The Value Mandate

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Introduction

Healthcare has entered an era that is vigorously testing leadership, resources and technology on multiple fronts. While conducting daily business, providers, payers, third parties and hybrid organizations also need to efficiently transition planning, finances and operations from fee-based to value-based care and reimbursement. At a higher level, the coordination of patient-centric care needs to span clinics, hospitals, integrated health systems, payers, imaging, pharmacy and other parties in the value chain. The preparations and changes being effected now will determine not only the success but the viability of many institutions going forward. Given the stakes, execution has never been more important.

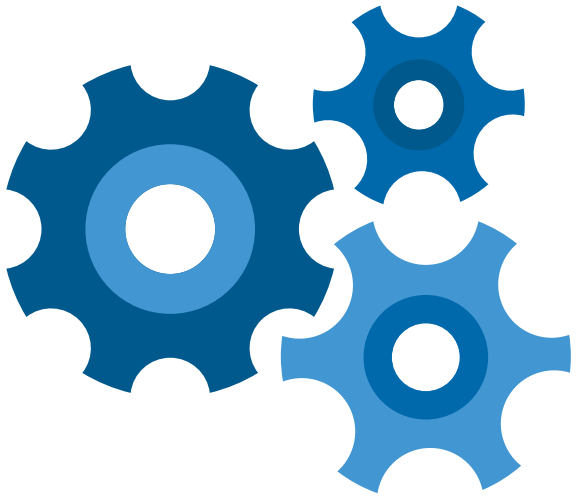
Such a challenge can only be met through adoption of practices, standards, methodologies and mandates supported by careful financial planning and budgeting, collaboration and technology adoption that supports data management and analysis. Only such a collective effort will achieve the efficiencies and meet the broad demands of lawmakers as well as the open market.

Daunting as the end goal may be, we can describe four essential pillars to support and direct us toward this outcome.

1. It begins with **building a healthy business** with optimized revenue cycles and reimbursement across service lines. At the same time, it must support viable ongoing core operations through cost management of supplies and resources. Costs and quality of care must also be measured against benchmarks and the performance of other organizations from claims handling to bedside care.

2. Organizations must **connect and coordinate** care across overlapping networks of providers in institutions, ambulatory and home care. Providers and payers need to align financial and quality-based reimbursement across sub-acute and chronic populations while managing risk and controlling costs. It also requires embracing mobile and Web-based platforms through security standards and standards-based APIs.

Introduction - Continued



3 **Continuously improving outcomes** must be driven by transparent, strategic goals enforced by accountability in order to effect real change at the stakeholder level. Crucially, clinical analytics programs will make use of secure, quality data to inform and advise stakeholders and managers at all levels of the organization to address costly issues of variability.

4 Finally, organizations and especially providers need to **manage risk** by understanding total patient costs and utilization inside and outside the network including pharmaceutical, labs, imagery, as well as clinical. At a higher level, they need to be able to aggregate and stratify populations in portfolios of risk exposure and performance.

The materials in this ebook are all dedicated to managing the pillars listed above and identifying the challenges and solutions available to address the new requirements of patient-centric, value-based healthcare and reimbursement.

- There are resources in this document dedicated to addressing financial performance through margin improvement and cost containment through revenue cycle management.
- Other resources address connectivity in examples of home care and hospice practices and working with supporting services.
- The need to continuously improve outcomes is supported in papers addressing variability through analytics, workflow, value-based models and usability.
- Risk, of course, overlays all these issues and is addressed throughout the content of this ebook.

We hope you will find the content illuminating and useful to your own plans and goals, and we stand ready to assist you with further resources and guidance.

Industry News

Healthcare finance execs see role for IT in shift to value
Greg Slabodkin, Health Data Management

Providers say they're not ready for the transition to value-based care
Joseph Goedert, Health Data Management

Why docs should embrace value-based care
Paul Taylor, M.D.

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Healthcare finance execs see role for IT in shift to value

Greg Slabodkin, Health Data Management

As healthcare moves toward new payment and care delivery models designed to improve quality and reduce costs, financial management is at the heart of the industry's transformation to become more value-based.

That's the consensus of healthcare finance professionals meeting this week in Las Vegas. At its Annual National Institute, leaders of the Healthcare Financial Management Association acknowledged the momentous changes that face the industry as it transitions from fee-for-service to value-based care, but at the same time argued that HFMA members are well positioned to take on those challenges head on.

"We have faced as an industry a wide-ranging set of changes that we had to tackle so that our communities could continue to receive the very best healthcare," said Mary Mirabelli, newly appointed chair of HFMA's board of directors. "We have gone through massive legislative changes, and each and every time, we've figured out a way to make it work."

Mirabelli, vice president of global healthcare practice at Hewlett Packard Enterprise, asserted that the latest transformation in healthcare means "new processes, jobs, roles, systems and technologies" as well as the "integration of services, blurring of roles, and the merging of organizations." Ultimately, she said the changes that finance professionals have been asked to manage are endless.

As the industry continues to evolve to alternative payment models, Mirabelli believes that HFMA members must seek to "thrive" during these uncertain times, working hard to "understand the implications of our financial statements, our revenue, our clinical care, and to do the right thing."

Nonetheless, results of a newly released KPMG poll of nearly 300 healthcare executives show that a majority now say that value-based contracts will hurt profitability versus 47 percent two years ago. In addition, the survey found that the most significant impact from the changes in the delivery of care will come from growing connections with lower acuity healthcare centers, disease management and increased use of telemedicine.

According to Jim Landman, HFMA's director of healthcare finance policy, perspectives and analysis, both providers and payers are feeling the pressure of market forces that are reshaping the industry. He contends that consumerism, population health, and value-based payment are erasing the traditional boundaries

Healthcare finance execs see role for IT in shift to value - Continued

Consumerism, population health, and value-based payment are erasing the traditional boundaries between hospitals, physicians and payers, which require new levels of collaboration in this rapidly changing environment.

between hospitals, physicians and payers, which require new levels of collaboration in this rapidly changing environment.

"One of the things we're seeing is new combinations emerging in all sorts of ways and forms, whether it's an official merger, an affiliation, a joint venture, or a partnership," said Landman. "We're seeing healthcare systems and health plans doing this, and physician practices and health plans doing it."

With patients at the center of care, he argues that it's more important than ever for health plans, hospitals and physicians to be "on the same page," working together for financial and clinical alignment, and that there are core capabilities that organizations must develop to succeed under value-based payment and care delivery models, including health information technology and healthcare analytics.

Gordon Edwards, chief financial officer of Wisconsin-based Marshfield Clinic Health System, said that his organization continues to invest in IT and analytics.

"Data helps drive decisions that we make on a daily basis," exclaimed Edwards. "We have been an adopter of technology early on."

Marshfield's ambulatory electronic health record system is homegrown. The integrated regional healthcare provider, which generates $2 billion in revenue evenly divided between its health plan and care delivery, offers a portal for patients — 25 percent of whom use it — and boasts that it has been providing telemedicine services for nearly 20 years.

"IT has been and will continue to be an area of focus and investment," added Edwards. "In some regards, it's become more important than ever."

Originally published by Health Data Management, June 2016. Click here.

Providers say they're not ready for the transition to value-based care

Joseph Goedert, Health Data Management

The nation is on a fast-track in shifting to value-based care payment models, and to an extent, providers are moving faster than they're able to adapt.

Providers need to make progress on a variety of fronts to succeed under value-based care, involving both the use of technology and other operational changes. Many organizations, while in transition, are still in the early phases of demonstrating key capabilities, such as determining their costs and tracking financial information.

Given the rapid shift, it's no surprise that providers aren't comfortable with their readiness for the move to value-based care, and that was confirmed in a recent survey by HIMSS on cost accounting, released last week.

In large part, the profound shift in reimbursement is being led by the Department of Health and Human Services, which last year set the goal of having 30 percent of Medicare payments tied to value-based reimbursement by the end of 2016. The transition is happening faster than anyone thought possible, with HHS recently reporting that its goal was met this month.

Providers are making the shift, but generally they are not feeling comfortable with or adept at handling the new challenges of value-based care, says Pam Jodock, senior director of health business solutions at the Healthcare Information and Management Systems Society.

In the HIMSS analysis of results, only 3 percent of respondents said they believe their organization is highly prepared to make the transition to pay for value from the current reimbursement approach of fee-for-service.

Many providers have forged ahead with value-based contracts, hoping to figure things out with Medicare as they go along, Jodock says. Statistics bear out her contention — a total of 477 accountable care organizations are now participating in the Medicare Shared Savings and Pioneer ACO programs.

If the end result is that providers meet cost savings goals on clinical treatment but triple their administrative costs to collect and analyze data, process claims and make payments, then you haven't really achieved your goals.

However, she notes that regulators and providers need to be thoughtful about how quickly providers can make changes, if they can put the appropriate infrastructure in place to be successful in the long-term. For instance, providers still struggle in sharing information electronically within the same delivery system, much less with outside providers.

Further, some of the technologies needed to facilitate value-based care aren't yet widely available. For example, Medicare wants hospitals to manage an episode of care across provider sites across the continuum of care, but to do that, facilities need consolidated billing functions to manage the entire episode of care. Under bundled payment arrangements, Medicare will reimburse the hospital, which then dispenses payments to various units of the hospital as well as to outside providers.

Providers say they're not ready for the transition to value-based care - Continued

Even the idea of establishing costs is a challenge for providers. The survey found that while many healthcare organizations have a formal process for determining healthcare costs, only 39 percent regularly review those costs to ensure that information is current.

In future models that include risk-sharing arrangements, hospitals also will be responsible for assessing losses and sharing rewards among providers responsible for an episode of care, Jodock says. "We currently don't have those processes in place."

Respondents to a new HIMSS cost accounting survey also have concerns that there are no consistent definitions of the services to be included in a bundled episode of care.

While HIMSS supports the move toward value-based payments, it would like the transition to occur more cautiously, and that Medicare take into consideration findings from the cost accounting survey before moving into an implementation phase that could include assessing financial penalties.

The survey found that in the short-term, vendors need to work on solutions to let disparate systems better share data, and hospitals and other providers need to create ways to handle data exchange in the interim.

Healthcare providers use an array of factors when determining service prices with profit margin necessary to maintain financial health and actual cost to deliver the care emerging as the most important factors. But, fewer than one-third of respondents to the HIMSS survey said they have the ability to evaluate these costs in an automated fashion, even though many have plans to expand price transparency efforts.

Provider organizations are looking for tools to share and track quality and financial information between providers and for consistent definitions and business practices that can be applied in all settings, regardless of who the payer may be.

The fear is that just as the electronic health records meaningful use program required providers to use technology that's not yet available, the same scenario is playing out again to some degree under value-based payments.

"The point of the survey is to make sure the train is not derailed down the road," Jodock says. If the end result is that providers meet cost savings goals on clinical treatment but triple their administrative costs to collect and analyze data, process claims and make payments, "then you haven't really achieved your goals," she adds.

The intent of the survey, she emphasizes, is not to be critical and not to short-change the clinical cost savings that can be achieved through alternative payment models, but there is a complimentary administrative side as well that must be considered.

Originally published by Health Data Management, March 2016. Click here.

Why docs should embrace value-based care

Paul Taylor, M.D.

As an internist who has used population health management techniques for a decade, I have no illusions about the challenges and costs of matching PHM care with value-based payment models, but I have found successes through a shift in mindset and care delivery approaches.

Information technology and other support mechanisms are in the early stages of aligning to support the evolution in care delivery, so it's difficult to assess the final destination that doctors will eventually reach.

Primary care providers should enjoy their work more and see increased reimbursement within VBC models, as PCPs on the front lines can have the greatest impact—and coordinated care planning opportunities — on the "sickest" or most complex chronic care patients.

Within my practice, we have navigated, and continue to navigate, through private insurance programs, PCMH initiatives, a CMS Shared Savings ACO and, just this year, the beginnings of our status within CMS's new Next Generation ACO model.

Through it all, the paradigm shift has been around responsibility; what's the nature of my responsibility to my patients and how do I approach and track that? Is my responsibility encounter-based or is it more longitudinal in terms of my entire patient panel?

I see it as a more holistic approach away from episodic or even repeat visits to thinking about what happens between encounters and what resources can be matched to needs around social determinants or medical history or basic communication.

Embracing the care team approach is key to those mindset and care delivery paradigm shifts that are necessary for providers to succeed with value-based care. And the care team should not just be in a practice silo. It should include all transition of care or referral settings, the hospital coordinator, the PharmD, the dietician and all staff liaisons, the spectrum of the clinical and non-clinical elements patients can have access to between visits.

A quality manager, with provider direction, can really help make all of this work smoothly. This is someone who can proactively oversee and coordinate the care team and processes and be responsible for the outcomes measures that are reportable to payers for these value-based care programs.

Patients will increasingly embrace the care team approach and the increased access or the personal touch it can bring them. They will come to value the levels of care they thought only "their doctor" could bring.

There are other challenges for providers as we are transitioning to more VBC programs, but there are also solutions. Currently my practice is involved with at least 10 reimbursement programs, each with its own set of standards and patient populations within my overall panel.

Quality measure standards. Population-level risk. Utilization and cost of care. In- or out-of-network. Care teams and effective technology capabilities are critical for sorting through these variations and delivering high-quality care. Automating the quality program expectations and requirements helps our care teams know what they need to focus on for each patient.

Why docs should embrace value-based care - Continued

A lot of this work needs to be done in my office, but this is also where the health system can be a support system.

I currently practice within a layered structure. I'm a hospital-employed physician, with the hospital itself owned by a multi-state health system. My large, multi-specialty employed physician group as well as many independent primary and specialty care practices are all part of our local health network. Here is where support comes in. The network contracts with payers on behalf of the providers, takes responsibility for VBC IT, aids with quality program certifications or recognitions, and is a care management process educator and facilitator. Our network really helps bring our healthcare community together and rallies us around our growing number of VBC programs.

As a primary care physician, I see a lot of frustration and an increasing rate of burnout in medicine. However, I do think that the transition to VBC and team-oriented care has a lot of promise to help physicians rediscover the joy of practice that has often been eluding us.

Simply getting out of a production-and-visit volume mindset can help a lot. If we are spending our time with our sickest patients and leveraging our care teams, we will make more of a personal impact, which is rewarding. Being financially rewarded for delivering high-quality care also fits well with physician personalities and will help us feel like we are being compensated for the value we want to provide — high-quality care.

Our EHRs have significantly reduced our productivity and focused our time on a lot of meaningless clicks that don't bring value to anyone, so the coming transition in the meaningful use program to focus on using technology to improve patient outcomes — rather than using an EHR just to use an EHR — will hopefully improve our day-to-day patient care experience.

Other changes should help as well, such as increased use of telemedicine. Value-based care should also allow telemedicine to live up to its potential, which can help the many providers and patients in rural areas get access to specialty care that may be difficult or impossible to obtain in an FFS world. This will benefit specialists and health systems and expand their reach and open markets as well.

For our practice and network, the past decade has provided a good foundation for our ongoing transition to VBC, which is about to accelerate and become even more detailed for my Medicare population. The MIPS and APM payment tracks within the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is something we look at more as an opportunity at this point, rather than a challenge. We'll know more about the proposed rule this year, but we've learned enough about how to succeed with other programs that we know we will do well, whatever the MACRA requirements may be.

A lot of the frustration with medicine that we see from both providers and patients is actually rooted in the FFS payment model and its emphasis on volume. Rewarding providers for delivering high-value care and delivering that care using a proactive care team approach enabled by the right technology can improve not only clinical and financial outcomes, but also improve the human satisfaction of those who both use and deliver healthcare services.

As physicians, we should not only embrace the transition to value-based care, we should push it along any way that we can.

Originally published by Health Data Management, March 2016. Click here.

Providers lag behind in transition to value-based payment

Greg Slabodkin, Health Data Management

Despite efforts to move the healthcare industry rapidly to value-based contracts, it appears that provider organizations are struggling to make the transition.

Moving to the information systems and data requirements of the new reimbursement system, which rewards more coordinated, value-based care, is proving to be a daunting challenge, as organizations still try to remain economically viable in a fee-for-service world. A recent survey of provider organizations suggests that only a tiny percentage provide more than half of their care under value-based care arrangements, a target that federal agencies have set for the industry.

Meanwhile, nearly two-thirds of respondents said that 10 percent or fewer of their contracts are tied to value-based care initiatives.

The results stand in stark contrast to the hopes of the Centers for Medicare and Medicaid Services. In January 2015, CMS announced that it was rapidly moving to a payment system based on value not volume, setting ambitious near-term goals.

At the time, industry observers knew it would not be an easy transition for providers. Now, responses to a new survey, conducted for Health Catalyst, an analytics vendor, suggest providers are still amassing the tools and expertise they need to take on more value-based care contracts.

“Healthcare providers are struggling because this is a new way of doing business,” says Dan Soule, vice president of product management for analytics vendor Health Catalyst, which is focused on risk-based decision making. “It’s incredibly hard for these organizations to figure out how they provide care under value-based models and yet still support fee-for-service.”

The Health Catalyst survey of healthcare executives, representing 190 U.S. hospitals, shows that a mere 3 percent of health systems currently provide more than 50 percent of the target set by CMS, while just 23 percent expect to meet it by 2019—a year after the agency plans to have more than half of all Medicare reimbursements value-based.

The survey also found that 62 percent of health systems have either zero or less than 10 percent of their care tied to the type of risk-based contracts identified by CMS as “value-based,” including Medicare accountable care organizations and bundled payments.

Earlier this year, CMS reported that it had reached its goal of having more than 30 percent of Medicare fee-for-service payments linked to quality and cost outcomes by the end of 2016 — about a year ahead of schedule. And, the agency says it is also on track to have more than 50 percent of Medicare fee-for-service payments in alternative payment models by 2018.

“In the payment arena, we were at zero percent alternative payment models then hit the 30 percent goal, and I think we will reach the 50 percent goal by the end of 2018 — or before,” said Patrick Conway, M.D., CMS acting principal deputy administrator and chief medical officer.

Conway made the remarks earlier this month at the ONC Annual Meeting in Washington, adding that health IT are the tools that will be used by providers — who are accountable for quality and total cost of care in alternative payment models — to drive better outcomes for patients, which he said is the ultimate goal.

Providers lag behind in transition to value-based payment - Continued

Officials contend that the use of HIT, such as electronic health records, and healthcare analytics are critical pieces for providers to succeed with APMs. "If you want providers, in particular, to be accountable for their outcomes and for the cost of care, then there needs to be good communication among the various patient touch points," Meena Seshamani, M.D., director of the HHS Office of Health Reform, told the ONC annual meeting.

To succeed with risk-based contracting, 52 percent of respondents to the survey cited the importance of analytics; that was more than twice the percentage that mentioned quality improvement as the most important factor in delivering value-based care, the next most frequently mentioned answer.

Despite the importance that hospital executives say they place on analytics, Soule believes that it is a "big hole" in these organizations' abilities to understand their respective businesses.

"It's more than analytics. It's also understanding their costs," he says, adding that population health management is critical to controlling the high costs and outcomes that come from patients with chronic conditions.

As Soule notes, 5 percent of patients with chronic conditions account for 50 percent of the cost in the Medicare program. "You need to make sense of a lot more data to be successful," he asserts. "You need to be able to look at the clinical data as well as at the claims or billable kinds of charges in order to determine who the patients are that you should focus your resources on."

Regardless of the how they plan on achieving success, the survey of hospital executives paints a picture of broad support for the goals of value-based reimbursement. In fact, all but 1 percent of respondents expect their organizations to be engaged in at-risk contracts over the next three years.

When asked at the ONC annual meeting about the industry's response to this "pivot" to value-based payment, Conway referred to a survey of healthcare CEOs conducted about five years ago in which he said "the majority of them were like this value-based stuff is interesting but I'm not sure it's real."

More recently, according to Conway, another survey found that 90 percent now believe that value-based reimbursement is fast becoming a reality, while about a third of respondents admitted that they're "not sure how to do it — especially, small rural providers."

Not surprisingly, the Health Catalyst survey conducted in May 2016 found that small hospitals with fewer than 200 beds comprised the majority of those reporting that they didn't have any at-risk contracts. According to the survey, smaller hospitals are five times less likely than larger organizations to have access to sufficient capital to make risk-based contracting work.

"Most organizations, particularly smaller ones, don't have a lot of data with which to try and really understand their business — not the least of which is they have no idea what their costs truly are," adds Soule. "They don't have a clue."

Still, Conway said the good news is the healthcare industry now has a health IT infrastructure in place to aid in the drive toward delivery and payment system reform. "The challenge is now how to use that infrastructure for maximal improvement in health," he concluded.

Originally published by Health Data Management, June 2016. Click here.

Financial Management

Conquering Margin Improvement in a Changing Environment

The healthcare environment is constantly changing. To survive and thrive in today's evolving healthcare world, you must effectively and efficiently manage your business to not only achieve better patient health outcomes, but to do so at lower costs. To do this, you need to identify and focus on the margin improvement opportunities for your organization.

Read More

Achieving Financial Health on the Road to Value-based Care

Healthcare organizations are primarily focused on patient care and health outcome, but financial well-being is equally important for organizations to continue to provide the highest-quality care. The importance of financial health can't be overlooked on the road to value-based care.

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The Business of Revenue Cycle Management: Cost Containment Strategies in an Era of Value-based Business Models

Hospitals and medical practices are faced with making the move from productivity-based operational models to budgeted care-based business models. Driving down costs is a critical metric impacting how hospital executives and physicians begin to view and shape the business of revenue cycle management interoperability, but barriers still remain.

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Interested in accelerating your progress in building a healthy business? Click here to contact a financial management expert from McKesson.

Connectivity

4 Must-have Elements of Radiology Workflow in a Value-based World

The transition to value-based care is pushing radiology beyond its traditional borders. In order to achieve better patient outcomes, radiologists and their colleagues need broad access to both data and images. A more integrated, collaborative radiology workflow can connect both systems and people, which helps provide much-needed context for better patient care.

Read More

Interoperability Comes to Home Health and Hospice

Hospitals and post-acute care providers such as home health and hospice organizations are working more closely together than ever before, but better care decisions come from having better information readily available for caregivers. Interoperability increases the quality of care for those struggling with significant illness, injury and chronic conditions.

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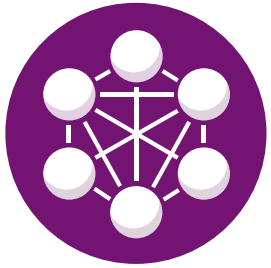


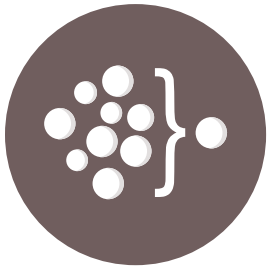
The Interoperability Equation: Removing Barriers to Make It All Add Up

The need for a connected healthcare system and the reality of healthcare reform has fueled progression toward a more interoperable existence. The overall complexity of health care, combined with a lack of widely adopted standards, has made the journey a bit more arduous. Great strides have been taken toward achieving true interoperability, but barriers still remain.

Read More

Interested in accelerating your progress in connecting and coordinating care? Click here to contact a connectivity expert from McKesson.

Data & Analytics



15 Insights to Managing Quality Outcomes

The shift from volume-based care to value-based care is here and the pace of change is rapid. There is no doubt that reimbursement will be based on your ability to achieve the highest-quality outcomes. While the destination of value-based health is crystal clear, how to get there – and how fast – is not. Is your organization ready to succeed?

Read More

Role of EHRs in Data Accessibility and Analytics

Data out is only as good as the data being put in. Michael Blackman, M.D. discusses the importance of EHRs in data accessibility in this Q&A.

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Videos — Ask the Experts:

How are analytics helping you manage core operations?

What analytic capabilities are your highest priorities?

Interested in accelerating your progress in continuously improving outcomes? Click here to contact a data & analytics expert from McKesson.

Value-based Health

Focus Ahead Report: Navigating the Journey to Value-based Health

In today's dynamic world of health care, a more collaborative, interconnected system is emerging — and the business of health care is growing more dependent on patient outcomes. To navigate this change and achieve sustainable success, health care executives are asking important questions about the journey from volume to value.

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Accountable Care Services Playbook

Navigating the path to accountable care services is easier with a roadmap. To develop, manage and grow your ACO you need results-driven insights, tools and guidance. This playbook will help you manage everything from your infrastructure, policies and procedures, to your specific documentation, contracts and agreements.

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Journey to Value: The State of Value-based Reimbursement in 2016

Health care is well along the journey towards full value-based reimbursement. Bundled payment is projected to grow fastest over the next five years. Network strategies are changing. And payers and hospitals are struggling to scale these complex strategies. These are the findings of the national research study on health care's transition from volume to value.

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About

McKesson Technology Solutions (MTS) is part of McKesson Corporation, a Fortune 5 company completely focused ahead on the business of better health. Our aim and passion is to help you chart a clear, achievable path as healthcare transforms toward value-based care. Our technology solutions and services span payers, hospitals, physicians and pharmacies. No matter where you are in the journey to value-based care, we are your strategic partner for successfully navigating what's ahead.