COPE HEALTH SOLUTIONS

# Value-Based Care – Are You Ready?

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The U.S. Health Care landscape is shifting at an unprecedented pace. Since implementation of the Patient Protection and Affordable Care Act (ACA), reimbursement policies and methodologies have undergone significant changes alarming providers (i.e., hospitals, health systems, physicians, allied health and post-acute providers/professionals across the country). 2015 was especially remarkable due to significant policy changes in Medicare, setting in motion the move towards value-based care for all governmental and commercial payors.

***Key Policy Changes***

Early in 2015, the U.S. Department of Health & Human Services (HHS) announced a plan to move Medicare reimbursement from the traditional volume-based, fee -for-service (FFS) payment model to quality-based, value-based alternative payment models. Accountable Care Organizations (ACOs) and bundled payment arrangements began to emerge. HHS also established aggressive goals and timelines to tie traditional fee-for-service payments to hospital value-based purchasing and readmission reduction programs (85% in 2016 and 90% by 2018). At least 30% of the payments in 2016 and 50% by 2018 must flow through alternative payment models.

On April 16, 2015 President Barack Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) law, ending the legacy Sustainable Growth Rate (SGR) for Medicare Part B physician payments. The new law includes multiple major policy changes (i.e., Medicare physician payment reform, permanent two-year CHIP extension, post-acute and inpatient hospital payment updates, and delay in Medicaid Disproportionate Share Hospital (DSH) payments). In order to incentivize effective outcome- based care practices, Medicare physician payment reform provides two tracks of reimbursement methods – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM). MIPS consolidates Meaningful Use, Physician Quality Reporting System (PQRS) and other value-based modifiers into a single performance-based payment incentive in the traditional fee-for-service system. APM provides bonus payment through ACOs or Bundled Payments if providers meet defined requirements. Both tracks utilize the traditional "carrot and stick" method of providing incentives to providers who meet the requirements, and penalties for those who fail to do so. The MACRA law received strong support from both political parties, and unlike the ACA, most health care industry experts believe the transition to value-based payment has strong staying power in the years to come.

***Strategic Outlook***

Passage of MACRA firmly set the course away from fee-for service payment towards value-based care reimbursement. Medicare providers need to be compliant with either track to avoid payment penalties moving forward. However, transformation to new reimbursement models is not as simple as flipping a switch. Most agree it's uncertain if MACRA will significantly change or reinforce current underlying health care economics.

While most believe MACRA is likely to remain after the upcoming presidential election due to strong bipartisan support, additional substantial shake-ups to the health care industry (e.g., gradual tightening of regulations and benefit obligations to reduce resource waste and abuse) can be expected.

2016 will be significant as providers work on developing and implementing their own value-based payment transformation strategies to avoid losing revenue/profit margins in the years to come. Unfortunately, no cookie-cutter solution that will work for all providers exists; but general guidelines exist that providers can leverage in order to be successful in the current rapidly changing reimbursement environment, including:

**Know your patient population**. Your ability to more effectively manage your patients' care will facilitate increased-control over outcomes of care. Better outcomes will be tied to and enable providers to take advantage of additional incentives under the new regulations. In addition, knowing your patient population enables providers to identify potentially expensive, high-risk patients and patient groups; and, once identified, allows providers to apply targeted interventions and population health management skills and strategies to turn potential losses into revenue gains.

**Understand the true cost of care.** The transition from FFS to value-based payment often times shifts financial risk to the provider. An important benefit of understanding the underlying and often complicated cost structure will enable providers to identify potential and often difficult to find cost reduction opportunities, drive meaningful benchmarks and develop capabilities to better negotiate at-risk pricing or contracting with payors and other care partners, under a population health management and reimbursement environment.

**Develop a clear vision and strategy**. Just as Rome was not built in a day, the transition to value-based care most likely will not be accomplished immediately. Providers need to develop a business strategy that supports the organization's or practice's vision of transforming care to take advantage of increased revenue opportunities and payments. The chosen strategy will have a better chance of being successful if it's developed utilizing relevant data and deep assessments of various aspects of the organization (i.e., technical infrastructure, current quality and performance, staffing, network and the patient community). Gaps and misalignment with the value-based care environment need to be proactively addressed to ensure success. Significant culture shift will be required; and effective risk management is crucial to help ensure a successful transition process.

**Operational Excellence**. By any measure, high quality care and improved patient health are critical criteria by which we evaluate providers in our network. By investing in permanent structure and a systematic approach to process improvement, providers will be able to develop a deep, sustainable culture of quality improvement in order to apply consistent lean methodologies across the organization and continuum of care in the network. In addition, implementation of tools such as Balanced Scorecards or provider dashboards to monitor key performance indicators will be critical to establishing accountability, making data-driven decisions and measuring success at the provider and network level.

Again, are you ready for value-based care?

**About COPE Health Solutions**

COPE Health Solutions has deep expertise in value-based payment strategies and implementation, enabling our partners to define and implement their vision for population health.

*For more information about how COPE Health Solutions is helping clients across the country prepare for renewal based value-based payment implementation and planning, please contact:* consulting@copehealthsolutions.org.