Run to Risk: Making the Shift to Value-Based Payments on Your Terms

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CMS's recent announcement of a new mandatory bundled payment program for heart attacks and cardiac bypass surgery is the fourth major announcement coming out of the Center for Medicare and Medicaid Innovation in 2016 related to bundled payments. This suggests it is continuing to push forward on its goal of tying 50 percent of Medicare fee-for-service (FFS) payments to alternative payment models (APMs) and 90 percent of traditional Medicare payments to quality and value by 2018. And as goes Medicare, so goes healthcare; a national task force composed of providers, employers, and major private payers has declared its intention of transitioning 75 percent of its members' business into contracts with incentives for health outcomes, quality, and cost-management by January 2020.[1]

This shift to value-based payment (VBP) models is often met with resistance. We see seemingly smart leaders unable to make decisions because they are paralyzed by the "silent killer" of fear. Such anxieties are not completely unfounded; while FFS has been abysmal for the economy, many have profited from over-testing and over-treatment. Further, earlier tests of value-based models, including the first-generation ACO model, saw underwhelming financial performance.

The Run to Risk

What's easy to forget is that in many ways, healthcare reform is still in its earliest stages. Reducing costs and improving quality isn't easy. Healthcare is part of a much broader and complex ecosystem; transforming it is hard work and will take years of cross-collaboration among numerous sectors of the economy.

Even though payment reform is still evolving, the financial future of any healthcare organization rests squarely on the early and earnest adoption of the right VBP arrangement for its unique situation. With the commitment from CMS, employers, and payers to tie payment to value, it is not a matter of if but a matter of *how* organizations go about planning for transformational change. Organizations that enter into value-based arrangements on their own terms and select the models that make the most sense for them will be able to capitalize on early learnings and get paid for what they already do: providing high-quality, appropriate care for patients. Below are five principles that healthcare leaders should be mindful of as they navigate the journey to value-based reimbursement.

Key Board Takeaways

As healthcare organizations navigate the journey to value-based reimbursement, boards should be mindful of these principles:

- Early adopters will have more time to gain the experience necessary to prepare for the shift to predominantly value-based reimbursement.
- During this shift, providers are likely to operate simultaneously under different reimbursement models.
- Incentives from FFS and VBP contracts will need to be organized to maximize the value from each type of contract.
- Organizations that delay their entrance into VBP run the risk of allowing other players to capture attributed patients before their own models are initiated.

1. Early Adopters Win the Day

Providers that have embraced VBP models are already gaining important experience in the transition toward outcomes-based reimbursement. Over the next decade, the markets will shift to predominantly value-based reimbursement, and those not ready will be left behind and find it impossible to operate profitably.

Regardless of profitability under value-based systems as presently constituted, providers need to develop capabilities now to provide cost-effective, outcomes-based care. While some providers still experience financial stability under the FFS model, profits will continue to erode as public and private payers move continually toward reimbursement based not on the quantity but the value of services delivered.

Waiting to move toward value-based models will come at a cost as competitors continue to forge ahead with efforts to operate under different types of reimbursement models. Early adopters have time on their side as they become savvy in the intricacies of VBP, gain a head start on articulating their value under these new arrangements, and subsequently corner the market with favorable payer and employer contracts.

2. Get Comfortable Living in a World of "Fusion" Reimbursement

Value-based care models and FFS reimbursement are not canceling each other out. The options under value-based care fall into a vast continuum, from upside-only risk associated with retrospectively reported quality measures to full-risk models in which providers deliver care under a fully capitated agreement. The wide variety of risk tolerances and reimbursement models in the value-based continuum should ease concerns surrounding future financial instability.

During the transition to a payment approach that deemphasizes FFS, providers are likely to operate simultaneously under different models. At least for the time being, this fusion approach allows providers to gain valuable experience while mitigating the effects of taking on large amounts of risk in a short period of time.

3. Organize Incentives to Maximize Value

Transitioning a greater proportion of payments into value-based contracts can feel like a dicey move. There may be a period of time in which total revenue decreases, because the pressure on FFS revenue will increase faster than it can grow through value-based reimbursement. To mitigate this revenue impact, savvy organizations must fuse incentives from FFS and VBP contracts into gainsharing and co-management agreements that maximize the value from each type of contract. Given that most organizations will have both FFS and VBP contracts with payers at different points along the continuum, operationalizing this information is no small effort. However, since both reimbursement types will be the new reality for years to come, it will be well worth any struggle.

4. The Master Class in Patient Attribution Begins Now

One of the fundamental tenets of VBP is provider and payer accountability; because of it, parties have a strong financial incentive to closely monitor patient care and outcomes across the full care continuum. Providers care for a group of "attributed" patients—to whom their VBPs are directly tied—and are held responsible for those

1 Health Care Transformation Task Force, "Major Health Care Players Unite to Accelerate Transformation of U.S. Health Care System," January 28, 2015.

patients' outcomes. Organizations that delay their entrance into VBP run the risk of allowing other players to capture attributed patients before their own models are initiated, inadvertently forgoing future business and revenue opportunities.

In addition, providers' responsibility for patients across the care continuum calls for stronger partnerships with post-acute care organizations. Early adopters are already working with post-acute care organizations to standardize care based on their care protocols, and more aggressive organizations are thinking about buying or building post-acute assets. Waiting too long may lead to missing the opportunity to partner with the most beneficial post-acute partners.

5. There Is a Time and Place for FFS

A common misperception of VBP models is that they encourage providers to do less, often at the expense of a patient's care needs. Similarly, this logic encourages the flawed perception that FFS models only incentivize providers to do more, through potentially unnecessary services. VBP models are actually built on the principle that improvements in tools and technology better enable providers to give patients the care they need while avoiding unnecessary treatment. And while FFS models have earned a bad reputation, there may continue to be scenarios in which FFS payments are more appropriate, such as unavoidable ER visits and ensuring patient access in areas with a provider shortage. By embracing a fusion approach, organizations can equip themselves to operate under a variety of reimbursement models and appropriately respond to patient needs.

Implications for Board Members

Good patient care is good business. Healthcare executives willing to step up and make the necessary changes to their care models will transform care on their terms. In doing so, their organizations will lead markets and become places where doctors want to practice and patients want to receive care. Board members, executives, providers, and payers must commit to building communities where doctors are rewarded for giving high-quality care that is cost-effective.

Modeling the courage and transparency necessary to improve healthcare is a legacy worth leaving. Putting the interests of patients above those of every other stakeholder group is a conscious decision leaders make every day. Our patients and their families deserve nothing less.

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