Essentials for transformative healthcare delivery success

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Alternative payment model (APM) and value-based care (VBC) initiatives, driven by government and commercial healthcare payers and organizers, are market forces impacting how healthcare delivery is organized, prioritized, valued and financed.

The numerous and still growing APM and VBC initiatives in the healthcare delivery and payment market are diverse and evolving with arrangements that vary by payer (e.g., government, commercial, self-insured), by organizer [e.g., accountable care organizations (ACOs), clinically integrated networks (CINs) and independent physician associations (IPAs)], and by benefit plan (e.g., commercial plans, Medicare Advantage plans, self-insured plans, public assistance plans).

Such complex and dynamic forces create organization-wide challenges for medical practices to transform their existing missions, visions, structures, systems and routines to succeed within these new frameworks.

At the most basic definition, APM and VBC initiatives are patient-centered and value the quality, effectiveness and efficiency of healthcare services delivered, as evidenced by certain actions and outcomes (Table 1). By comparison, conventional fee-for-service (FFS) initiatives are process-centered and value healthcare services delivered, as evidenced by service codes.

Although they are already significant market forces, these newer healthcare delivery and payment initiatives are still works in progress with payers and organizers evaluating combinations of variables, formulas and results. Position papers and articles from market players and thought leaders (e.g., payers, organizers, providers, consultants, analysts) abound with insights on what exemplifies APM and VBC initiatives and the results of investigations into whether these models meet their stated objectives.

MARKET VOICES

Major commercial payers report that the shift to VBC requires more than just new incentives. As outlined in a 2020 Humana report:

> *[V]alue-based care isn't simply a different approach. It's a revamping of processes; and an investment in practices and people. It's a mindset.*[1]

Brian Powers, MD, MBA, Humana's deputy chief medical officer, reflects that, "Humana made great strides this year in value-based care payment and delivery; but our work is far from finished."[2]

Similarly, Aetna states that "good preventive care may yield returns in cost savings and improvements in population health" and that "a proactive approach to care should lead to less disease burden, healthier communities, and even greater savings to the health system as a whole."[3]

A 2019 study for UnitedHealthcare — conducted by Alyna Chien, MD, assistant professor of pediatrics, Harvard Medical School, and Professor Meredith Rosenthal, PhD, Harvard T.H. Chan School of Public Health — reviewed 10 years of VBC initiatives. One of the major findings from the researchers was the need for "substantial organizational change," adding that "every detail of the day-to-day running of provider operations needs to be reconfigured to deliver on this new model."[4]

KNOWLEDGE AND SKILL ESSENTIALS

One of the means to keep up with evolving industry standards as it relates to VBC is the Body of Knowledge (BOK) for Medical Practice Management, the foundation for the medical group management industry. The BOK serves as the structure for all ACMPE assessments, examinations and leadership development programs.[5] The BOK is built on essential domains of competence

(i.e., knowledge and skills) that medical practice executives must possess to be successful.

With an abundance of healthcare delivery and payment experimentation ongoing, the BOK was updated in 2020 with the addition of a new domain, titled "Transformative Healthcare Delivery" (THD).[6]

Like the other domains, the THD domain has unique content (e.g., care models, payment models, organizational models, innovation and emerging technologies)[7]; additionally, it requires competence across the five other domains as prerequisites to gain proficiency with its subject matter.

The THD domain reflects the complexities and challenges of the ongoing healthcare delivery and payment revolution.

AWARENESS AND ADVOCACY

Consistent with establishing THD as a domain within the BOK, MGMA actively promotes physician leadership and group practice models as the means for continued progress on the development of APM and VBC initiatives.

MGMA recognizes the magnitude of the ongoing healthcare delivery and payment reforms and is positioning medical practices and medical practice executives — through awareness (e.g., the BOK) and advocacy — to be active and influential participants in the change process.

Through its advocacy, MGMA is complementing its direct support of professional development through the BOK with campaigns to educate political and business leaders about the value of medical practice involvement in healthcare reform.

The MGMA 2021 Advocacy Agenda, published in January 2021, calls for continued value-based delivery reform and the development of new APMs to expand participation opportunities for group practices of all specialties.[8]

Transformative healthcare delivery initiatives are the same but different

Payers and organizers are seeking to achieve quality, effective and efficient patient-centered healthcare delivery through their respective THD initiatives. To meet those objectives, all THD initiatives have common foundational constructs of rules, resources and representatives (the 3Rs), but that is largely where the similarities end.

TABLE 1. HEALTHCARE DELIVERY VALUE CATEGORIES AND ASSOCIATED ACTIONS AND OUTCOMES

Value categories	Associated actions and outcomes
Healthcare delivery quality	• Preventive and wellness care • Vaccinations and screenings • Chronic care monitoring, tests and treatments • Medication adherence
Healthcare delivery effectiveness	• Pre-office visit preparations • Annual wellness visits • Managing transitions of care • Care management for chronic and complex conditions • Comprehensive and accurate HCC[A] coding • Assessing and addressing SDoH[B] • PCMH infrastructure • Positive patient experience
Healthcare delivery efficiency	• Total cost of care less than projections • Validating suspect conditions • Appropriate use of E.D., inpatient and ASC[C] locations • Limited unexpected inpatient readmissions • Limited use of high-cost specialty services • Prescription of generic and preferred drugs

(A) Hierarchical condition coding, (B) Social determinants of health, (C) Ambulatory surgery center

Rules, resources and representatives can be defined and combined by payers and organizers to create an almost unlimited variety of arrangements. For that reason, the 3Rs work well as a method for medical practice executives to organize information, thinking and planning about THD initiatives:

- Know the rules.
- Master the resources.
- Optimize the representatives.

Know the rules

The rules promulgated for THD initiatives (including APM, VBC and other reform initiatives) are at the discretion of the respective payer or organizer and delineate

1. *Who* is a covered member (or beneficiary) and attributed to a given medical practice,
2. *What* healthcare delivery actions and outcomes are valued,
3. *How* the healthcare delivery actions and outcomes are valued, and
4. *When* the healthcare delivery actions and outcomes are valued.

The rules are the most complicated features of THD initiatives — challenging medical practices to develop flexible structures and routines to participate and succeed with a variety of arrangements. Rules can change from year to year and sometimes in the course of a year. Rules are a mix of healthcare delivery science and the current healthcare delivery and payment priorities of the respective payer or organizer.

- ***Who*** is a covered member and attributed to a given medical practice. Healthcare delivery must be determined accurately and verified frequently. Attribution (e.g., empanelment) is the assignment of responsibility for healthcare delivery quality, effectiveness and efficiency (e.g., the value categories described in Table 1) to a primary care provider (PCP) and/or practice for a designated patient. The medical practice must understand the attribution process and frequently audit the rolls of primary care providers and patients who are being associated with the medical practice. Any combination of incorrect or missing providers and/or patients with whom payers and organizers are associating the medical practice will result in performance measurement inaccuracies and must be corrected.
- ***What*** healthcare delivery actions and outcomes are valued (Table 1) as determined by payer and organizer priorities may be measured via claims data, lab and test results, data entered into payer-specific health information portals, or evidenced by medical practice infrastructure such as care management resources and/or recognition as a patient-centered medical home (PCMH).

  Healthcare delivery actions and outcomes generally fall into the value categories of quality, effectiveness and efficiency.

  A quality measure tends to be scientifically derived and is generally accepted as evidence of healthcare delivery accuracy and correctness (e.g., the right care). An effectiveness measure tends to be process oriented and is generally accepted as evidence that healthcare delivery happened on a timely basis (e.g., the right time). An efficiency measure tends to be financially derived and is generally accepted as evidence that healthcare delivery happened in the most appropriate setting (e.g., the right place).
- ***How*** actions and outcomes are valued can be through discrete payments per unit of action (e.g., $50 per pre-office visit chart prep completed) or per attributed member (e.g., $5 per member per month in support of a medical practice's care management resources), or through complex formulas with weightings and thresholds applied to calculate an end result (e.g., healthcare delivery quality scores compared to peer groups to determine a medical practice's share of healthcare delivery savings).
- ***When*** actions and outcomes are valued (e.g., the timing for results calculations and payments) is generally based on a calendar year beginning in January or a fiscal year beginning in October. Payers and organizers will decide what actions and outcomes are valued monthly, quarterly or annually for each plan year. For example, infrastructure payments in support of care management resources and/or PCMH recognition might be made monthly. Shared savings payments based on weighted healthcare delivery quality scores might be paid annually after all the plan year's data have been collected and analyzed.

LEARN MORE

Transformative Healthcare Delivery is one of six domains of the BOK. For information about Board Certification and Fellowship via ACMPE, visit **mgma.com/acmpe**.

Interested in proving your mastery of the BOK domains? Consider pursuing an ACMPE Certificate program: **mgma.com/certificates**.

Master the resources

Data and analytics are some of the most important resources needed for success with THD initiatives. Reliable and real-time information is key to stewarding the right care, at the right time, in the right place. Reports and information guide medical practices on healthcare delivery priorities and process improvement tactics.

To facilitate the collection, analysis and exchange of data with medical practices, payers and organizers provide access to sophisticated health information portals integrated with claims processing systems and health information exchanges. As a result, health information portals can track real-time, patient-specific information on receipt of wellness, acute, and chronic care services; the completion of tests and test results; and transitions of care (e.g., admissions, discharges, transfers).

Payers and organizers will adopt specific health information portal applications that meet their needs and interests. As a result, medical practices find themselves challenged to become proficient with the functionality of different portals from various payers and organizers, along with the different sets of rules.

In addition to the variety of health information portals to navigate, medical practices must also decide how to assign responsibility for health information portal management. Will the responsibility for interacting with the portals, generating reports, and analyzing information be assigned to a specialized department of the medical practice, deployed to each of the medical practice's sites, or a combination of the two approaches?

Mastering the functionality of payer health information portals through a centralized, decentralized, or hybrid approach will impact timely and effective use of information,

development of productive workflows and engagement of patients.

Optimize support from payer representatives

Even before the introduction of THD as the newest domain within the BOK, it had already been well documented that medical practice executives need a diversity of knowledge and skills to manage complex and dynamic medical practice enterprises.

THD initiative market drivers — the payers and organizers — recognize the existing demands on medical practices and the new demands that THD initiatives present. To deliver on expectations and projections of these newer healthcare delivery and payment initiatives, payers and organizers have marshalled a new generation of representatives to support the engagement of medical practices.

Representatives could technically be considered resources, but they are deserving of their own category within the 3Rs construct by virtue of their distinct and integral contributions toward achieving THD initiative success.

With conventional fee-for-service initiatives, payer representatives act as provider network builders, fee schedule negotiators and claims adjudication problem-solvers. They tend to be reactive in their roles and meet with medical practice executives when requested.

With THD initiatives, payer representatives act as rules translators, resource educators and transformation coaches. They are proactive in their roles and constantly creating opportunities with medical practice executives, physicians, managers, and support staff to identify tactics for generating healthcare delivery quality, effectiveness and efficiency.

CONCLUSIONS

In the healthcare delivery and payment market, fee-for-services initiatives have not gone away and THD initiatives have not taken over. The revolution against high cost and disorganized healthcare delivery and the evolution toward cost effective and coordinated healthcare delivery are ongoing simultaneously. As a result, medical practice executives are flying the plane and building it at the same time.

Just as the factors that make up the human condition are complex and interconnected, it appears that the preferred healthcare delivery and payment model may be heading in a similar direction — reflected in THD as a new domain in the BOK to house the complex and interconnected concepts (e.g., care models, payment models, organizational models, emerging technologies) that are being built and tested.

Tools such as the 3Rs of THD initiatives (Table 2) — rules, resources and representatives — help medical practice executives think about the demands of these newer healthcare delivery and payment models, plan for transformation efforts, and evaluate the outcomes for patients and the medical practice enterprise. ■

TABLE 2. THE 3Rs OF THD INITIATIVES (INCLUDING APM, VBC AND OTHER REFORM INITIATIVES)

Foundational constructs	Elements and components
Rules	<u>Who is covered</u> • Attributed members (or beneficiaries) <u>What is valued</u> • Healthcare delivery quality • Healthcare delivery effectiveness • Healthcare delivery efficiency <u>How is it valued</u> • Discrete payments • Payments per attributed member • Payments via multivariate formulas with weights and thresholds <u>When is it valued</u> • Calendar plan year • Fiscal plan year • Annually, quarterly or monthly
Resources	• Health information portals • Analytics on healthcare delivery quality, effectiveness and efficiency
Representatives	• Rules translators • Resource educators • Transformation coaches

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NOTES

1. Humana. Value-based Care Report: Physician progress and patient outcomes. 2020. Available from: digital.humana.com/VBCReport.
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3. Aetna. "Better health at lower costs: Why we need Value-Based Care now." Available from: aet.na/3wIZfUY.
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6. MGMA. "Transformative Healthcare Delivery." Available from: mgma.com/thd.
7. MGMA. "ACMPE Exam Specifications and Body of Knowledge Framework." Available from: bit.ly/3yx7FKG.
8. MGMA. "2021 Advocacy Agenda." Jan. 21, 2021. Available from: mgma.com/advocacy2021.