

# Taking on risk in the emerging value-based healthcare economy.

Provider engagement and alignment strategies  
for better care and financial health.

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## Introduction

There is no doubt that the healthcare industry is moving relentlessly toward a value-based business model in which delivering the highest-quality care at the lowest cost will gradually replace fee-for-service reimbursement for the provision of healthcare services. Yet both payment models will exist for some time. Surviving is simply not enough—novel, creative approaches are critical to achieving long-term business objectives in support of every organization's healthcare mission amid a highly competitive environment and increasing cost pressures.

The burden on providers today is of great concern. Burnout from ever-changing regulatory and administrative requirements is at an all-time high, and one of the major challenges to sustainably navigating both traditional volume-based payment models and risk-adjusted outcome-oriented models is engaging and aligning providers and other frontline professionals on the value of those models to them and their patients.

A comprehensive approach to provider engagement is required to accelerate implementation and successful adoption of value-based care programs. This paper details best practices for evolving clinical processes that streamline, simplify, and automate workflows through technology. Compensation and incentive structures are also explored to align stakeholders for success while balancing the need to support dual reimbursement models. Choosing the right technology and an experienced partner that brings resources, solutions, and proven outcomes offers a strategic advantage.

## The basics

Healthcare professionals must understand that their willingness to change well-entrenched practice patterns is a key success factor in moving the overall healthcare delivery system away from a predominantly volume-based business model to one that is more value-based.

Unfortunately, many of these providers have been jaded by prior efforts to introduce new technology into the delivery system that claimed to bring higher quality and patient safety to care delivery workflows. Instead, these efforts mainly brought about time-consuming interference with clinical care processes. Many providers have concluded that the widespread use of some technologies seemed to benefit the finance and billing departments much more than the quality or clinical care departments. Furthermore, many providers believe these systems tend to slow down care delivery and hamper production in organizations where compensation models are mainly dependent on production metrics, e.g., worked relative value units (wRVU).

It is understandable then that providers, especially employed providers in hospital or healthcare systems, would look skeptically at attempts to align and engage them with the adoption of new additions to the clinical documentation process. Understandably, they question whether this is just another attempt to bring financial benefits (profit margins, market share) to their employers at the expense of the employed providers who are tasked with more work at the bedside or exam room levels.

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## Offer a better experience to your provider community

Coker Group, a nationally recognized healthcare advisory firm, works with Nuance to ensure durable success during migration to outcomes-based delivery by using AI-powered Quality and Risk Adjustment healthcare solutions. With 30 years of experience in healthcare consulting, Coker has extensive expertise in provider engagement, workflow design, change management, and incentive planning for all types of provider organizations.

Coker's national database of provider compensation data, benchmarking, and compliance has helped more than 300 clients address the most challenging aspects of advanced clinical system deployment—provider alignment, acceptance, and sustained participation.

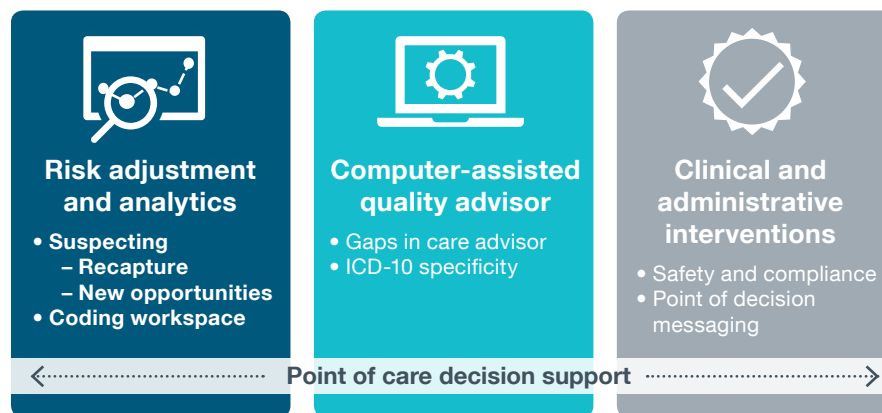
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## Technology considerations

Healthcare delivery organizations need an integrated approach to provider engagement that leverages the expertise, knowledge resources, and benchmarking data from a well-regarded market expert as they implement risk adjustment and quality solutions. Coker Group has worked extensively to drive physician engagement in numerous organizations and has tailored professional services complementing the Nuance® Quality and Risk Adjustment (QRA) solution, an artificial intelligence (AI)-powered platform that supports the capture of hierarchical condition categories (HCCs), addresses gaps in care, and enables proactive payer-provider collaboration models. The solution presents critical information from patient medical records at the point of decision-making to enable providers to make informed clinical decisions and achieve appropriate reimbursement.

Figure 1 below outlines the three key components of the Nuance QRA solution—designed to engage providers with meaningful, actionable data.

Figure 1:  
**An AI-powered platform for delivering actionable interventions to providers**



This unique and exclusive combination of Nuance’s best-in-class technology with Coker’s provider engagement services supports the journey toward risk-adjusting quality and cost data in many value-based reimbursement models, along with meeting future needs through a unified platform for provider-payer collaboration and “just-in-time” patient engagement.

While regulation and increasing demands on providers and frontline professionals continue to increase alert fatigue and provider burnout, Nuance’s QRA solution applies AI and sophisticated natural language processing (NLP), along with preference setting and case prioritization capabilities, to assist healthcare providers with bringing focus and high-value actionable intervention opportunities into the provider workflow. The approach goes beyond the limitations of claims data analysis with medical records review that includes both structured and unstructured data, enhancing the accuracy of the information available to the provider at the point of care. The level of care

is elevated, and provider-patient interactions are optimized without the need for costly manual reviews. These activities support the delivery of clinical interventions, achieving more complete and accurate documentation and streamlining coding, without overtaxing providers with administrative tasks.

As risk-adjustment models become more pervasive, identifying HCCs that can be coded and used to generate a risk-adjustment factor (RAF) score becomes increasingly important. The Medicare Access and CHIP Reauthorization Act (MACRA) and its two quality payment programs (the merit incentive payment system, or MIPS, and alternative payment models, or APMs) use this data for purposes of fairly comparing quality and cost data in value-based reimbursement models. Offering in-workflow guidance to the provider will help create documentation that better supports the diagnosis and treatments provided. Thus a more accurate picture of the complexity and severity of the patient population is available for comparison with national benchmark databases used to adjust risk.

Even purpose-built technology does not resolve the need for providers to be educated and guided in using technology to deliver optimal care and capture clinical documentation and HCC charge codes appropriately. Thoughtful modification of established workflows must be completed with provider and frontline professional involvement, leading to adoption of the technology and acceptance of new clinical workflow processes.

Thus, the first step that must be taken to bring about provider acceptance of new technology is to convince providers that it will be of significant value in delivering high-quality patient care, and demonstrate how it will benefit them specifically, as well as the health system and organization for which they work.

### **Making the case**

Two questions must be answered for providers who are being asked to modify long-standing behaviors and practices that have served them well:

1. How will making these changes help them deliver better quality (improved outcomes, enhanced patient experience) and more cost-efficient care to their patients?
2. What's in it for them—i.e., will they do all the work to create the required change while others reap the benefits?

The answer to number 2 may also be the answer to number 1, in that many providers are truly motivated by the value (defined as quality per unit of cost) they can bring to the patients they serve. Therefore, even though an individual provider may have to endure some hardships (and change is very difficult for most), if the benefits to the patient and provider can be clearly demonstrated, then incremental change may be worth the effort.

It may be very difficult to convince providers that the extra time required to capture HCCs for risk-adjustment purposes will be of direct or immediate benefit to their patients. While it is true that better and more complete documentation of a patient's clinical condition usually leads to better care for that patient, many providers feel that they do an adequate job of this already and look at coding and clinical documentation improvement (CDI) requirements as extra work imposed on them by payers, regulatory agencies, and large healthcare employers. Given this skepticism about the value of a

new way of doing things, especially risk adjustment and resolving gaps in care, most providers will need other incentives to align them with the use of this technology and engage them in its adoption and incorporation into the delivery system.

## Incentives

While financial incentives are extremely important in driving behavioral change among healthcare providers, other motivating factors should be considered.

Healthcare professionals usually take great pride in standing out from their peers in terms of performance, as measured by a variety of metrics. Most providers believe they care for a uniquely complex and challenging patient population. Therefore, quantifying the risks inherent in a specific provider's patient panel and comparing this with others can serve to drive compliance with the use of a purpose-built technology like the Nuance QRA solution, which reveals critical intervention opportunities and supports reliable documentation of risk factors (HCCs, demographic data, socioeconomic stress, and others).

But in another respect, providers tend to strongly gravitate toward the cultural norms of an organization and do not wish to stand out from the generally accepted behaviors of their peer group. Many peer review committees and other groups charged with correcting behaviors deemed to be outside an organization's standards find that one of the simplest and most effective ways to deal with such behavior is "the cup of coffee conversation"—where a respected peer sits down, one-on-one, with the outlier provider and simply tells the person "That's not the way we do things here." Again, while there are exceptions to every rule, most healthcare professionals fear the stigma that comes from not conforming to one's peer group or not living up to the generally accepted standards of the organization in which they work.

Combining the two powerful motivators described above into one incentive can be a very effective way to drive adoption of a new technology—make individual performance and peer comparisons available while offering guidance to address challenge areas.

## Financial incentives through compensation model design

Before using financial incentives to drive changes in workflow, a healthcare organization should make sure that its reimbursements and compensation models are aligned. It is counterproductive for an organization to incentivize the capture of HCCs using technology through a compensation model if very few of the organization's reimbursements depend on these risk-adjustment parameters, i.e., if the organization takes on very little risk in its payer contracts. Up until now, most provider groups that did not deal heavily with Medicare Advantage or other risk-based reimbursement models were free to ignore the capture of HCCs. As MIPS, APMs, and other commercial pay-for-performance plans—such as bundled payment or shared savings plans—become mainstream, the accurate reporting of quality and cost data driving proper risk adjustment will be an essential part of most clinical documentation improvement programs, allowing for fair comparison benchmarking. Thus, most organizations will have to financially incentivize their providers to get on board with these important tasks.

It is also important for providers and healthcare administrators to be highly involved in setting the performance incentive categories and metrics. Buy-in on both sides is essential to make sure the organization and its providers are fully aligned. Incentive compensation can then be used effectively to drive adoption of this new technology and underscore the importance of the endeavor.

For instance, many organizations now earmark approximately 5-10% of provider compensation and put these dollars at risk for performance on carefully selected quality, patient experience, and cost efficiency metrics. With the rollout and full implementation of MACRA and MIPS in January 2019, this percentage of total compensation may need to be increased, especially for providers whose payer mix is heavily weighted toward Medicare. For those providers, perhaps 20-25% of compensation should be geared toward incentive compensation, and of that amount, perhaps 5-10% should be directed toward a bonus for those who embrace and fully utilize the solution. Note the example in Figure 2 below.

More specifically, consider a provider whose practice is 50% Medicare and who is receiving a base salary of \$200,000 a year. Here, we would recommend that 25% of this base (\$50,000) be targeted for performance incentives, with up to \$10,000 available for optimally utilizing the Nuance QRA solution. For instance, providers for whom the number of HCCs captured from one year to the next differed by less than 10% would receive the full bonus. However, if the change in capture rate exceeded 10% but was less than 50%, the provider would receive one-half of the bonus, or \$5,000. Finally, if the HCC capture rate showed a gap of more than 50%, then the underperforming provider would receive no bonus, with appropriate intervention to determine the underlying cause.

**Figure 2:**  
**Performance incentive bonus structure**

Base salary	Performance target 25% of base	HCC gap < 10 % incentive	HCC gap 10-50% incentive	HCC gap > 50% incentive
\$200,000	\$50,000	\$10,000	\$5,000	\$0

Over time, the above 25% performance bonus could be increased as more and more payers in the provider's marketplace move to a value-based reimbursement model. This would require careful timing to ensure that the compensation model did not get out of sync with the predominant reimbursement models used by payers in the market or fair market value. This requires frequent monitoring and attention by the employed provider network and those responsible for determining the compensation models used in these organizations.

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## Successful provider engagement strategies

- **Seek to understand** current provider workflow challenges and involve providers in process improvement efforts.
  - **Leverage the expertise,** knowledge, and benchmarking data from a well-regarded market expert while implementing risk adjustment and quality solutions.
  - **Clearly articulate** how changes will help providers deliver better quality outcomes and more cost-efficient care to their patients.
  - **Design incentive programs** that offer transparency in performance and outcomes data.
  - **Prior to making changes** in workflow, a healthcare organization should make sure that its reimbursements and compensation models are aligned.
  - **Choose the right technology** and an experienced partner that brings resources, solutions, and proven outcomes as a strategic advantage.
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## Conclusion

Engagement and alignment of providers, especially those employed by healthcare systems and companies managing Accountable Care Organizations, require careful attention to those factors that motivate and drive healthcare professionals to change long-established behaviors and practice patterns. Coker Group has helped many organizations as they face this challenge, and delivers expert provider alignment services to support clients with adoption and utilization of Nuance's Quality and Risk Adjustment solution.

This balanced approach to provider engagement helps healthcare delivery organizations successfully navigate the many changes on the horizon. This approach should incorporate the natural inclination for most healthcare providers to want to stand out from their peers and be recognized for their personal performance. It should also take advantage of the fact that most providers want to fit into the cultural norms and accepted standards of behavior of their organization. Finally, organizations should carefully and methodically use financial incentives to motivate change and do so in a way that ensures alignment with the changing reimbursement models now appearing within the healthcare economy, while at the same time accommodating frontline professionals' needs.

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### About Nuance Communications, Inc.

Nuance Communications, Inc. is a leading provider of voice and language solutions for businesses and consumers around the world. Its technologies, applications and services make the user experience more compelling by transforming the way people interact with devices and systems. Every day, millions of users and thousands of businesses experience Nuance's proven applications. For more information, visit [www.nuance.com/healthcare](http://www.nuance.com/healthcare) or call 1-877-805-5902. Connect with us through the healthcare blog, [What's next](#), [Twitter](#), [LinkedIn](#) and [Facebook](#).

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