paid for every single thing they did for the patient. And some people believed this set up an inappropriate kind of reward system as providers were incented for doing more things, rather than being paid for a quality outcome. That's now changing."

In theory, a switch to value-based care many seem like something that should be relatively straightforward. As organizations see costs continue to rise without significant changes to the quality of care, they understand it is the right thing to do for patients. But as is so often the case, what seems straightforward and right in theory can be more difficult than expected to put into practice.

"Across the community, there is a heightened focus on cost effectiveness," says Alejandro Reti, M.D., M.B.A., Chief Medical Officer (CMO) at Optum Analytics. "But the results seen from value-based care initiatives, including accountable care organization (ACO) type initiatives, have been quite variable. It is a change that involves a lot of complexities. So it's no surprise that organizations are wondering how they can make effective, targeted adjustments to make value-based care really work for them."

"Historically, healthcare was paid for piece by piece. As a patient moved through an episode of care, the provider was often paid for every single thing they did for the patient. And some people believed this set up an inappropriate kind of reward system as providers were incented for doing more things, rather than being paid for a quality outcome. That's now changing."

— Ernie Valente, Ph.D.

More than Just a Shift in Payments

Derek Pederson, Vice President of Medical Informatics Advisory Services at Optum, says that one issue is that providers are unclear about the risk as they are taking on new value-based care agreements. Often providers we work with are looking for ways to understand how to best manage risks under their current processes and workflows.

"Providers typically don't have the information they need—they may not even have access to the information that they need—to make good decisions that allow them to provide quality care and manage their costs," he says. "Getting that kind of data into clinician's hands to help impact care delivery and cost is critical. One of the biggest struggles that providers have as they enter into value-based care arrangements is getting the information to best support the kind of decision-making they need to be successful."

Without that data, it's hard for provider organizations to know what a value-based contract should look like—and how that contract will translate into the care given to the patients they serve. Sam VanNorman, Vice President and General Manager of Optum Managed Analytics Services, says this has huge ramifications for an organization's success with value-based payments.

> "Too many organizations sign on the dotted line without understanding that they are now at risk for the total cost of care," he explains. "And that's because they haven't done the groundwork. They don't understand whether the contract represents a feasible business model, one that they can truly succeed under. They don't have the information required to understand what that contract now means for the quality and experience of care for their patient populations. They don't know what the trade-offs will be between quality care and costs. Because getting to that point requires a lot of upfront work and change management."

A first step is to look at an organization's current payment workflows and technological infrastructure. Valente says that organizations have optimized their systems of care to maximize revenue under fee-for-service payment models. As such, the first step is to take a long, hard look at how those existing workflows and processes may get in the way of value-based care adaptation.

"To shift to a new payment system, you are tugging against years and years of systems that were developed by some pretty intelligent people, systems that are ingrained into how they do their business. You can't just bust it up like glass," he says. "You are going to have to pull, tug, and cajole that existing system into a new one that is able to meet the new and different expectations about how care is delivered. And when you have limited resources to change those systems in ways that will help you profit from the new payment methods, it can be a huge limitation."

Such a shift requires carefully managed change—working with physicians at the ground level. And, as Reti states, more systematic processes that allow provider organizations to document the care they give patients in such a way so they can recoup proper reimbursements.

It Starts with Collaboration

Systematic studies of successful adaptations to value-based care payment models have shown several indicators of success. They include more targeted risk adjustment—and that involves building the right collaborations to adjust systems of care from the ground up. Collaborations that allow health care organizations to get the information they need to deliver greater care at lower cost. And a good start is extending the relationships an organization has with other providers in their different affiliated networks.

"Value-based care is asking providers to traffic cop care. You have to follow a patient through multiple visits with different providers in order to track those outcomes," says Valente. "To traffic cop patients in that way, providers need to know other providers. They need to know what their options are as they are referring patients out so they can choose judiciously and make sure they are making the best decision for the patient."

But collaboration needs to go beyond ACO partners and other provider networks. Another relationship that needs to evolve is the one between payers and providers. Studies show that the two must share data in order to succeed in value-based care endeavors.[2] But that means changing the way that payers and providers currently do business.

"All too often, the payer/provider relationships are one-sided in terms of advantage. Their incentives, historically, have been quite different. That can get in the way of effective cooperation," says Reti.

VanNorman agrees. "Until incentives between payers and providers are really aligned, we're going to have payers and providers doing exactly what they've always done—work in opposite directions. Payers are going to be encouraged to reduce costs in any way they can while providers are trying to improve care," he says. "But if we can align those incentives and have insurance companies look at things from a total cost perspective, we can find ways to look at each patient longitudinally so that providers can better balance care with costs. We can help provider organizations better combine clinical and financial data to enter into contracts that make sense for them in the long run—and the payers are going to take notice."

Pederson says that alignment starts with transparency. If providers can get the claims data they need to better support clinical decision-making, they can better pull, tug, and cajole their workflows, as needed, to manage the risks inherent to value-based care agreements.[3]

"All too often, the payer/provider relationships are one-sided in terms of advantage. Their incentives, historically, have been quite different. That can get in the way of effective cooperation."

— Alejandro Reti, M.D., M.B.A.

"The payers can help providers be more successful by being transparent with that data. Yet, even then, provider groups may not have the resources to take that data in, parse it, clean it, and analyze it in a way that is clinically meaningful," he says. "But finding ways to get at that data to bridge the gap between clinical care delivery and the actuarial, financial analytics is key to success."

But what's more, they can learn from payers—and the ways they have been leveraging data to understand costs. "Health plans have been using predictive data models for years and they continue to refine those models to understand where they can reduce costs," Pederson says. "These aren't always things that the health plans are sharing with providers. But with more collaboration and transparency, the providers can better understand their risks, see what payers are seeing in the data, and then develop the right kind of plans to reduce the overall cost of care without sacrificing quality."

Bridging the Gap with Data

Value-based care results in a quality and cost conundrum for most health care organizations. Yet, having the right data—and strong platforms to analyze that data—can make all the difference, offering the kind of predictive analytics that can transform the path of value-based care initiatives. And, most importantly, those predictive analytics can help put the patient of the center of clinical decision-making—ensuring that providers can identify the interventions that provide true value to an organization's patient population.[4]

Zahoor Elahi, Senior Vice President for Optum, says that means that provider organizations need to take a long, hard look at their information technology (IT) infrastructure.

> "Being able to get at that data is going to be more and more important. Organizations are going to have to make key investments in infrastructure so they can work with this data in a way that is good for payers and providers," he says. "They will need to bring in data from both sides, and show benefit to both sides, as well as start to lay the foundation for new sources of data including social data, new IoT digital data, etc. All of that will involve more modern, connected technology."

With those key collaborative relationships and new technology platforms in place, Valente says providers will be able to better embrace the kind of organizational and systematic change to make better day-to-day decisions for each and every patient, whether they are trying to reduce re-hospitalizations or help patients better manage chronic conditions.

"These are the kind of decisions that reduce waste, cut costs, and improve care," he says. "They are the kind of decisions that are better informed through the appropriate insertion of technology and knowledge during the care process. The kind of decisions that allow providers to deliver better care to more people for less cost."

Reti agrees. And he says when provider organizations have access to that data—and the valuable insights the data can provide—they can hone in on the few key items where they can make the most difference. And those decisions can be led by the people who should be making them: the primary care teams.

"This will allow organizations to reorient and have value-based care changes led by primary care teams. This is more than just creating patient-centered medical homes. It's really tying primary care activity to other care coordination teams and activities," he says. "It's honing down into those key areas that can really make a difference and allowing providers to be innovative in their ways of finding efficiencies while, at the same time, giving patients what they want. It's really a way to have the best of both worlds in balancing care with costs."

Finding Your Path to Success

VanNorman says, more and more, it's clear that there is no one-size-fits-all approach to a successful value-based care plan. Each and every organization is different. Each and every organization will have different aspects of their organization—and care delivery systems—that need to evolve. Yet, he argues, there is one thing that all of these organizations will share. And that's the need to continue placing clear emphasis on patients. It's the one sure way to get to value.

"Having that great point-of-care clinical decision support is being able to have a good view of the whole patient. And that means being able to deal with a mountain of data for the individual," he says. "But it's also about being able to understand the population. It's being able to stratify your population into different risk groups. It's about being able to understand the four or five meaningful things that you can do to really provide value across the organization. But it's really hard work to get to that point."

Pederson agrees. "Being able to get the claims data is important—but then you have to take that data and organize it into clinically relevant and meaningful units of analysis so clinicians can understand it and understand how to act on it," he explains. "Then it's about leveraging your predictive models and refining them so you can continue to make the changes you need to make to be successful."

As stated, this kind of shift is a big change for provider organizations—and benefits from thorough change management with buy-in from all key stakeholder groups. VanNorman says the best advice he can give to health care organizations is to just get started. Value-based care is not going away. Organizations that find ways to optimize their current processes to make value-based care work are going to be the ones who survive—and thrive—in the future.

"There's no doubt about it. This is a cultural transformation," says VanNorman. "It's about looking at health care in a different way. It's about understanding things as a provider that you maybe didn't have to understand before. 'What should a good value-based care contract look like for my organization? How can I best prepare my physicians? How can we transform our care teams to really operate like care teams instead of physician-driven administration squads?' "

Valente agrees. "What ails our system is the death of a 1,000 cuts, of not having the right information in place to guide day-to-day decision making," he says. "So adopting some of these different payment methods can be really helpful in focusing the attention and the effort of provider organizations in a really productive way to address those 1,000 cuts in a manner that is not only financially advantageous but also results in the better care of patients."

"This is a cultural transformation. It's about understanding things as a provider that you maybe didn't have to understand before. 'What should a good value-based care contract look like for my organization? How can I best prepare my physicians? How can we transform our care teams to really operate like care teams instead of physician-driven administration squads?'"

— *Sam VanNorman*

The face of health care is changing.

Health care is shifting into a new era of value-based care payment models. It is a shift that requires organizations to make some serious changes. Health care organizations will need to undergo serious change management at the organization level. They will need to change their care delivery systems, work closer and more transparently with payers and other health care partners, and put strong IT platforms in place to collect and analyze key data. And, in doing so, they can truly aspire to value, recouping the most of value-based care payments while still providing the highest quality care to their patients.

To learn more about how Optum can help your organization weather the shift to value-based care—and provide the analytics, expertise, and infrastructure needed to pursue true value and outcomes-based success metrics, visit **https://www.optum.com/Datainfocus**.

Additional Sources

1. http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective
2. https://www.healthdatamanagement.com/news/providers-payers-must-share-data-to-succeed-in-value-based-care
3. https://healthpayerintelligence.com/news/3-key-strategies-for-a-successful-payer-provider-relationship
4. https://home.kpmg.com/us/en/home/media/press-releases/2017/01/payers-providers-see-population-health-taking-hold-despite-challenges-kpmg-survey.html