Vatica Health™

Value-based care today

A survey of healthcare professionals on the front lines

Abstract

While **85%** of provider groups believe that value-based care (VBC) will lead to improved patient outcomes—and **50%** plan to move to a global risk model in the future—many practices are still experiencing challenges along the road to VBC.

The transition to VBC has taken longer and proven to be more challenging than expected. We surveyed over 100 managers and executives of primary care practices and health systems across the country with more than 100 employees to learn more about what's working for them and what still needs to be addressed so everyone can fully realize the financial and clinical benefits of value-based care.

Providers are committed to VBC. A vast majority believe it will lead to better and more efficient care and improved outcomes, which will enable people to live healthier lives.

Nevertheless, much work remains to be done. At present, less than half (44%) of respondents are receiving their VBC payments from upside-risk arrangements and shared savings, with only 10% receiving VBC payments from full risk. Given the complexity of VBC and alternative payment models, providers must incorporate new resources and tools to support their efforts.

While providers continue to experiment with a variety of tools and solutions—with varying results—they are highly (80%) aligned on the primary obstacles slowing their transition to VBC. Providers cite a lack of administrative support (41%), staff (39%), and clinical support (36%) as their top concerns. They report that payers are largely supporting them in their VBC efforts, primarily through education and training and tools for care management and care coordination, but rank "better collaboration and alignment with payers" as most valuable in the transition to VBC.

These findings confirm that while providers believe in the importance of VBC, they need dedicated clinical and administrative staff to accelerate the transition. With dedicated resources to help navigate the complexities of VBC and increased collaboration with payers, they can complete the transition and fulfill VBC's promise of improved care and lower costs.

44%

of respondents are receiving their VBC payments from upside-risk arrangements and shared savings

Top concerns for providers:

41% **Lack of administrative support**

39% **Lack of staff**

36% **Lack of clinical support**

A report from the front lines of VBC

Delivering high-quality care has always been providers' primary motivation, but the old payment models were not well aligned with this objective. Unlike the legacy fee-for-service (FFS) care model that compensates providers based on the number of services they deliver, VBC connects providers' compensation to the health outcomes they deliver for patients. VBC payment models are designed to incentivize providers to focus on prevention, early intervention and care coordination to drive up quality and drive down costs.

It's been 15 years since the first legislation was passed to begin testing this hypothesis by moving healthcare providers from the existing FFS model to VBC. In the intervening years, healthcare providers, payers and CMS have piloted and adopted a wide range of alternative payment models aimed at delivering better care at lower cost. While the cooperation of the entire healthcare industry is necessary to make VBC work, the burden falls disproportionately on primary care providers. As the workers on the front lines of the transition to VBC—in an extremely dynamic environment—primary care practices can provide a vital perspective on where we are on the journey to VBC and what needs to be done to accelerate the smooth transition.

About the survey respondents

The survey solicited the perspectives of healthcare industry professionals in leading provider organizations on five key topics: patient care, VBC payments, the VBC transition, payer support, and the role of data.

Specifically, survey respondents were:

- **Individuals working at the manager level and above at primary care practices, health systems or multi-specialty practices, including primary care with 100+ employees**
- **Individuals working in care delivery/care management, executive leadership, finance/accounting or operations**
- **Individuals familiar with reimbursement models and/or payments**

Providers believe strongly in preventive care to support VBC but recognize that increased engagement with Medicare patients is required to improve care and enable better care coordination and care management.

While they acknowledge that increased care coordination and care management will move them forward on their VBC journey, they believe more education and training is the top priority at this point.

97% **of respondents say preventive care (such as wellness visits) is important to improving VBC performance and patient outcomes.** There is an overwhelming consensus among providers on the necessity of providing preventive care to patients for VBC to work. The delivery of more consistent preventive care can significantly reduce patients' risk of chronic disease and mitigate the exacerbation of existing health conditions. This finding underscores how significant are the challenges presented by unengaged patients who are not getting the essential preventive care upon which VBC depends.

21% **of respondents cited patient engagement (21%) as their biggest challenge in transitioning to VBC.** Before they can even begin addressing the clinical resources needed to provide effective preventive care, providers must first overcome an early obstacle: connecting with patients and building the knowledge base and relationships that foster patient engagement.

+50%

More than half of Medicare patients have not had a telehealth visit, nor do they receive in-home RA assessments. This response suggests that an opportunity exists for practices to reach unengaged patients who are less likely to come to an office visit. Telehealth visits in particular could enable practices to engage patients efficiently and ensure continuity of care.

51%

Care coordination was voted the #2 top tool (51%) with the greatest potential to help transition to VBC. Providers understand the value of forging links with other care providers and community resources to help ensure that all patient needs are met and complementary care is provided between office visits. As more payers offer care coordination programs, it is likely practices will turn to them increasingly for both support and links to other care providers and community resources.

41%

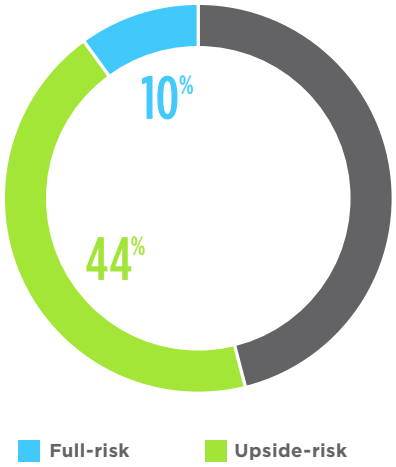
Care management ranked third (41%) among the top tools to help transition to VBC. Care management is essential to helping patients with chronic conditions and comorbidities maintain their wellness and avoid health emergencies and unnecessary hospital visits. This will likely motivate more practices to increase their collaboration with payers that offer care management services as they seek to build relationships with less engaged patients.

Healthcare providers' biggest challenges in transitioning to VBC:

Patient engagement

Unpredictable revenue

Staff and clinical support



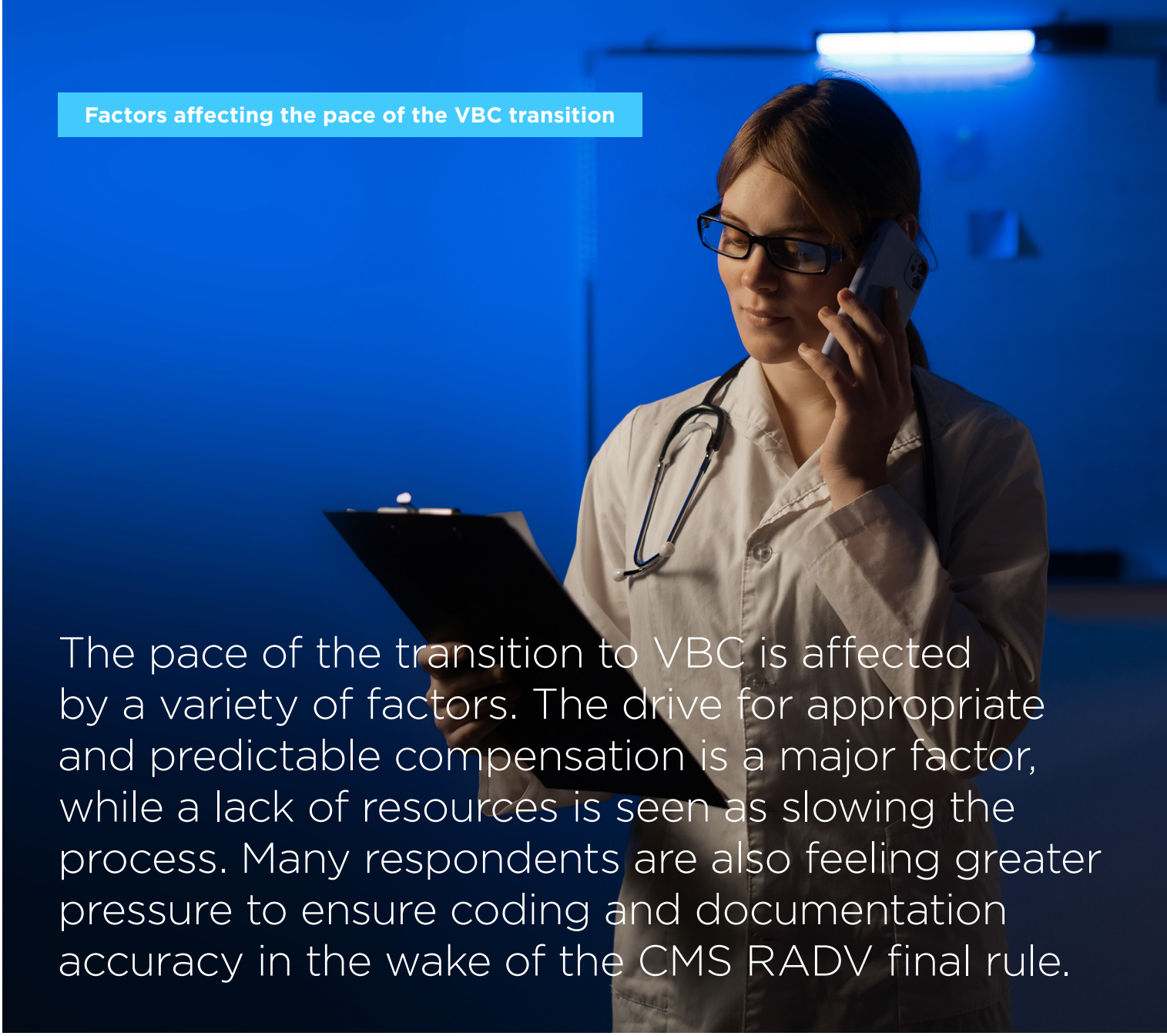
Only 10% of VBC payments are from full risk. And less than half (44%) of healthcare providers receive their VBC payments from upside-risk arrangements and shared savings.

The VBC payment picture shows an industry in flux.

According to survey respondents, FFS still represents about half of their reimbursements. This is actually higher than the 40.5% in FFS payments reported by the **Health Care Payment Learning and Action Network** (HCPLAN) for 2021. If CMS hopes to achieve its **goal** of having every traditional Medicare beneficiary in a VBC relationship by 2030, the FFS/VBC payment mix will need to shift more quickly to VBC.

49% **of payments still come from FFS.**
VBC reimbursements represent a slim majority (51%) of responding providers' payment mix. The payment scales are starting to tip in favor of VBC, but the pace of change must accelerate to meet the CMS goal.

Factors affecting the pace of the VBC transition

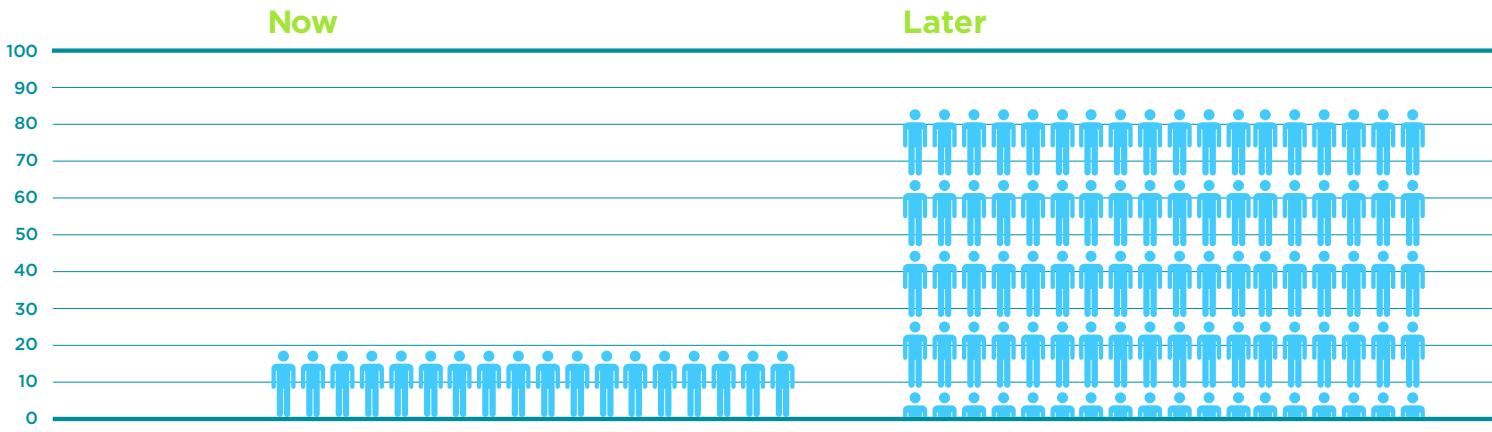


The pace of the transition to VBC is affected by a variety of factors. The drive for appropriate and predictable compensation is a major factor, while a lack of resources is seen as slowing the process. Many respondents are also feeling greater pressure to ensure coding and documentation accuracy in the wake of the CMS RADV final rule.

The biggest factors accelerating the pace of the VBC transition are appropriate/predictable compensation (63%), policy requirements (48%) and the financial impact of COVID (39%). Respondents are dissatisfied with the current unpredictability of their revenue streams. They see the full implementation of VBC as the way to ensure more consistent revenue, providing the assurance they need to maintain operations and make decisions about new investments in capabilities and resources. Policy requirements from CMS are also seen as driving the VBC transition, as providers seek to maintain regulatory compliance and earn CMS incentive payments. Finally, the financial impact of COVID continues to be a factor. Early estimates forecast that the pandemic would result in **$15.1 billion** in losses for primary care providers, and the survey results suggest that providers see the negative revenue impact of COVID as proof that the FFS healthcare model is unsustainable.

36% **of respondents cite staffing/time/expertise as their biggest challenge to transitioning to VBC.** Clearly, there is a desire to change, but a lack of experienced staff is holding providers back. An overwhelming majority of those polled cite staffing and administrative support as the biggest missing pieces.

84% **of providers surveyed feel the need to add staff and additional resources to properly transition to VBC; however, only 18% said they would hire immediately.** This response captures the conundrum facing many providers; while additional resources are sorely needed, uncertainty about their VBC progress may be keeping them from bringing on full-time staff in the near term. This reluctance to hire is also likely compounded by financial challenges and healthcare labor shortages.



After staffing, providers' top VBC challenges include patient engagement (19%) and unpredictable revenue streams (15%). Survey respondents' #2 and #3 VBC challenges can be seen as downstream effects of their #1 challenge—staffing. With sufficient resources and expertise, they would be better equipped to engage patients, which would, in turn, accelerate their VBC transition and stabilize revenue predictability.

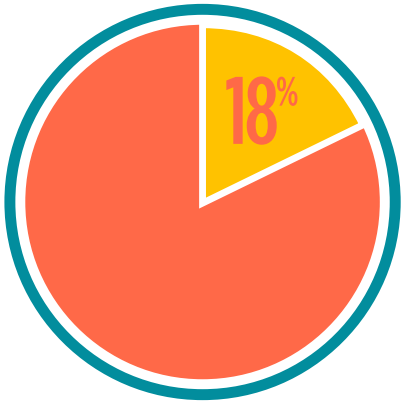
Respondents named "education and training" the most important tool for supporting the transition to VBC. Despite the ongoing efforts of CMS, payers and providers to build VBC knowledge among provider staff, gaps in skills still remain. By ranking "education and training" as the most important tool needed (ahead of "care coordination" and "care management"), respondents may be indicating that efforts to build and share knowledge must continue to take priority, at least in the near term.

21%

More respondents (21%) ranked "VBC expertise" as the #1 most valuable resource in the transition to VBC. While providers highly value resources such as "better collaboration and alignment with payers" and "administrative and staffing support," more of them chose "VBC expertise" as most valuable than any other. This suggests that VBC knowledge is still in short supply in many provider organizations and continues to hold back their progress.

53%

More than half of respondents (53%) think the VBC shift will place more importance on coding compliance/accuracy. It's been estimated that overpayments to Medicare Advantage Organizations could top **$75 billion** this year. With the issuance of the CMS RADV final rule earlier this year, providers are under increased pressure to ensure coding and documentation accuracy. This response suggests that they will need to focus strongly on compliance and coding accuracy as they move forward in their journey to VBC and highlights a conundrum that providers are not trained to be expert coders.



Only 18% of respondents indicate a "very high" familiarity with HCC risk adjustment coding. Only a small percentage of providers are sufficiently knowledgeable about a vital topic that has the potential to increase their risk adjustment yield or trigger exposure in a RADV audit. While providers used to let payers worry about risk adjustment coding, the shift to VBC places a burden on them, as it impacts patient care, outcomes and, ultimately, their payments.

Payer support

Many payers are collaborating with providers and offering a wide range of support. Only 8% of respondents reported receiving no tools or support from payers. Providers value the support that payers provide but also believe more collaboration and payer-sponsored resources are needed.

Most healthcare providers receive collaboration and support from payers—but still believe more is needed.

The leading types of support provided by payers are "education and training" (43%), "care management assistance" (37%), "care coordination assistance" (34%) and "VBC contract management" (31%). Payers are offering providers help across a broad range of VBC-related responsibilities. Providers value these resources, and as they make greater use of them, it should strengthen collaboration among payers and providers.

Payers are slightly less supportive with IT-related tasks. Payers have offered "data aggregation and analytics services" to only 29% of providers. Still, fewer (26%) have been offered help with "quality of care gap analysis" or "risk adjustment coding."

Only 12% of providers report that all their Medicare patients receive in-home risk adjustment assessments from their insurance companies. While many payers work with vendors to offer in-home risk adjustment assessments, the conversion rate is typically low. An alternative approach to drive higher adoption would be provider-integrated risk assessments.

Data

Providers understand the importance of data and being able to efficiently operationalize it. VBC success depends on getting the right data to the right place at the right time.

#4

Providers ranked "data aggregation and analysis from disparate sources that can be used at the point of care" as the #4 most valuable resource in the transition to VBC. Providers want to optimize their time with patients in the office. To do that, they want comprehensive, up-to-the-minute insights to be accessible during the patient's office visit.

86%

of respondents say they receive data/information from Annual Wellness Visits that impacts patient care. Providers are making good use of Medicare's Annual Wellness Visits, taking the opportunity to talk with patients about their medications, psychosocial health, exercise and activity, daily functioning and mobility, and any memory issues.

#8

Providers ranked "more comprehensive patient data" as the #8 most valuable resource in the transition to VBC. This response suggests that providers do not feel they are currently getting a complete record of all the factors and history that contribute to their understanding of a patient's current health status and that they will need that data to succeed in VBC.

Healthcare providers' most valued VBC resources are:

1. **Administrative and staffing support**
2. **Better collaboration with payers**
3. **Broadly sourced data aggregation and analysis at the point of care**

These survey results deliver good insights from the frontlines and provide reasons to be optimistic about providers' progress on the road to VBC—as well as recommendations on how that journey can be improved.

On the positive side, providers know what they need to be successful and further their VBC transition. At the same time, they acknowledge that gaps exist between their goals and current experience and resource levels.

Healthcare providers' top VBC transition need is people—specifically:

41% **Administrative support**

39% **Staff**

36% **Clinical support**

While survey respondents believe that clinical and administrative staffing is their most critical need, many also admit that they are not in a position to add staff in the near term—and that the team they currently have in place is not as VBC-savvy as it needs to be.

Vatica Health is here to bridge those gaps, offering solutions that fulfill three key needs to VBC enablement—human resources, expertise and powerful technology—where they are needed most, at the point of care. Vatica's expert clinical teams ensure accurate coding and compliance while facilitating staff education, skill development and knowledge transfer. Vatica technology powers these resources, enabling providers to spend less time on coding and administrative tasks—and spend more time with patients.

For more information on how Vatica is supercharging providers' VBC journey, visit **vaticahealth.com**.

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