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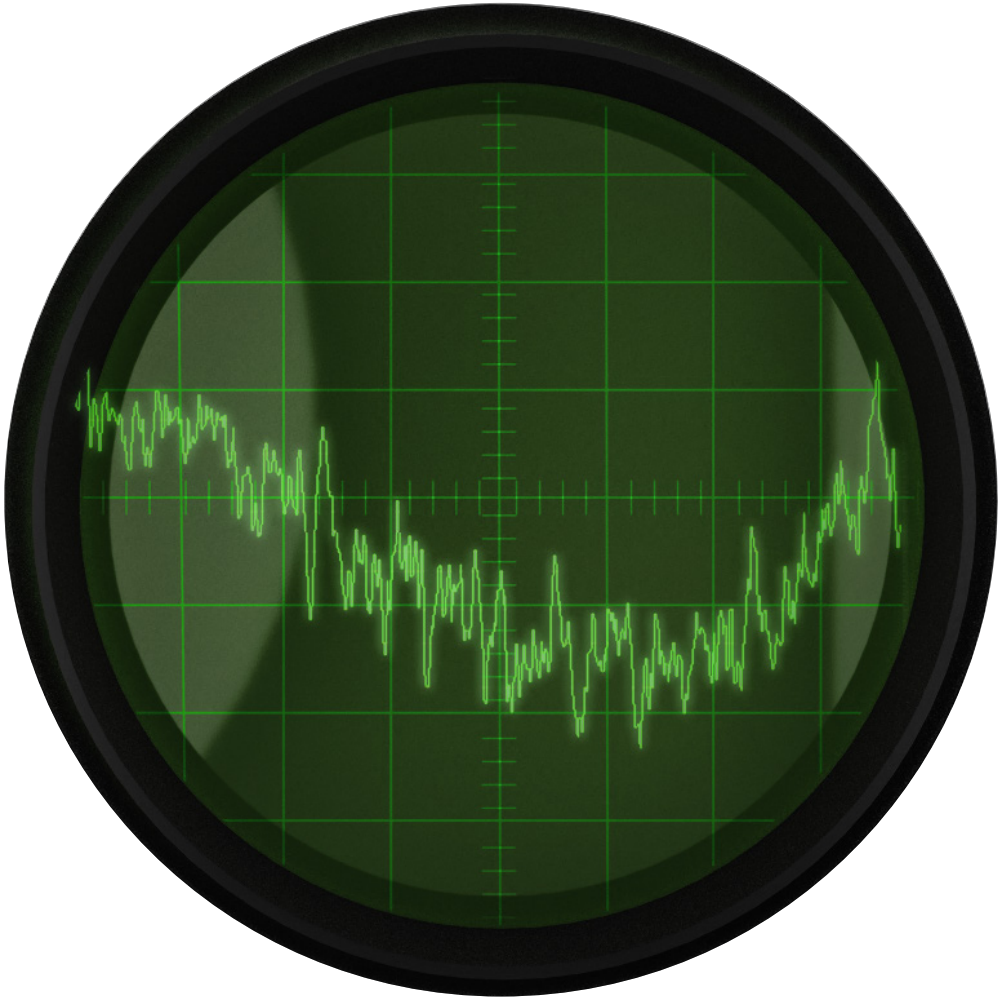

Value based care transformation: Providers

4-Part Blog Series | Blog 2

MAKING AN IMPACT THAT MATTERS since 1845

Part 2

Smart first steps: What immediate actions can be taken to enable growth through value-based care?

In the **first blog** of this four-part series, we shared common factors cited by health care providers that are driving greater participation in value-based care (VBC) arrangements—from regulatory changes to competitive pressures, health equity imperatives, changing consumer expectations and, more recently, the growing need to be less dependent on fee-for-service (FFS) revenue after experiencing financial losses during the COVID-19 pandemic. These macro trends have accelerated adoption of value-based payment models as providers and payers continue to shift away from FFS. For health care providers, once the sense of urgency is there, the question then becomes . . . where do you start?

Strategy and positioning assessment

For organizations that are just beginning to strategize for VBC, the journey often starts with a current-state assessment. The goals of the assessment should be to determine market dynamics, evaluate key capabilities that enable success in value-based contracts, and formulate what a financially sustainable VBC strategy looks like. We often see these assessments completed in four general steps:

1. **Develop a fact base:** Evaluate external market and internal enterprise information to build a baseline
2. **Review capabilities:** Assess organizational maturity across key VBC capabilities
3. **Evaluate contracts and perform financial modeling:** Identify opportunity in current contracts, and forecast financial impact of future VBC strategy
4. **Develop a roadmap and set goals:** Plot future activities against a timeline to achieve enterprise VBC goals

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Develop a fact base

In health care delivery, evidence-based practice is critical to providing the most effective care to patients based on the best available data to support treatment decisions. This same concept should underpin the decision-making process for health care executives as they explore value-based payments. Developing a fact base, or body of evidence, should lay the groundwork for a VBC assessment and lead to a current-state understanding of the VBC environment and factors affecting enterprise strategy. Factors can be organized into two categories based on internal vs. external data sources:

External/market factors

Population Dynamics: Analysis and summarization of population characteristics, use rates, and social determinants of health (i.e, income, access to transportation)

Competitive landscape: Review of competitive landscape, degree of consolidation, and competitor strategies and capabilities

Payer/provider landscape: Review of payer/provider landscape in market, degree of consolidation, adaptation or strategies for value-based care programs, and strategies and capabilities

Regulatory: Review impact of national and local regulation on market

Internal enterprise factors

Payment model: Understanding of the underlying payment model used by the organization currently and revenue generated from the payment model

Financial performance: Review of financial performance for total enterprise and by entity (as applicable), including net profit/loss, performance against benchmarks, or amount of bonus achieved

Performance drivers: Identify the top three to five performance drivers, including operational or financial metrics, contract terms, membership/patient growth factors, or other drivers.

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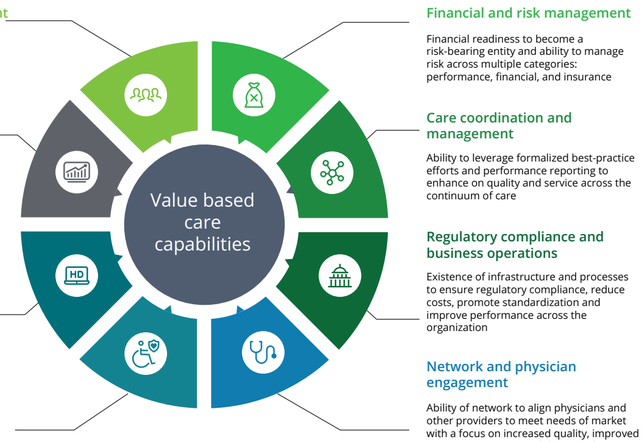
Case example

A physician-led accountable care organization (ACO) with a high percentage of primary care physicians (PCPs) partnered with Deloitte to assess opportunities for shifting their revenue models from traditional FFS to VBC or risk-based arrangements with existing and future payers. By leveraging the ConvergeHEALTH by Deloitte Network Insight (NI) tool—a proprietary accelerator that combines detailed demographic, hospital, physician, health plan, and client data to gain clear insights into the market landscape—they were able to identify low Medicare Advantage (MA) penetration in their market with higher-than-average growth. This suggested an opportunity to enter into MA contracts with payers, a strategic decision that prompted ACO leadership to recognize the need for greater alignment with specialists in order to adequately serve the needs of an MA population.

Review capabilities

Deloitte's VBC capability framework can help provider organizations determine whether they possess the right tools to successfully deliver value-based care and ultimately drive alignment of health system components with the care model. This step in an assessment involves evaluating an organization by applying a tested model to compare capabilities against leading practice through both qualitative (such as interview facilitation) and quantitative analyses (through scoring subcomponents of each capability).



Leadership, governance, and talent

Ability to engage and align leadership, staff, and governance structure(s) to make decisions and execute toward an integrated model of care

Reporting and analytics

Ability to apply analytic techniques to generate descriptive and prescriptive analytics on outcomes (e.g., cost, utilization, quality), and inform the care team with actionable insights

IT Infrastructure and interoperability

Ability to leverage integrated systems and prcesses to support business requirements of value-based care models and other organizational vision, goals, and strategy

Patient experience and engagement

Ability to create a differentiated, high-quality patient experience in order to help retain patients in the network and promote improved outcomes

Financial and risk management

Financial readiness to become a risk-bearing entity and ability to manage risk across multiple categories: performance, financial, and insurance

Care coordination and management

Ability to leverage formalized best-practice efforts and performance reporting to enhance on quality and service across the continuum of care

Regulatory compliance and business operations

Existence of infrastructure and processes to ensure regulatory compliance, reduce costs, promote standardization and improve performance across the organization

Network and physician engagement

Ability of network to align physicians and other providers to meet needs of market with a focus on increased quality, improved patient experience, and decreased costs

As a result, organizations can understand where there are capability gaps that need to be filled to achieve VBC goals.

Case example

A nonprofit health system engaged Deloitte to complete a VBC capabilities assessment as it looked to build a more robust care management program to enable more effective contract negotiation with payers regarding taking on risk for covered lives. Through assessment, the engagement team identified foundational capabilities in the care management program's identification and stratification process. Enhancements were recommended to enable the care management team to serve larger populations of attributed lives, including the recommendation to integrate additional data sources to account not just for clinician and claims data, but also social drivers of health, adherence data, and urgency for intervention.

Evaluate contracts and perform financial modeling

As a provider organization looking to grow the VBC portfolio, the sheer volume of value-based payment models out there can be overwhelming.
A recent report from the Medicare Payment Advisory Commission (MedPAC) noted that since its inception 10 years ago, the Center for Medicare and Medicaid Innovation (CMMI) has tried 54 different payment models and is expected to offer 13 different alternative payment models throughout 2021—with more than 30 payment "tracks" for providers to choose from[1]. For finance leaders, it becomes critical to understand the potential for gains and losses for these various models.

Beyond the opportunities that new VBC contracts present, the ability to manage competing incentives of value-based payment models and existing FFS contracts becomes the dilemma of every hospital CFO shifting to VBC. This challenge—amplified by rising costs and declining reimbursements that continue to impact margins—underscores the importance of evaluating contracts and performing system-level financial modeling.

The finance and payer contracting functions must work together to identify opportunity areas within VBC contracts, compare contract terms, and ultimately identify the conditions that lead to a more favorable long-term financial positioning compared to the current state.

Case example

Many health systems continue to have interest in participating in new and existing CMS and CMMI payment models. Deloitte has helped health systems and clinically integrated networks (CINs) understand what potential financial performance could be in these programs and how participation could affect overall system financials. This information has been a critical piece for provider leadership in determining participation in these programs.

Develop a roadmap and set goals

A VBC roadmap brings together findings from a well-developed fact base, capabilities assessment, and financial analysis to plot future activities on a timeline and help prioritize resources, effort, and organizational focus. An effective roadmap clearly communicates the milestones and dependencies along the way to transforming from a FFS organization to a business model built on value. It should help address the following questions:

- Where will you invest?
- What will you build organically?
- Where will you partner?
- Where do you buy and integrate when building or partnering is too challenging?
- How and when will you transform your talent?
- How will you meet your future technology needs?
- What initiatives can begin right away?
- How fast should we move into value-based arrangements?

Furthermore, a roadmap helps to drive alignment among key stakeholders and obtain buy-in from leadership around defined goals. Goals can be focused on a number of quantifiable measures. Some common metrics include the number of attributed lives in value-based arrangements, number of patients enrolled in care management programs, percentage of revenue in VBC contracts, percentage of provider compensation tied to value-based incentives, or a certain percentage increase in in-network spend. What is important is that these metrics represent the tipping point where financial opportunities from VBC begin to outweigh revenue reductions from FFS. With a defined set of goals and a roadmap of how key metrics can be achieved, provider leaders should have the clarity needed to best position their organizations for the future.

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Conclusion and transition to part 3

Even with a well-thought-out plan for greater investment in VBC, living in both a VBC and FFS business can often feel to health care providers like straddling two canoes moving in opposite directions. At some point the organization will need to decide which canoe they want to commit to (while never fully abandoning the other). Our next piece in this series will provide some answers to the roadmap-related questions above, particularly around which initiatives frequently come first for organizations, and how prioritizing those early can allow organizations to stay upright on their journey to value-based care.

Sources:

1. Thomas Sullivan, "Should CMS reduce its portfolio of APMs?," ***Policy & Medicine***, April 11, 2021

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