Provider Investment Plan to Succeed in the Emerging Healthcare Environment

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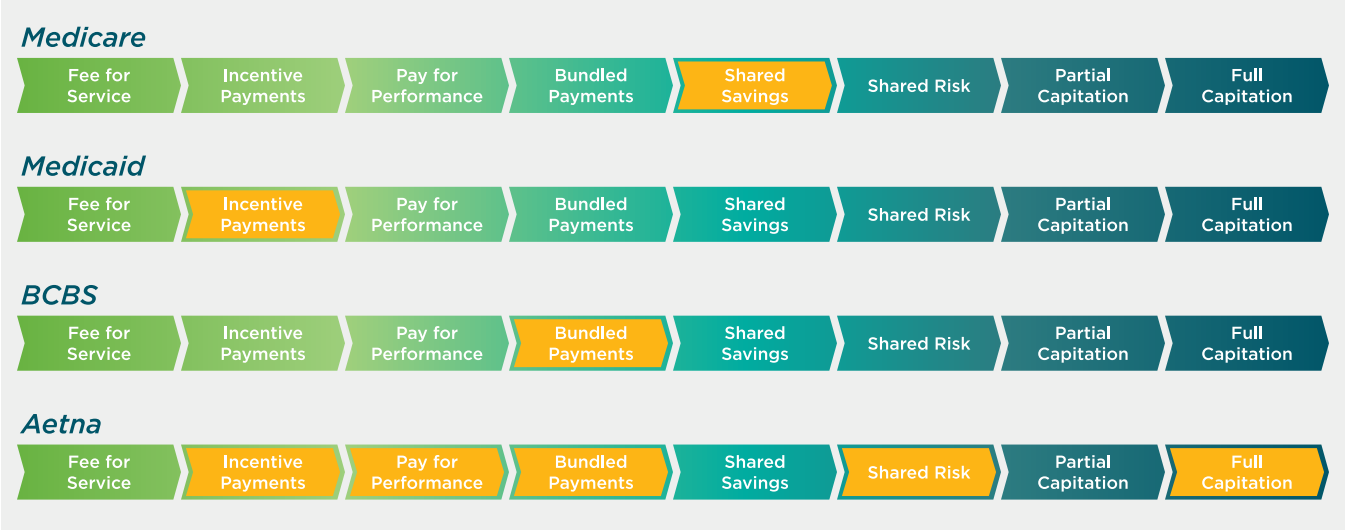
While attending the Value-Based Care Summit, Dr. Jesse M. Ehrenfeld referenced in his speech that for every one hour physicians spend working with patients, they spend two hours doing administrative tasks such as EMR, and likely an *additional* two hours at home doing charts or working with families. At the same conference, it was discussed that there are approximately 300,000 apps for providers, and there are now apps to prescribe apps to clinicians, based on their projected needs. There is so much competing for physicians' time, including the time needed to perform billable services, i.e. competition with their ability to generate revenue.

MedPAC has recently called for the Merit-Based Incentive Payment System to be redesigned, citing complexity, while at the same time there have been multiple pieces written on MIPS being a format for Medicaid transformation. The time pressure is going to get greater before it lessens. While we have all seen the spectrum of value-based payments, which ranges from fee for service to capitation, providers are on multiple spectrums at once depending on payer partners.

Providers are on multiple value-based payment spectrums at once, and are being evaluated on different sets of measures by different payers.

Having to function on multiple spectrums is one problem for providers but they are also being evaluated on a different set of measures depending on the payer. For example, Aetna might want improvement on diabetics, while at the same time BCBS incentives are focused on reducing hospitalization for asthmatic children. Concurrently, a provider electing to



Existing on multiple payment spectrums might look like this graphic, with the yellow indicating the type of value-based contract a provider might have with different payer partners.

be a MIPS participant requires multiple areas of improvement for a Medicare population that might not have a tremendous amount in common in terms of acuity with the rest of the patient population.

Electronic Health Records, value-based contracting and care delivery are requiring more effort from providers and requiring them to practice very differently. A popular analogy is that doctors used to have a toolbox with a hammer and a screwdriver, and now they also need a hacksaw, a couple different wrenches, etc. This has led to overburdened providers and a significant level of burnout, jeopardizing the goals of value-based reimbursement—better outcomes and lower cost growth. To succeed in this emerging environment, providers have two major areas of investment to improve their chances of success: time and money. I'd like to lay out the framework for what I call the ***Provider Investment Plan.***

For physicians to build a workable investment plan they need to consider how they will allocate their time and money to be successful in the short term and the long term. They can't solely invest in long-term technology to address healthcare and payment models in 2024 or else they won't remain open long enough to get there, yet they do need to have an eye on the future to have opportunities for success with the upcoming payment models. At the same time, they still need to invest in short-term and near-future strategies to develop their portfolios.

Understand and articulate your metrics in current and future value-based reimbursement models.

If you've signed one value-based contract, you've signed one value-based contract, and nothing more. However, there are likely many places in which there is overlap with the more incented types of services in more than a single contract. Using these metrics or conditions that recur as a starting point to invest in can maximize gains in both the best patient health outcomes and your reimbursements. Also, this

gives providers a strategic jumping off point for their other contracts; if you know you are investing heavily in the short-term to improve in an area, then there is good reason to weight your newer contracts on these populations where you can.

Differentiate investment strategy for process measures versus outcomes measures.

As providers move along the multiple spectrums of value-based reimbursement, the opportunity for financial success (and freeing up time) moves from initially getting patients to come into the office to get compliant and healthier, to using maintenance and resolution as a way of keeping them out of the hospital and staying compliant and healthy.

The maintenance and resolution focus is due to incentives being rooted in the completion of process measures like requiring all diabetics to receive care and testing that meets clinical benchmarks. Step one to helping people receive the appropriate testing is getting them into the office, so some understanding (and investing) needs to go into efforts to identify and remove the barriers that keep patients from being seen in the office. Are their specific social determinants of health impeding patients from getting into the office (lack of transportation, scheduling problems, etc.)? Does your clinical team know what the social determinants of health are and how to track them for your patient population? Is there a patient satisfaction or patient experience issue? Are your patient issues due to cultural competency issues with the staff? After you have some clarity on what is keeping people *out* of the office, you can invest in the right things to get them *in* the office.

With respect to long-term maintenance of health and management of chronic conditions, the investments can look different. Particularly as you move to capitation, what technologies allow you to focus on your sickest patients while providing access to your better managed

patients? Are there community resources or different levels of staff that can be trained to work with different groups to ensure people are staying on their plan? What amount of time should be invested in researching what is new in payment so you can stay ahead of emerging trends?

Identify areas in which your payer partners should be driving the investment.

Providers should understand the resources they need and where they should most efficiently leverage the resources they have, such as helping the most patients while still maintaining revenue in order to stay open and deliver care. This deep understanding will allow them to better ask the payer what their role is in the success of value-based reimbursements and improving patient health. If the goal is truly to improve long-term health, then the payer role extends past generating contract terms and into contributing resources for success. Are there technology gaps that a provider can't acquire that would drastically improve care coordination for payer members and reduce long-term cost growth in some markets? Is there a role for payers to train providers to improve their skills to be more successful, whether it be on clinical skills or patient skills? Providers who can convey to their payer partner a clear investment plan know where they will have gaps and can clearly articulate where they need to partner, either with payers, employers, other providers, and/or community partners.

Healthcare is changing and providers are being asked to do a lot more a lot differently. There are many good reasons this is happening with lofty, important goals. For providers to successfully change healthcare, they need to think about treating patients differently. They also need to treat their business differently. Fortunately, through planning and understanding the changes, providers can appropriately invest in themselves and their patients.

MORE RESOURCES

About the Author: Thomas Friedman is the senior product manager in payer and community health at Relias. Tom brings executive experience working in healthcare payer strategic planning, finance, government affairs, and analytics having most recently served as the Director of Policy, Planning, and Analysis for the State Health Plan of North Carolina. He has worked in multiple states (such as North Carolina, New Hampshire, and Massachusetts) and in multiple payer settings including commercial, Medicaid, Medicare, as well as dual eligibles. Tom received his Bachelor's degree from the University of Arizona and a Master's of Public Administration from the University of Delaware.

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