Today’s Health System Must Change — And Deliver Outcomes

Cerner Corporation
Lumeris
Economic, political and social influences are driving the health care industry’s move toward value-based care. This transformation, which requires a change in both the care delivery and business models, calls for payers, providers and consumers to acquire new skills and rethink their role in the health care value chain. In the new world, everyone must align around outcomes.

An Industry in Flux

The health care marketplace must accelerate from volume-based payments to value-based models. Why? Simply put, the nation cannot afford ever-increasing spending on health care services, which now consumes nearly 20% of the U.S. gross domestic product.¹

Government and private sector efforts have spurred alternative methods of paying for value to accelerate payment beyond traditional fee-for-service (FFS) reimbursement. Accountable care organizations (ACOs), bundled payments and pay-for-performance models are just a few examples of value-based arrangements that encourage providers to take on more risk.

But while there is industrywide discussion around pursuing population health initiatives, most activity is still limited to upside-only or limited-risk arrangements. For providers and health systems to gain substantive access to the health care dollar and value opportunity, they must embrace a path to full risk and insurance product strategies — which require new capabilities (Figure 1). Thus, while industry players generally agree value-based payments are the way to go, there isn’t yet consensus on how to get there — or how fast the transition should take.

Figure 1. To gain more access to the health care dollar, health systems must take on increased risk. However, the operational complexity of these advanced programs increases significantly.

What is value-based care?

Value-based care can be defined as health care delivery that is accountable for both clinical and financial outcomes. It encompasses a wide spectrum of risk levels and programs, such as ACOs, bundled payments, shared savings and partial capitation, all the way to full risk models.

¹Source: CMS.gov; National Health Expenditures 2017 Highlights
Factors Driving the Push to Value

- Regulatory programs pushing value-based models (e.g., Medicare Advantage, alternative payment models, Primary Cares Initiative, direct contracting)
- Shifting patient demographics toward an aging population
- Reduction in reimbursement rates from public and private payers
- Primary care physician aggregators building independent provider networks
- Payers employing physicians through vertical integration
- Emphasis on primary care and increased shift from inpatient to outpatient care delivery
- Prevalence of high-deductible health plans and consumer demand for quality and cost information
- Employer pressures to manage costs and directly contract with providers
- Health systems launching their own health plans
- Advances in health care technology (e.g., virtual care, telemedicine, health apps)

Continued Pressure on Health Systems

Declining reimbursements from public and private payers, increased consumer expectations and new competitive threats to health system physician alignment are all putting a strain on health systems to find a viable path toward sustainability and away from FFS. With all these pressures comes the recognition that survival in value-based models requires major change.

New Challenges Require New Capabilities

Although the industry has not historically supported value-based models, the impetus for change is strong. Health systems and provider organizations are intent on keeping consumers at the center of care and providing high-quality, cost-effective care.

Achieving total population health management — better managing the sick and keeping the healthy well — requires new skills for all stakeholders. Each will have to navigate their own journey. As health care shifts to this new paradigm, the lines that once strictly defined their positions in the marketplace will blur.
Payers Must be More Collaborative

Value-based payment models turn the historically adversarial role between payers and providers on its head. The emphasis on improving health care quality while containing costs translates into efforts such as: focusing on preventive care, reducing unnecessary utilization, preventing duplication of services, reviewing medication adherence, avoiding hospital-acquired conditions and readmissions, and reducing hospital length of stay. Payers cannot succeed in these endeavors without collaborating closely with providers.

Payers will need a collaborative model to align incentives, coordinate operations and engage providers to deliver higher-quality, cost-effective care. Providers can’t be true allies in value without access to the cost, utilization and quality data needed to track results and identify opportunities for improvement. A collaborative approach will help to better coordinate programs and operations, enabling providers to deliver a better patient experience without wasteful duplication.

Providers Need a Population Health Mindset

As providers assume accountability and risk in value-based payment models, they will need to implement new processes more familiar to payers. Providers must concentrate on what it means to manage patients (both clinically and financially) at the individual and population level before they can successfully take on meaningful risk sharing. That means they’ll need to not only focus on the patient in front of them but also on the patients in their panel, in their practice and ultimately their entire contracted population.

To achieve this wider perspective, providers need the appropriate tools to successfully evaluate population health data to find opportunities to improve quality and efficiency and track their performance. They’ll have to think outside the four walls of the clinic and hospital to build programs, aligning to have the right resources and tools to operationalize these programs. Moreover, they will need to move away from incremental pilot programs and embrace the shift toward full risk, dedicating resources and effort toward total population management.

Provider incentive contracts must also foster a vision of value. These arrangements must align value-based metrics between the payer and provider with those at the individual provider level, evolving over time as capabilities advance. Providers must also adopt a governance structure that enables performance review, best practice sharing and continuous improvement.

And for those provider organizations that want to become payers themselves, they must be prepared for the complex operational and financial requirements to run a health plan — which are far different than those of operating a health system.
Consumers Must Be More Engaged

To slow rising health care expenditures, many employers and insurers are asking consumers to pay more out of pocket for care. This trend is reflected in the increased prevalence of high-deductible health plans.

The rise in out-of-pocket costs has forced consumers to shop for value in health care services. As they pay more for the cost of care, consumers are also becoming more engaged in making care decisions.

This rise in health care consumerism means individuals will increasingly be asking providers for information about their pricing and quality performance. Consumers won't succeed as value shoppers, however, unless providers can offer that information in a meaningful way. Again, providers have a crucial role — being a trusted advisor who lays out care options and helps to guide patients in their decision making.

An Outcomes-based Model to Support Health Care’s Changes

Health care is a complex industry amid fundamental change. The shift to value — with its inherent focus on improving quality and containing costs — requires new models for care delivery and payment. A population health services organization (PHSO) is a proven model that can provide both. It is designed to bridge the traditional payer-provider divide by enabling providers to manage populations under value-based arrangements through implementing programs and tools necessary for sustained clinical and financial outcomes improvement.

Population Health Services Organization

A population health services organization is focused on optimizing value-based care managed services. This model is designed to bridge the traditional payer-provider divide by enabling providers to manage populations under value-based arrangements through implementing programs and tools necessary for sustained clinical and financial outcomes improvement.
About Maestro

Cerner and Lumeris have collaborated to provide Maestro™, a comprehensive service offering augmented by technology, designed to create strategic alignment between providers and payers in the value-based care arena.* The offering is focused on helping organizations improve financial, clinical and operational outcomes for new and existing value-based arrangements. For more information, visit maestrovalue.com.

About Cerner

Cerner health technologies connect people and information systems at more than 27,500 contracted provider facilities worldwide dedicated to creating smarter and better care for individuals and communities. Recognized globally for innovation, Cerner solutions and services assist clinicians in making care decisions and assists organizations in managing the health of their populations. The company also offers an integrated clinical and financial system to help manage day-to-day revenue functions, as well as a wide range of services to support clinical, financial and operational needs, focused on people. For more information, visit Cerner.com, The Cerner Blog or connect on Facebook, Instagram, LinkedIn, Twitter or The Cerner Podcast. Nasdaq: CERN.

About Lumeris

Lumeris enables a new model for healthcare. As a value-based care managed services operator, Lumeris helps health systems and providers deliver extraordinary clinical and financial outcomes. With partners across the country, we align providers and payers with a proven model that coordinates operational processes, resources and technology to achieve high-quality, cost-effective care with satisfied consumers and engaged physicians.

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