Achieving ROI When Transitioning to Value-Based Care

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July 19, 2016
Objectives

- Understand the impact of timing of value-based transformation and potential ROI
- Define ROI measures that are beneficial under both a FFS and value-based environment
- Lessons learned: How did one health system reduced out-of-network referrals (leakage) in their CIN?

Please note that the views expressed are those of the conference speakers and do not necessarily reflect the views of the American Hospital Association and Health Forum
The Measurement of Success Is Evolving

### From Fee For Service...

<table>
<thead>
<tr>
<th>Category</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Share</td>
<td>Adjusted Admissions</td>
</tr>
<tr>
<td>Quality</td>
<td>Process measures</td>
</tr>
<tr>
<td>Physician Alignment</td>
<td>Medical staff</td>
</tr>
<tr>
<td>Patient Acquisition</td>
<td>Emergency Department (ED)</td>
</tr>
<tr>
<td>Care Management</td>
<td>Case management</td>
</tr>
<tr>
<td>Provider Incentives</td>
<td>Relative Value Units (RVU)</td>
</tr>
</tbody>
</table>

### ...To Value-Based Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Share</td>
<td>Covered lives (attributed or capitated)</td>
</tr>
<tr>
<td>Quality</td>
<td>Outcome measures</td>
</tr>
<tr>
<td>Physician Alignment</td>
<td>Participating Physicians</td>
</tr>
<tr>
<td>Patient Acquisition</td>
<td>Patient Outreach</td>
</tr>
<tr>
<td>Care Management</td>
<td>Cross-continuum care coordination</td>
</tr>
<tr>
<td>Provider Incentives</td>
<td>Quality/Cost</td>
</tr>
</tbody>
</table>
In Value-Based Care, the Payment Structure is the Underpinning for Measuring ROI

Patient Volume as a revenue source will be replaced by dollars tied to risk: premiums, capitation, allocations of care dollars

- Most value-based ROI will be contract and population specific, but some will cut across all populations – these are the “golden nuggets”
CIN/ACO Value-Based Care Timeframe – Years 1 to 3

- **Month 3**: Define clinical quality programs, select metrics
- **Month 6**: Hire Network leadership, distribute Participation Agreements
- **Month 9**: Deliver population health technology
- **Month 12**: Receive payor data for contract negotiations
- **Month 15**: Finalize initial value-based contract (e.g. shared savings)
- **Month 18**: CIN/ACO’s can achieve financial ROI by Year 3 by having a large number of dollars tied to value-based contracts by Month 18, or increasing market share via the network
- **Month 20**: End of first 12 months of contract
- **Month 24**: Initial payouts
- **Month 27**: Claims data run out
- **Month 30**: Claims data run out
- **Month 32**: Payout of initial savings and incentives
- **Month 36**: CIN/ACO’s can achieve financial ROI by Year 3 by having a large number of dollars tied to value-based contracts by Month 18, or increasing market share via the network
- **Month 36**: Though organizations may begin with moving market share through improved physician alignment and outreach, greater ROI is achieved via successful risk contracts.

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Three Key Measures Achieve Significant ROI in Both VBC and FFS Worlds

**Increasing Market Share**

- Percent of your network’s share of total dollars in your primary service area

**Optimizing Risk Coding**

- HCC capture allows for more targeted disease burden management
- Adjustments to revenue for disease burden is significant

**Reducing Network “Leakage”**

- Incremental care your network would provide if your patient sought all of his/her care within your network
Quantifying the Magnitude of Growing Market Share

**Inpatient Market Share**

- Hospital A: 40%
- Hospital B: 60%

**Total value of inpatient market**

= $1 billion

**Market Share Increase**

On average, Valence CINs have an incremental market share increase of 25%, which equates to an **absolute market share increase of 10% for Hospital A** in their primary service area.

**Value of Shifting Market Share**

The value of a 1% shift in market share is equal to **$10M** in revenue.

**Total value of 10% market share shift**

= **$100 million**
Deeper Payor Partner Alignment of HCC Initiatives Provides an Opportunity to Create Synergies and Additional Revenues

<table>
<thead>
<tr>
<th>HCC Program Synergies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data process</strong></td>
</tr>
<tr>
<td>Data process review and remediation of all EMR, practice management systems, and data exchanges for truncated/dropped codes</td>
</tr>
<tr>
<td><strong>Data &amp; reporting</strong></td>
</tr>
<tr>
<td>Need for analytics and dashboards to stratify and prioritize membership/patients for risk score accuracy code capture: recapture of chronic conditions and targeting of high probability suspect conditions</td>
</tr>
<tr>
<td><strong>Provider education and training</strong></td>
</tr>
<tr>
<td>Need collaboration on physicians with overlapping members/patients in shared-risk based contracts</td>
</tr>
<tr>
<td><strong>Patient assessments forms (PAF) and annual reviews</strong></td>
</tr>
<tr>
<td>Potential in-home assessment (IHA) program with URMC home health clinicians ($)</td>
</tr>
<tr>
<td>Potential campaign for annual wellness exam with analytics for member customized patient assessment form (PAF) ($)</td>
</tr>
<tr>
<td><strong>Resource investments</strong></td>
</tr>
<tr>
<td>Potential investments in coding resources in high membership volume URMC clinics</td>
</tr>
<tr>
<td><strong>Quick hits</strong></td>
</tr>
<tr>
<td>Targeting &quot;no visit&quot; members/patients ($)</td>
</tr>
<tr>
<td>Targeting high value recapture opportunities ($)</td>
</tr>
</tbody>
</table>
## Leveraging Value-based Care Initiatives for ROI in your Network as You Transition from FFS

<table>
<thead>
<tr>
<th>Payment Source</th>
<th>Options</th>
</tr>
</thead>
</table>
| FFS MA payor contracts w/value-based physician compensation | - Build pay for outcomes metrics into future contracts to create financial incentives and momentum for physicians to drive engagement in quality initiatives.  
- Participation criteria can be used but often only effective as a short-term engagement technique |
| CMS Medicare Initiatives | - Medicare Comprehensive Primary Care Plus (CPC+) to leverage care management payments to help fund infrastructure development; zero risk program and provides capital for VBC resources and capability development  
- Medicare MSSP ACO to leverage CIN/Network infrastructure to create potential revenue stream and create exclusive PCP relationships for competitive positioning |
Create a Balanced Scorecard to Track Performance Over Time: **Risk Bearing Entity / CIN / ACO**

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Performance Metric</th>
<th>Data Source</th>
<th>Baseline</th>
<th>12 months</th>
<th>24 Months</th>
<th>36 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of lives tied to value-based contracts</td>
<td>Payor data</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Experience / Satisfaction</td>
<td>Payor data</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of providers in CIN (PCPs/specialists/employed or % of medical staff and/or market)</td>
<td>CIN</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td>ED/1000, Admit/1000, ALOS, 30 Day Readmissions (utilization by subset of product w/health plan compared to other commercial products)</td>
<td>Payor, Internal</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic Prescribing vs. Brand; including total prescribing (% and $)</td>
<td>Payor data</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician connectivity to Vision</td>
<td>Vision</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td>Total Savings Earned by CIN</td>
<td>CIN</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Total Incentives Distributed; including funds to hospital and average physician incentive (PCP and SCP)</td>
<td>CIN</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-network Utilization vs. out-of-network utilization (procedures, admissions, referrals, leakage)</td>
<td>Payor data</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
The URMC/MA Payor Analytics Work Group serves as the governing team charged with:

- Prioritizing requests and defining processes for data sharing and analytics, based on the goals of the partnership
- Providing clinical and claims data that can be used for identified opportunities in care management
- Providing and analyzing actionable information to address how growth and cost reduction can occur for both organizations
- Collaborating on analytical efforts of mutual benefit, including research and discovery
- Data governance, privacy, security
- Dedicate resources for prioritized analytical projects
- Accountability to URMC/MA Payor Partnership Leadership Team
URMC/AHP and Payor Collaboration – Pilot Program

Rolling out pilot at AHP PCP Advisory Meeting 4/28/16
- Reviewed power point
- Addendums received from providers
- Member list validation/status

Discussed Communication Process and Plan
- Cascading of pilot to others

Expansion of Project beyond pilot
- Payor has plans to roll out to additional practitioners
- Who/when are still under discussion
- Additional AHP practitioners
- Discussed timing and using lessons learned

Review rollout of Pilot at meeting in May
Case Study: What Did We Learn About Our Out-of-Network Referrals (Leakage)?

University of Rochester Medical Center
Accountable Health Partners (AHP) is a clinically integrated network of hospitals and physicians that exists to deliver quality healthcare and an outstanding patient experience and rewards its members for the value they bring to the healthcare system.
### Accountable Health Partners: AHP Physician Network

<table>
<thead>
<tr>
<th></th>
<th>Adult PCPs</th>
<th>PCP Pediatricians</th>
<th>Specialists</th>
<th>CNMs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>159</td>
<td>120</td>
<td>296</td>
<td>7</td>
<td>582</td>
</tr>
<tr>
<td>URMFG</td>
<td>179</td>
<td>15</td>
<td>1,040</td>
<td>14</td>
<td>1,248</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>338</strong></td>
<td><strong>135</strong></td>
<td><strong>1,336</strong></td>
<td><strong>21</strong></td>
<td><strong>1,830</strong></td>
</tr>
</tbody>
</table>
Reducing Out-of-System Referrals Helps Achieve Three Key Goals Within the URMC Strategic Plan

**Elements of the Strategic Plan**

- Be the local health system of choice
- Be the regional referral center of choice
- Generate financial resources that will allow our faculty and staff to thrive and enable us to support the strategic plan of the medical center and the UR

**Rationale for Leakage Analysis**

Keeping referrals in-network provides the greatest opportunity to manage quality and cost

When patients are referred outside of our network, care revenues are lost within our system
Defining “Leakage”

• Referrals outside of our clinically integrated network:
  • URMFG employed providers
  • URMC affiliates (hospitals, surgical centers)
  • Clinically integrated provider network’s private physicians
Project Goals

**PURPOSE**

• To identify barriers within our integrated system that result in clinical services and related revenue being referred (leaked) to providers who are not members of AHP

**Approach**

• Over a 2 month period, conduct interviews with ten of our employed primary care practices which account for approximately 75% of the system’s annual out-of-network clinical revenue.

• Develop general and department-specific observations, comments and recommendations

**Deliverables**

• Address each barrier with Medical Center and AHP leadership

• Develop next steps to reduce out-of-system referrals by our employed primary care physicians by 25% each year over the next two years. This equates to approximately $22 million.
The Psychology of Leakage

GEOGRAPHY: ACM is right down the street...

CUSTOMER SERVICE: Joan at Dr. Doe’s office is so easy to work with...

ACCESS: How quickly can I get my patient into a specialist?

NETWORK UPDATES: Who treats hemophilia?
## Process Improvements

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| **Access** | **EDs to schedule appointments w/URMFG faculty upon discharge**  
✓ Completed: 1000+ direct referrals from HH ED and Urgent Care Centers; SMH ED went live this month  
**Scale specialist network with expansion of primary care network**  
✓ Ongoing: 9 providers added in 2016  
**Expand urgent care**  
✓ Ongoing: 5 Urgent Care centers open, others planned |
| **Geographic Location** | **Establish multi-specialty practices in geographies without adequate specialty practices**  
✓ Carefully analyzing expansions in other geographies to ensure ROI  
✓ Expanding access to specialists through telemedicine solutions  
✓ Using new network design tools |
## Process Improvements

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendations</th>
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</thead>
</table>
| Network Updates    | **Develop updated listing URMFG physicians (printed/online)**  
✓ Access guide delivered to all PCPs; online tool in progress.  
✓ eRecord provider steering tool available by September.                                                                                                                             |
|                    | **Develop a “hotline” to call regarding issues and difficulties**  
✓ Three numbers established for distinct audiences: 275-URMD (providers), 276-3300 (patients), 275-KIDS (pediatric patients)  |
|                    | **Educate patients on benefits of receiving care within one system**  
✓ New patient kit completed and in distribution at all PCN locations                                                                                                           |
| Customer Service   | **Implement staff and clinician training to deliver responsive and respectful interactions with peers, patients, referrers**  
✓ Training rolled out to 5 groups, 70+ staff members, 12 managers  
✓ Planning for ongoing training.                                                                                                                                              |
### Process Improvements

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| **Policy** | Clearly communicate that patients should be admitted and/or procedures should be performed at one of the URMFG member facilities unless it is not in the patient’s best interests to do so  
✓ Communication under development collaboratively with URMFG and AHP  

Explore options for incentives to remove barriers to in-system referrals and to increase access  
✓ Phase II, requires careful consideration  

Perform an assessment of the capacity of our existing primary care network practices (e.g. panel size, open versus closed practices, etc.) and continue to expand the number of primary care practices  
✓ Assessment underway; strategic growth plan is drafted |
Measuring Success: Referral Measurement and Reporting

To measure progress against select metrics to ensure success, we will:

- **New data visualization tool, created collaboratively with Eagle Dream Health is available at the specialty and PCP level with drill down interactive capabilities.**

- **Identify, select and implement a software package that can collect and report referral measurement dashboard on real-time basis.**

- **Build functionality into eRecord to keep referrals in network – Epic Provider Steering Tool.**

- **Investment in resources and support tools to manage leakage in real time – “the golden nugget”**
Leakage 2.0

ACTIONABLE DATA!!!

• Study and understand referral patterns; inform regional expansion

• Share with practices; full engagement with data and goals

• Ability to set policies:
  • Faculty incentives
  • Benefit design plans

• Still...trending year to year will be difficult: changes in network and in patient population
**Clinical Variations Example: Use of Januvia**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Driver</th>
<th>Provider Count</th>
<th>Episode Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>Januvia</td>
<td>98</td>
<td>2,653</td>
</tr>
</tbody>
</table>

**Clinical Variation**

Review and compare the efficiency and effectiveness in care delivery among providers.

![Graph showing drug supply days per episode with Rx benefit against episode providers.](image)
Out-of-Network Referrals: Home Care Services
Take Away Points

• Establish a working relationship with your major payor for data transparency and to be successful in population health management

• “Clean house” - Meet with each of the departmental chairs and program administrators where specific observations, comments and recommendations are provided to continuously work on reducing out-of-network referrals

• Data, data, data - use data to further develop specialty-specific plans
  ✔ Build relationships with referring providers
  ✔ Expand capacity where feasible

• Consider policies that would further support in-network referrals, including benefit design plans

• Investment in these recommended areas is key and has great potential for high ROI
Questions?
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