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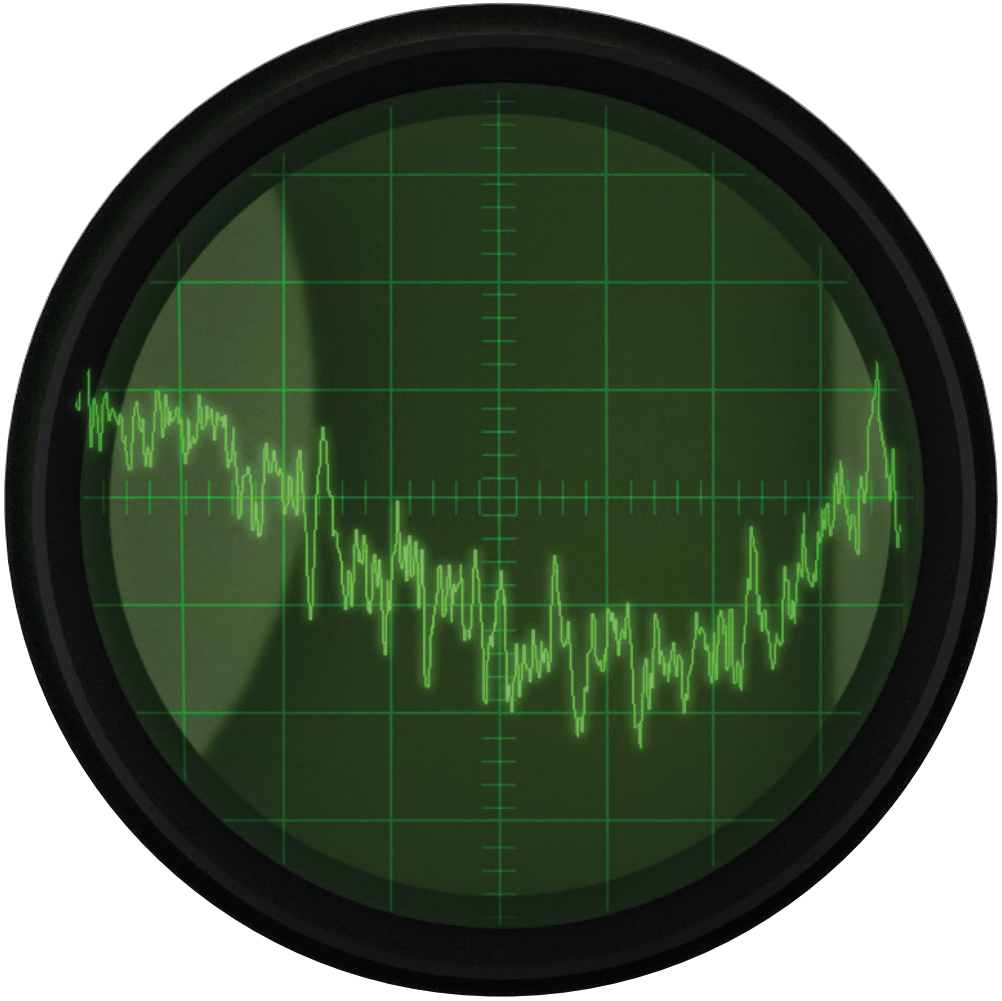

Value-based care transformation: Providers

4-Part Blog Series | Blog 3

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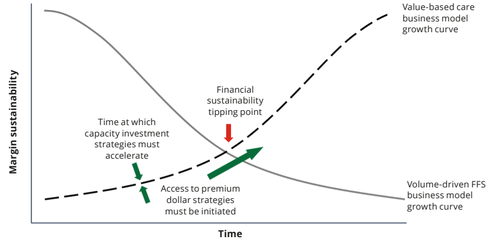
Value-Based Care Transformation: Providers | 4-Part Blog Series

Part 3: "No-Regrets" VBC Initiatives

Balancing between two canoes: How do you grow your VBC portfolio while continuing FFS operations?

Throughout this four-part series, we have examined some of the key questions and challenges we often see provider organizations tackle as they increase participation in value-based care (VBC) arrangements. From the initial motivators that prompt leaders to move away from fee-for-service (FFS), to smart first steps they take once in VBC, provider systems often face many of the same struggles in their journey to becoming more risk-capable organizations. Early on, the journey can feel like straddling two canoes-a now commonly used metaphor for having one foot moving in the direction of your FFS business, incentivized by volume of services, with the other foot moving slowly in the opposite direction. At some point in time, this conflict reaches an inflection point where the continued growth of your business depends upon having both feet firmly entrenched in one canoe. We refer to this as the tipping point: the point at which an organization's VBC financial opportunities start to outweigh FFS revenue reductions.



For many provider systems, reaching the tipping point is a multi-year journey, over the course of which the machine never stops; throughout this period of transformation, they must continue operating their business along the way. With the need for balance in mind, there are certain investments providers should consider that can result in benefits to both VBC and FFS revenue streams. These "no regrets" initiatives should be explored early on in an organization's VBC journey to realize quick wins, show faster return on investment to key stakeholders, and create savings that can be put toward long-term, strategic, value-based initiatives.

Case example

A southeast health system engaged Deloitte to enhance it's CIN with the goal of expanding primary care services within the communities it serves. The health system planned to offer community-based PCPs the opportunity to participate in VBC arrangements, such as it's MSSP ACO and commercial shared savings programs. Deloitte was tasked with identifying and targeting independent and small group PCPs for inclusion in the CIN based on performance value, capacity, access, and geographic coverage. By tailoring our Network Insight™ optimization algorithm, the Deloitte team was able to visualize geographic coverage of existing physician complement by specialty and identify primary care service gaps relative to the population. After targeting 400 PCPs to pursue for inclusion in the CIN based on value-based performance and market coverage, the health system enrolled over 100 PCPs in the first year of it's network expansion and realized $55 million in net new patient service revenue and a 10% increase in acute volumes in Year 1 directly attributable to CIN expansion and patient retention efforts.

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Physician network development and optimization

Growing and optimizing physician networks is one of the best levers available for improving bottom-line performance in a world where more organizations continue to transform their care models for VBC. As organizational strategy shifts from volume to value, it is imperative to have the right mix of primary care physicians and specialists in the right locations to succeed at value-based, outcomes-centered care. But it’s not just VBC incentives that promote the business case for network development. A growing physician network footprint can also serve as a FFS revenue driver due to improved clinical integration of services and increasing market share. The focus, however, should not be solely on bringing in a higher volume of physician practices, but screening for providers who are high performers against VBC metrics.

Case example

A population health-minded provider system engaged Deloitte to identify reasons for patients leaving the organization and to create a plan for enhancing patient retention. Deloitte evaluated claims data, operational infrastructure, and existing analytics capabilities to determine steps needed to mature the client's patient retention strategy and practices to those of a leading organization. The team identified a significant financial opportunity for incremental growth in defined populations. Working with client leadership, the team created a road map focused around setting up organization policies around referrals, on creating executive- and provider-level dashboards to track retention, tiering network physicians, setting up best practice alerts (BPA) in the electronic medical record (EMR) to guide improvement efforts, and setting up a referral contact center to facilitate and expedite the referral process.

Patient retention

Patient retention allows an organization to maintain and grow the proportion of services provided to a specific patient population within its owned or affiliated delivery system. We often refer to this as "in-system" or "in-network" spend, and each organization needs to develop a methodology to measure retention in a way that makes sense for their delivery assets and care model. Designing and executing on a patient retention strategy can increase FFS revenues, but more importantly, it allows providers to better coordinate care and monitor services being provided across the care continuum. This can lead to total cost of care reductions and increased quality of care-consequences that are also tied to VBC revenue in arrangements such as pay-for-performance.

Tracking patient retention remains a nascent capability for many providers, who often find it surprising how much financial opportunity actually exists once they finally see the claims data and analyze the patterns. A logical place to start with patient retention efforts is on the clinical services that have the highest "value," based on outcomes for the patient and margin for the provider, which allows an organization to maximize revenue while also delivering on VBC incentives. Regardless of payment model, providers should look to prioritize patient retention efforts and continually assess the needs of their consumers to improve their referrals process and build loyalty, reputation, and brand.

Case example

A large regional health care system embarked on an enterprisewide revenue cycle transformation to mitigate eroding margin impacting year-over-year net revenue yield. One of the key initiatives that made a significant quality and revenue impact was focused on elevating the client's Inpatient Clinical Documentation Improvement (CDI) program. The CDI program improvements required multiple initiatives, including:

- *Operating model redesign*
- *Hiring the appropriate number of resource requirements*
- *Developing analytics, key metrics, and a standard reporting package*
- *Providing training to clinical documentation specialists, medical coders and providers*
- *Developing an ongoing communication protocol*

Optimizing the CDI program enabled providers to better document the patient's clinical condition, improved capture rates of complications and comorbid conditions, improved severity of illness and risk of mortality scores, and supported the organization to achieve better financial performance and patient outcomes, which are important in a FFS environment and as they shift to a VBC arrangement.

Clinical Documentation Improvement (CDI)

In both VBC and FFS models, accurate clinical data is critical for care delivery and financial success. From a FFS lens and with respect to the inpatient setting, clinical documentation improvement (CDI) helps to ensure assignment of Medicare Severity Adjusted Diagnosis-Related Grouping (MS-DRG) codes for accurate reimbursement. As value-based payment models have continued to grow, reimbursement methodologies have evolved to include additional risk adjustment practices, such as hierarchical condition categories (HCC), to improve the documentation of secondary diagnoses that drive risk scores.[1] These risk scores are typically factored into PMPM or medical loss ratio (MLR) targets, which means the provider is managing total cost of care to a more accurate target (and hopefully is able to produce savings).

Case example

A large integrated delivery system in the northeast engaged Deloitte to help further support the market's accelerated push to receive clinical care and support in the comfort of the home. The client was looking to augment it's current ambulatory strategy of ASCs, urgent care models, and freestanding imaging centers by bringing acute care into the home, supported by remote patient monitoring, in-home provider visits, and near real-time medication and medical supply delivery. Deloitte conducted an assessment and will be designing the core technical and operational requirements to create a hospital-in-home program that provides a home-based alternative to traditional acute hospital treatment. The client wants to make a bold move in this space for several reasons, but primarily because a majority of its hospitals are at capacity and this program gives it an opportunity to meet surging demand from it's growing market presence.

Site of service strategy

Patients are gravitating toward convenient, accessible, and cost-efficient care. Some of this acceleration can be attributed to recent government policy around price transparency, site-neutral payments, and interoperability, as well as COVID-19 speeding up the adoption of virtual health. The data shows consumers are demanding more affordable care: 51% of consumers believe convenient access is the single most important factor driving care decision.[2] Providers need to adapt to these changing consumer and market dynamics by investing in digital and virtual capabilities as well as freestanding ambulatory facilities. This type of strategic investment allows a provider system to gain the full suite of services and assets in their network, and therefore able to manage a more comprehensive patient population. In terms of financial impact, these alternative sites of care not only present potential new revenue streams for health systems, but also provide an opportunity to reduce the total cost of care for a patient.

Case example

A large academic medical center was struggling with low operating margins and, due to their market regulatory requirements, needed to focus on expense management and cost control as opposed to volume and revenue growth. It wanted to improve operating margins and move it's cost and utilization position to a midpoint ranking when compared to national peer institutions. Deloitte conducted a cost transformation assessment across clinical and nonclinical areas at the client's major hospitals and partnered with hospital leadership to deliver the design and implementation plan for a new operating model. Cost savings totaling more than $100 million were realized for the system through changes in patient care delivery and workflows to reduce variation from evidence-based leading practices.

Cost-reduction levers

While the initiatives described earlier are primarily aimed at revenue generation in both FFS and VBC contracts, a wide array of cost savings initiatives also exists and should be considered to improve financial performance in both FFS and VBC. Some of these cost-reduction efforts could include:

- **Performance improvement:** Focusing on business model configuration, process engineering and automation, and organizational design to help you generate measurable and reportable returns on investment
- **Reducing clinical variation:** Standardizing care delivery to ensure that high-quality and cost-efficient care is being provided.
- **Workforce planning and non-traditional labor sources:** Innovating across the talent life cycle and utilizing a greater number of talent options—including contractors, freelancers, crowdsourcing, and joint ventures-to transform work, workforce, and workplace.
- **Standardization of services and bundling contracts:** Standardizing, streamlining, and integrating business processes and vendors across finance, human resources, supply chain, and other departments to increase efficiencies and reduce costs.

As regulatory reforms and reimbursement rates continue to evolve, health care providers will need to keep in mind these expense-oriented levers and other innovative cost structures that improve operating margins without hindering their ability to provide high-quality care.

Conclusion and transition to part 4: reaching the tipping point

As organizations enter into VBC contracts, they often are unsure of how far to go. *How many contracts should we enter into with payors? When should we consider taking downside risk, and how much should we take? Will this cannibalize FFS business?* These questions get to the core of the aforementioned tipping point. Most organizations have yet to reach this tipping point and are still focused on the volume of services they provide rather than managing the total cost of care for an individual or a population. These organizations are in a tricky position where they are balancing two business models with competing priorities. The good news is the above investments and capabilities should help an organization with both these business models. However, success in the VBC will depend on more than just one or two of these capabilities alone. CDI, for example, may represent a lower hanging fruit that can lead to shared savings, but long-term success in VBC is best accomplished through care delivery transformation. As provider organizations progress in their VBC maturity, some of their more FFS-driven programs and investments may need to be sunset in favor of more population health-minded items.

Our next piece in this series will highlight what additional areas we would recommend focusing on if an organization is "all-in" on VBC.

Sources:

1. Centers for Medicare and Medicaid Services, The Hospital Value-Based Purchasing (VBP) Program, 2021.
2. NRC Health, "2020 Healthcare Consumer Trends Report," 2020.

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