Data-driven Care Strategies for Successful Performance with Value-based Contracts

July 10, 2019

Agenda

- Value-based Care and the Rise of Integrated Networks
- Value-based Transformation Begins with Data
- Leveraging a PHM Solution to Optimize Care Management
- Using Analytics to Drive Compliance and Performance
- Examples of Successful Value-based Programs and Lessons Learned

Value-based Care and the Rise of Integrated Networks

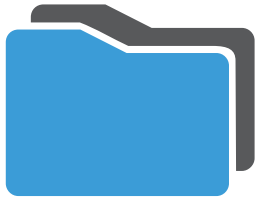
The Benefits of Value-based Care

Patients

- Lower costs
- Better outcomes
- More personalized care
- Increased satisfaction with care

Providers

- Better care efficiencies
- Increased patient satisfaction
- Shared savings bonuses
- Stronger care network



Payers

- Stronger cost controls
- Reduced risk
- Increased efficiency through payment bundling

Suppliers

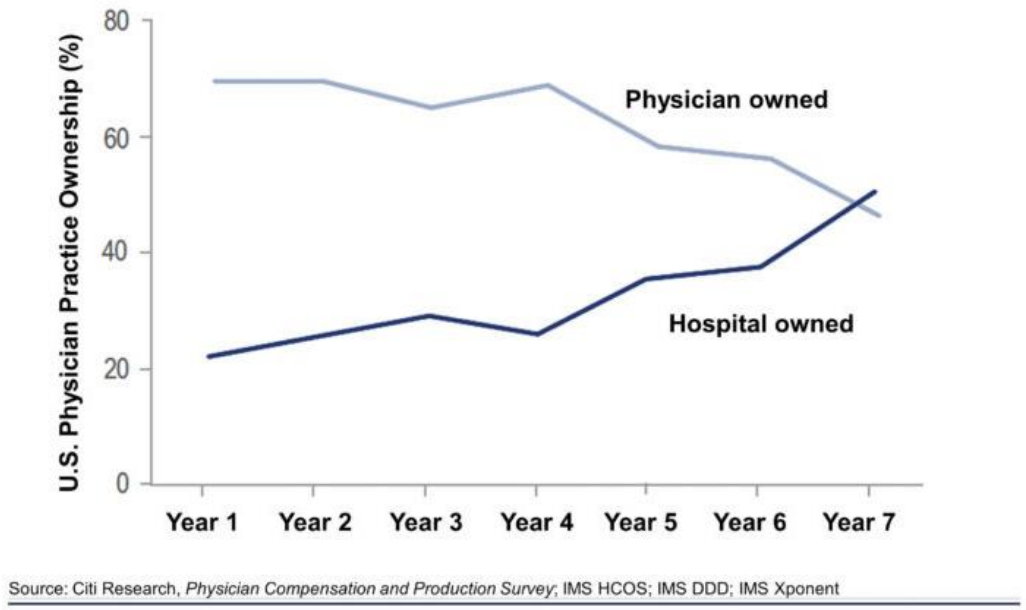
- Alignment of prices with patient outcomes
- Responsive inventories, lower supply chain costs

Society

- Reduced healthcare spending
- Better overall health

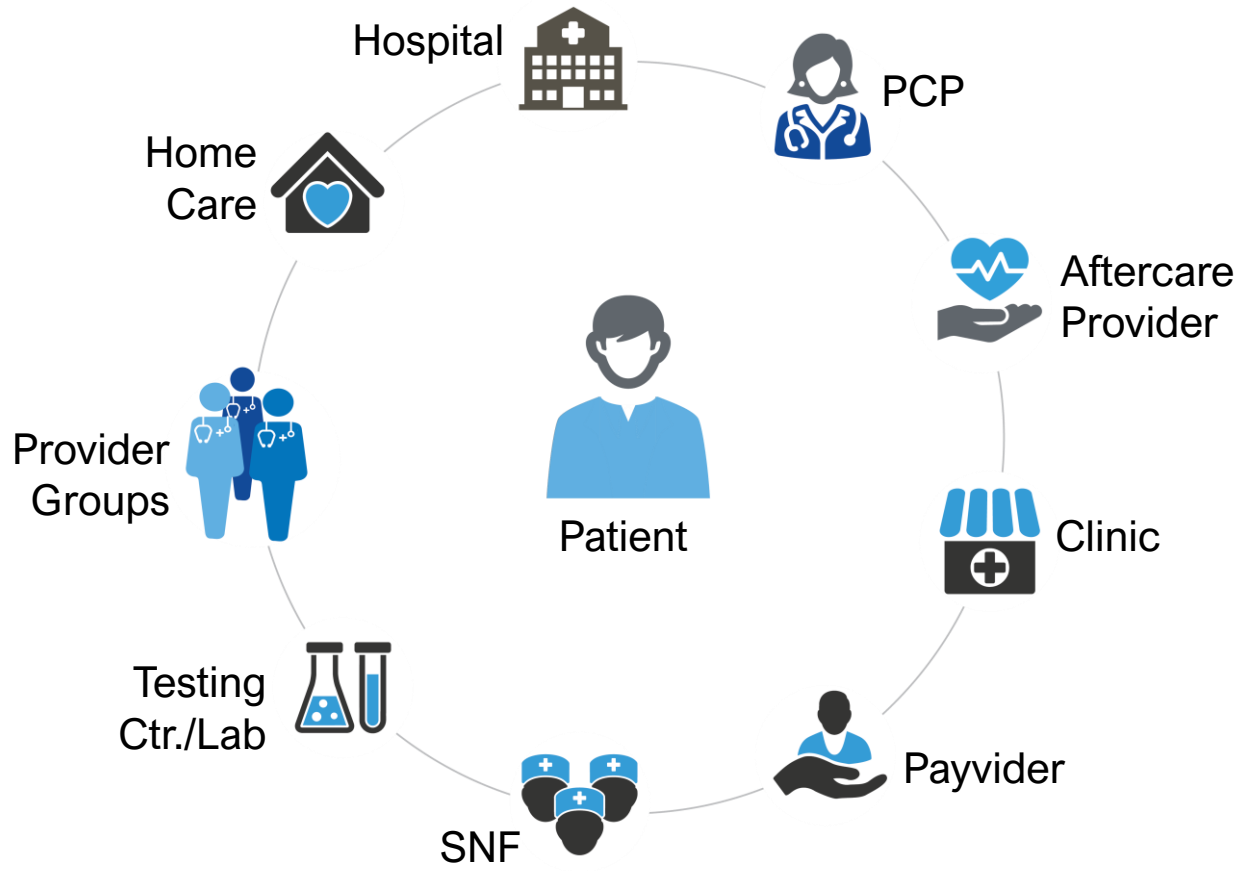
The Rise of Integrated Networks

Declining Practice Ownership

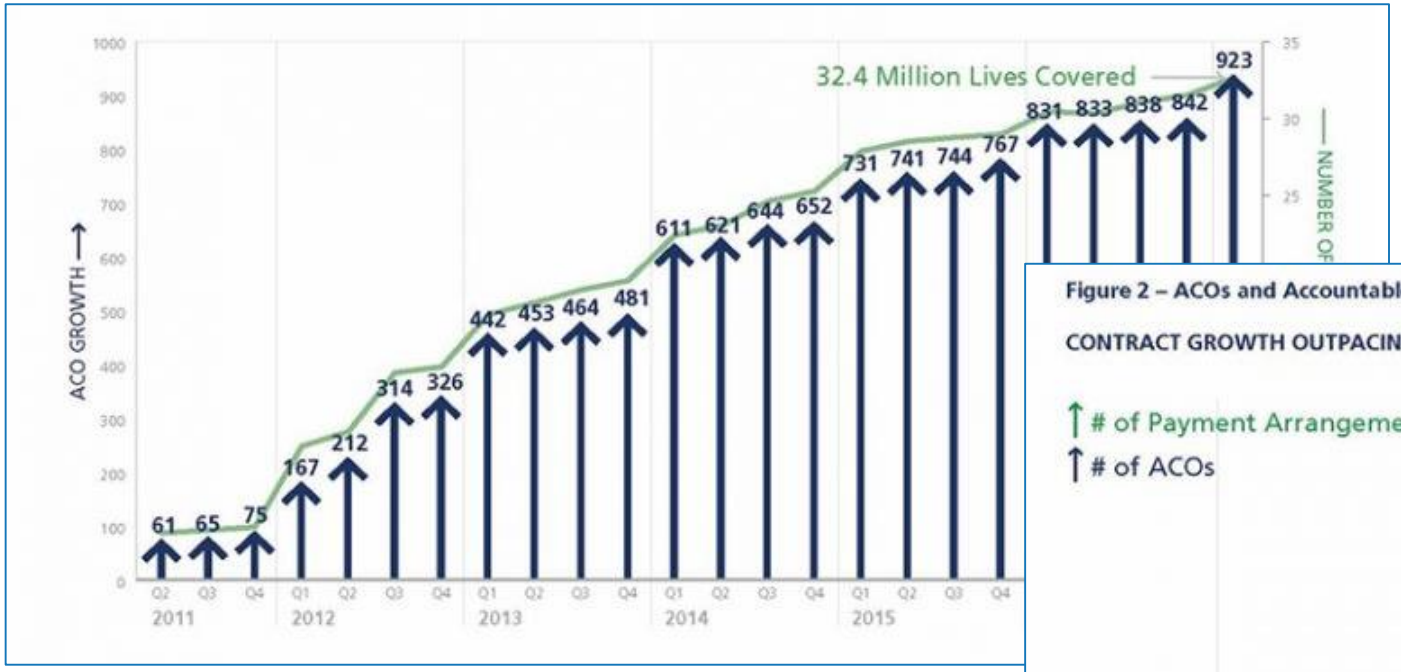


Source: Citi Research, *Physician Compensation and Production Survey*; IMS HCOS; IMS DDD; IMS Xponent

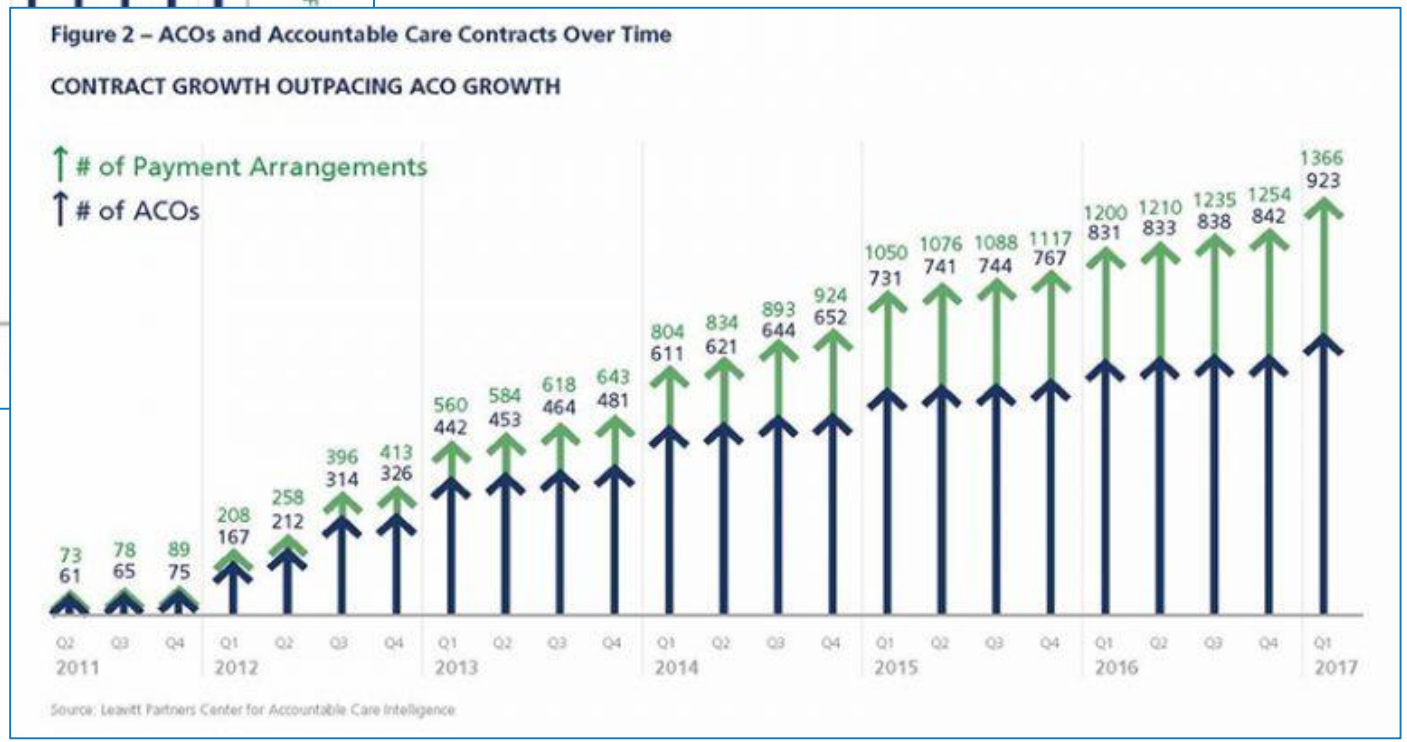
New Types of Organizations: ACOs, IDNs, CINs, PCMHs, and Others



Growth in Value-based Programs



ACOs and Covered Lives Over Time



ACOs and Accountable Care Contracts Over Time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Value-based Transformation Begins with Data

Aligning with Value-based Initiatives

Determine your patient population, care model, and partners

Find the right population health management (PHM) solution

Identify the right data feeds to ingest & aggregate to provide a comprehensive and accurate longitudinal medical record and a 360 degree view of patients

Employ analytics to asses the overall health of the covered patient population and identify high-risk, high-cost members and associated care gaps

Make informed, evidenced-based decisions when creating and executing individual patient care plans

Use quality metrics and established benchmarks to assess performance.

Value-based Transformation Begins with Data

1 → 2 → 3 → 4

Data Transformation

- Identify data sources to enable a comprehensive view of patients' healthcare and to feed a robust analytics platform
- Understand/educate stakeholders on the meaning of available data

Analytics Transformation

- Assess available data in context of current requirements and goals
- Establish benchmarks and quality metrics to follow
- Identify and evaluate opportunities for care and network growth
- Prioritize opportunities
- Plan for ongoing analysis

Care Transformation

- Identify high utilizers and care gaps to optimize care delivery and management
- Look for opportunities to decrease hospital admits/LoS
- Determine patient and provider engagement strategies

Payment Transformation

- Align PHM with financial goals, balancing risk to set a sustainable course
- Ensure payment for value by correct coding

Performance Transformation

Use accumulating data, benchmarks, and quality metrics to drive performance improvement in outcomes, quality of care, efficiencies, and revenue

Which PHM Solution Is Right for You?

Ensure the value of your data by selecting the right PHM solution

Transition to value-based care, optimize contract negotiations with payers, and boost clinical and financial performance by closing gaps in patient care and developing targeted, personalized care plans and interventions.

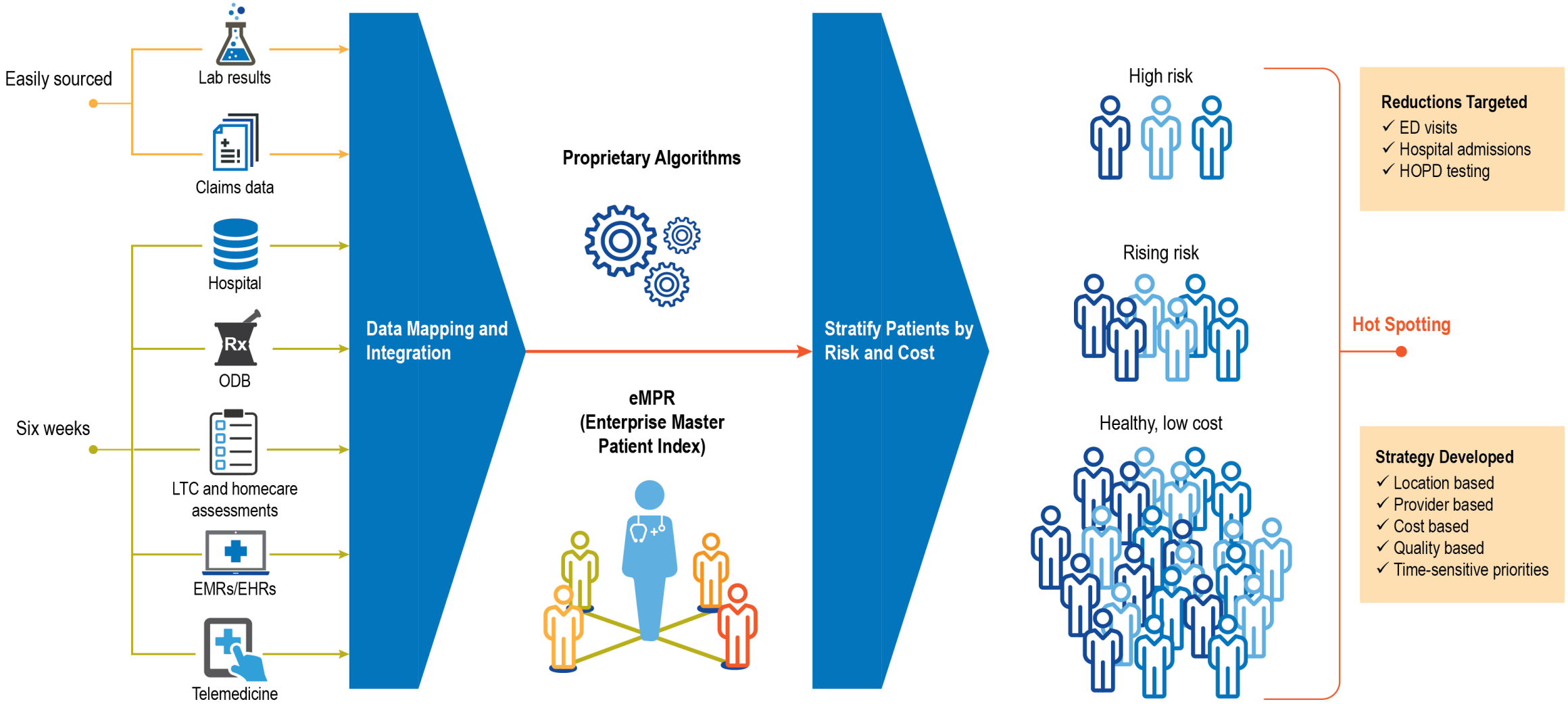
- ☑ Raise MSSP performance by leveraging platform functionality and reporting features
- ☑ Easy-to-read dashboards that help close gaps in care
- ☑ Deliver comprehensive reports to help providers understand performance and trends on contractual quality metrics
- ☑ Integrate behavioral health and social determinants of health assessments
- ☑ Streamline chronic care management and annual wellness visits for maximum reimbursement
- ☑ Modules that support Comprehensive Primary Care Plus (CPC+), and the Oncology Care Model (OCM)
- ☑ Submit data on behalf of participating providers for MIPS/MACRA
- ☑ Submit GPRO data for the ACO

Leveraging a PHM Solution to Optimize Care Management

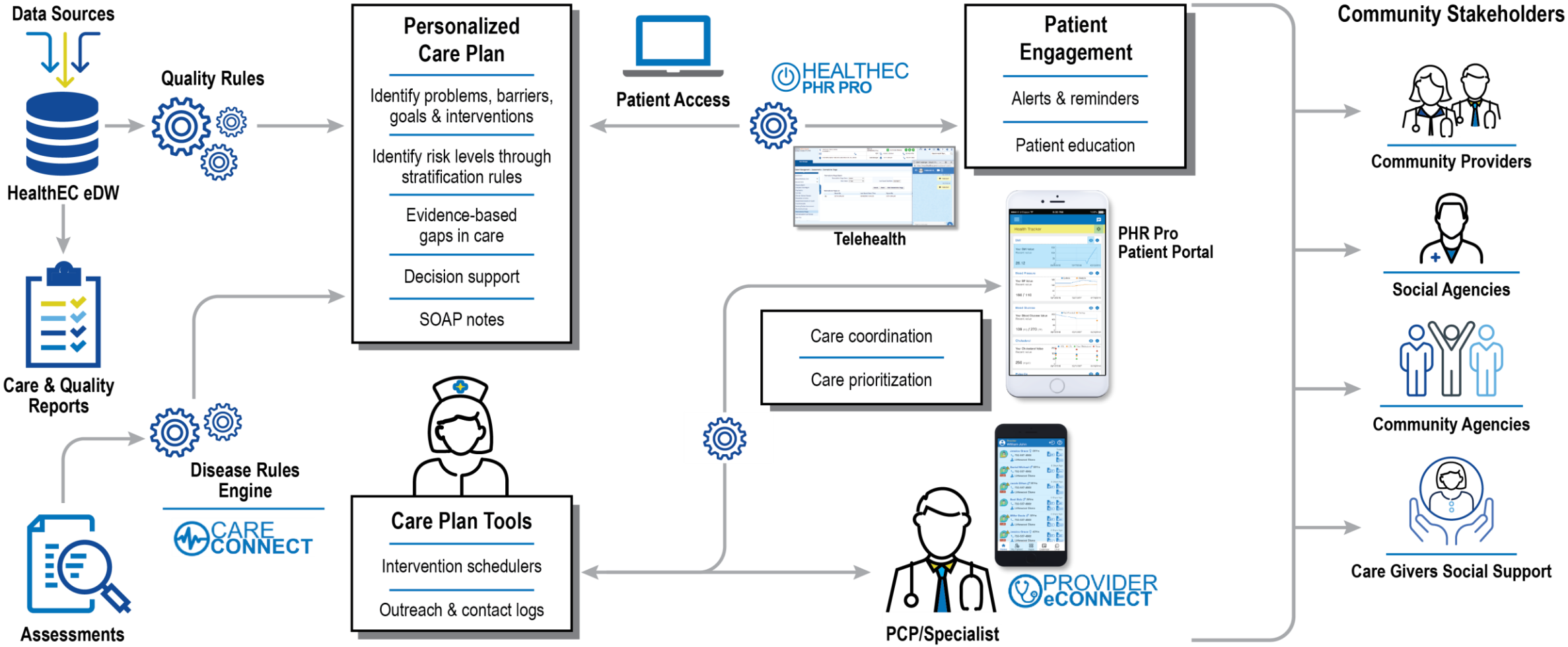
360° View of the Patient's Care

- **MCO and Network Performance Monitoring**
  - E-Infrastructure – share clinical and financial data and eReporting
  - Peer profiles and performance on quality and cost
  - Distribution methodology and network management
  - Strategy for risk contracts – partial or full capitation models
  - Out-of-network use and network and services strategy
  - Monitor claims adjudication and contract performance
- **Medication Monitoring**
  - Patient identification and adherence to medication
  - Compliance and overuse
  - Special focus on controlled substances and opioids
- **Hospitals, Clinically Integrated Networks, and IDNs**
  - Score cards for community providers
  - Facility profile on cost, utilization, quality hospital participation in bundling, and episode-based programs
  - Monitoring of risk-based contracts
- **Health Plans**
  - Provider profiles with continuous monitoring of HEDIS scores
  - Real-time EMR data integration

Population Cohort and Risk Stratification



HealthEC "Personalized" Community Record



Care Coordinator's Dashboard and Workflow

- Targeted prompts for high-risk, high-cost patients
- Workflow tools to prioritize cases and monitor case load
- Individualized plans of care to close gaps (including payer-specific targets), prevent exacerbation of illness
- Incorporating community-based providers

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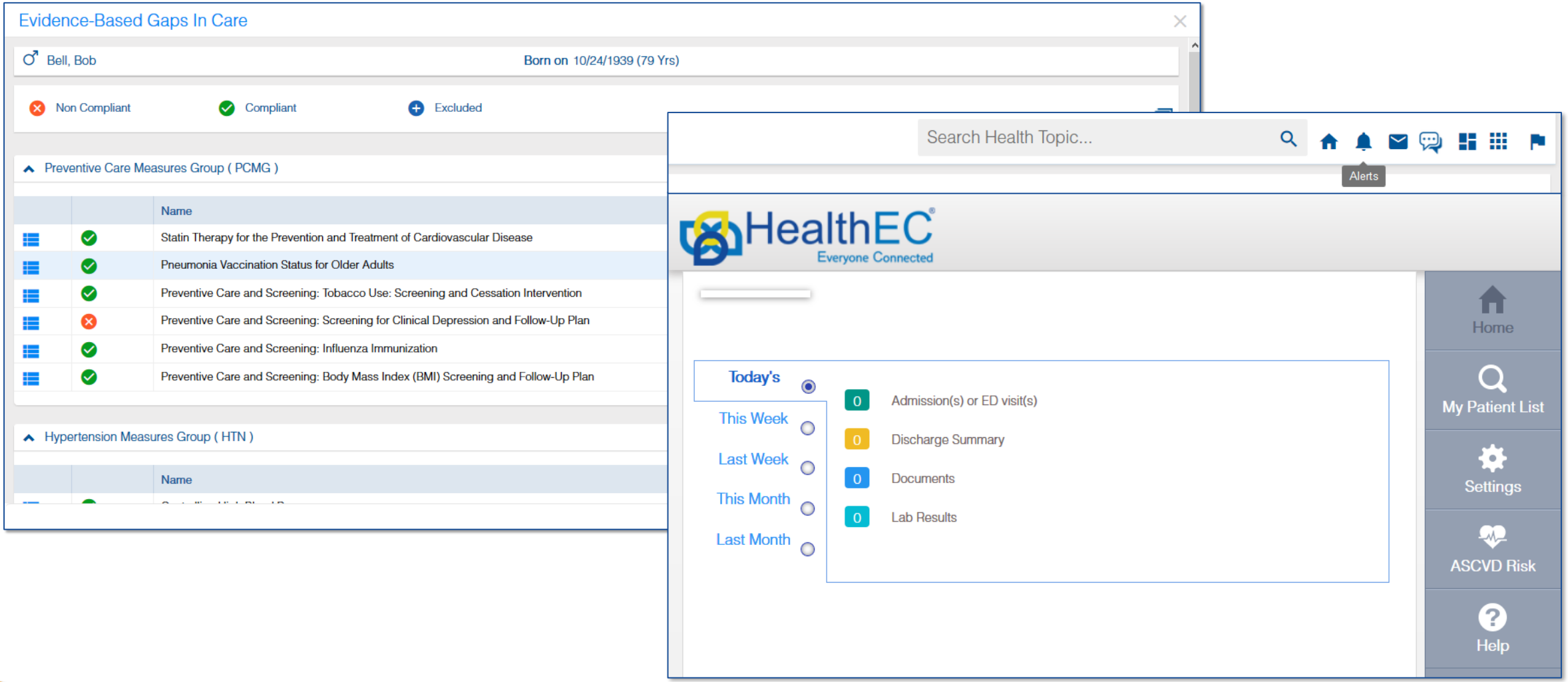
Care Gap Monitoring and Event Alerting



Executing a Care Coordination Strategy

Built-In Patient Assessments

- Complex case management
- Disease management – chronic illnesses
- Depression screen – PHQ 2/9
- Cognitive function
- Fall risk
- Chronic case management
- Prevention at home

Social Determinants of Health

- Telemedicine triage
- External nursing review
- Annual wellness – HRA
- Pre-visit summary

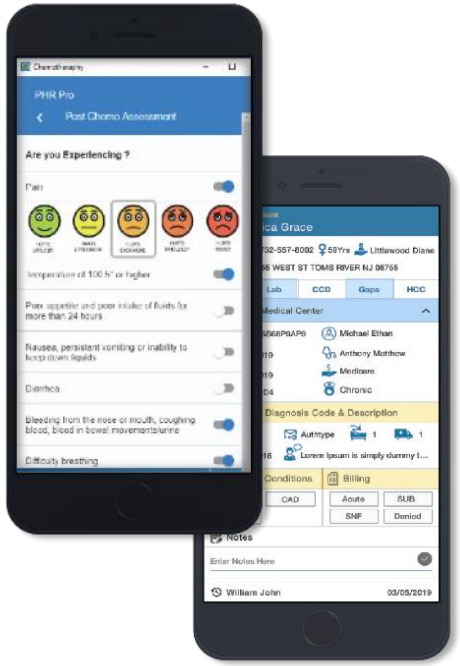
Results-based Approaches to Care Coordination

An approach based on:

- Predictive risk, predictive cost, resources utilization
- High- or rising-cost patient
- High-cost diagnosis or cost per patient
- High-ER users and non-emergent use of ER
- Frequently admitted patients or admissions for low acuity
- Re-admissions by facility, diagnosis
- Focus on chronic care or annual wellness
- HCC risk adjustment factor maximization strategy
- Medication adherence rates
- Quality score improvement

Provider and Patient Engagement

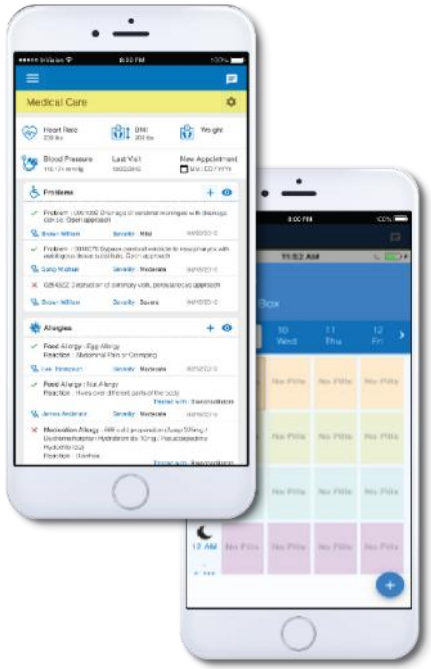
Provider



- ✓ Notified when patients are in the ER; communicate with hospital staff
- ✓ Send/receive patient summaries
- ✓ Notifications for care gaps,, labs, and referral close loops
- ✓ Arrange for transition of care
- ✓ View Important/out-of-range results for labs and radiology
- ✓ Secure messaging for patients/providers/care coordinators in the network

HealthEC Connects Patient to Provider on a Meaningful Level

Consumer/Parent/Caregiver



- Reminders and alerts
  - Sent by providers and care coordinators
  - Self-entered by patient
- Tracks actions and rewards them on positive outcomes

- ✓ Appointment follow-up
- ✓ Assessments
- ✓ Referral close loop
- ✓ Medication alerts
- ✓ Care plan follow-up
- ✓ Patient education
- ✓ Test result out-of-range alert
- ✓ Customized data access

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Using Analytics to Drive Compliance and Performance

Library of Over 270 Industry-Certified Quality Measures

NQF, NCQA, AHRQ, CMS, URAC, TJC, AMA-certified measures

40+ Clients Served

Build Custom Measures

Fast Delivery Time

HealthEC offers flexibility to ingest data and feed it into the standard framework for building measures that can be customized for generating any set of quality measures.

CMS Core	eCQM	HEDIS	Star	MIPS	OCM	Health Homes II
69	10	73	2 Categories	271	13	10

Provides real-time performance monitoring reports

Timely update of codes

All business rules are prebuilt into the platform

Easy database access via basic queries

- View composite score
- View performance by measures
- Compare plans
- Sort/filter view ratings by line of service, plan, practice, provider
- Drill down to the level of patient
- Easy to navigate user interface

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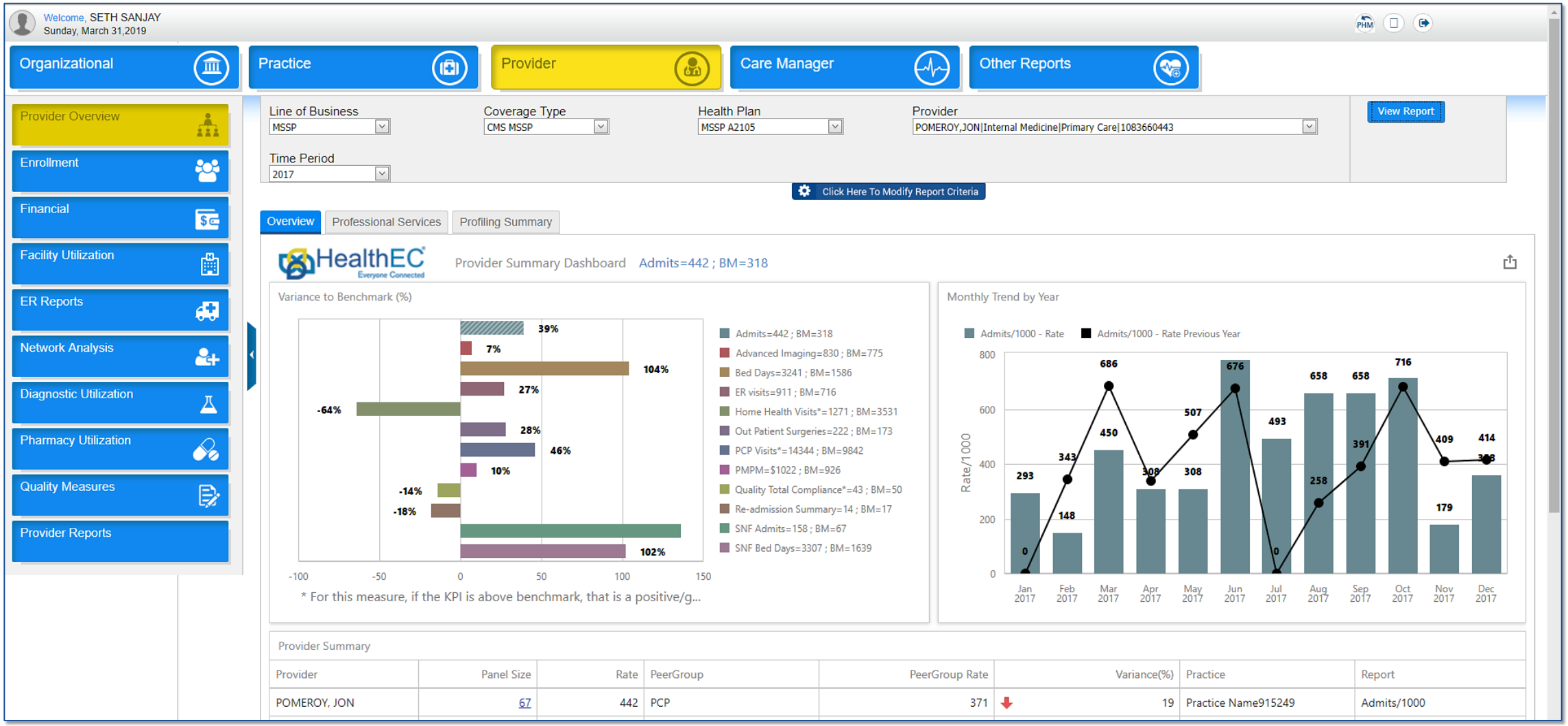
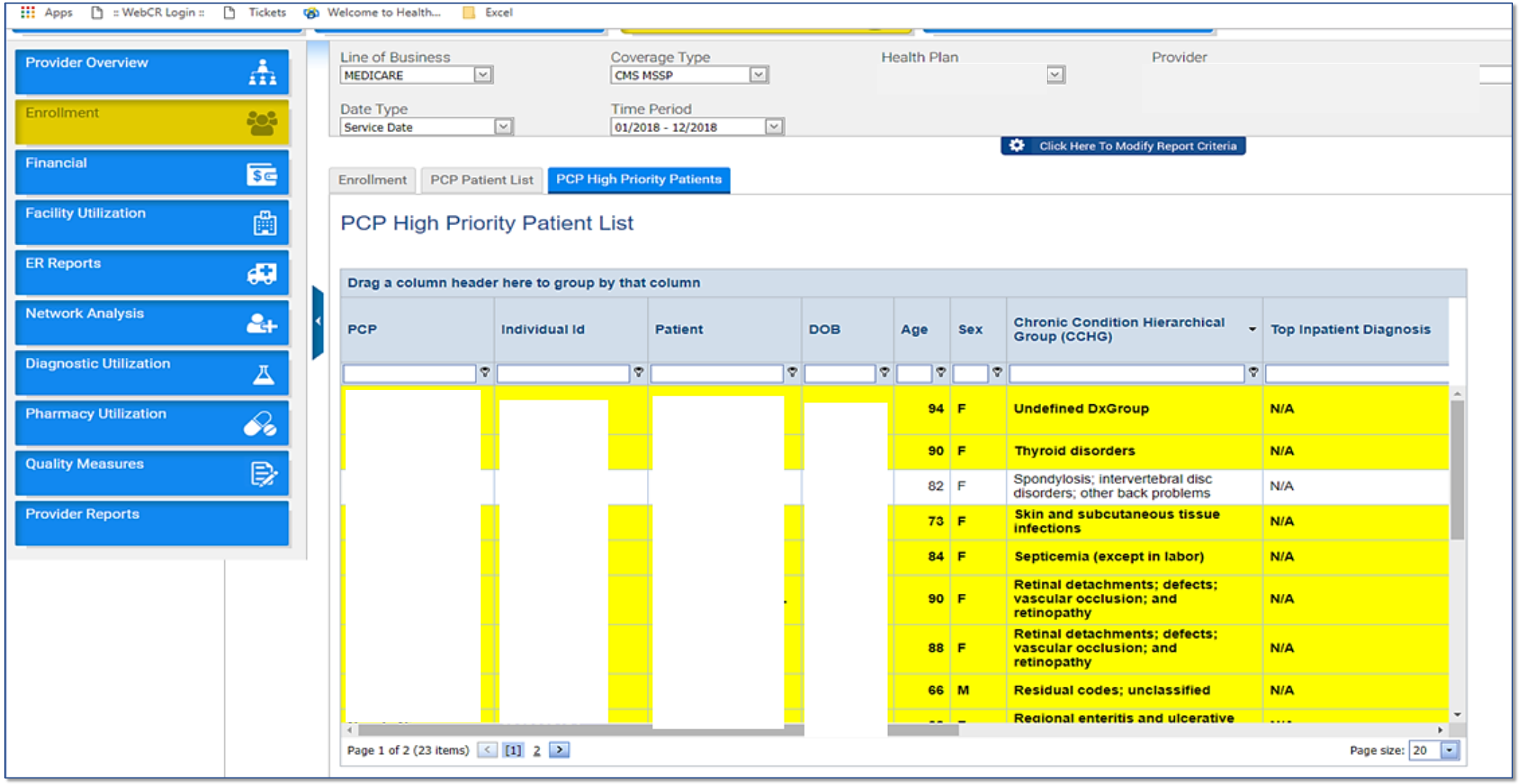
Dashboard – Provider Overview



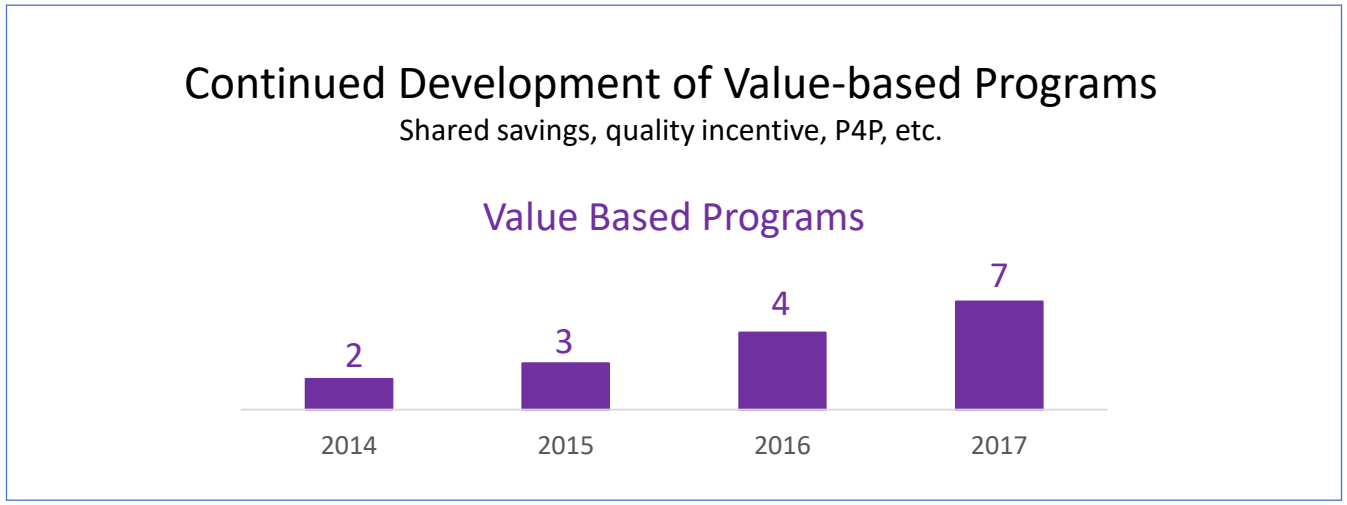
Dashboard – PCP High-Utilization Roster

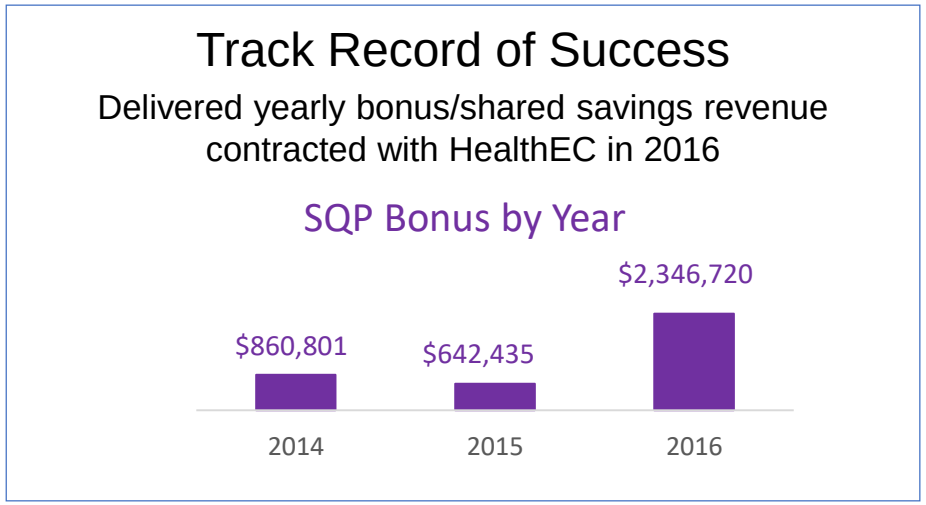


Examples of Successful Value-based Programs and Lessons Learned

Case Study: Shore Quality Partners

SHORE QUALITY PARTNERS





- **Next steps**
  - Engage in downside risk contract no later than January 2019
  - Further diversify value-based contracts with new payers to reduce dependency on any one contract
  - Expand primary care physician base to balance economic and demographic related challenges
  - Increase accountability for physician-related performance metrics

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Case Study: Princeton Physicians

- MSSP, Next Gen ACO, commercial VBP with Blues, Cigna
- 600+ independent physicians
- 480,000+ patients
- Partnered with HealthEC in 2015
- 75% of providers participated in the enterprise data warehouse
- 250 providers from 150 practices participated in a practice transformation undertaking
- 39 PCPs moved to a full-risk Medicare program (next-generation ACO)

Results for subset of 16,000 patients commercial and MA

- Princeton PO Physicians outperformed a comparison group of 26 organizations:
  - 9.30% reduction in PMPM in first year, with lowest IP costs
  - 2nd lowest IP utilization in the State
  - 5th lowest ER utilization in the State
  - Level 4 in quality and patient satisfaction measures
- **Over $ 4.2M in SHARED SAVINGS**

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Case Study: ACMG

The Accountable Care Medical Group (ACMG) of Florida is a privately held ACO that supports physicians serving diverse populations throughout Florida, South Carolina, Georgia, California, and Pennsylvania. ACMG utilizes HealthEC's PHM suite.

Goals

- Enable participating physicians to monitor utilization/quality performance throughout the year so GPRO reporting is less stressful
- Provide acute event notification services to physicians
- Guide care coordinators in day-to-day activities, including ER admits, risk prevention, and maintaining quality measures while ensuring current time markers for care coordination
- Optimize care coordination programs for the diverse populations served
- Improve individual service quality performance compared to historical benchmarks
- Reward physicians for quality performance so that better performing physicians receive larger shares of savings
- Educate physician participants of the financial, risk, and quality benchmarks required to maximize bonuses
- Identify and differentiate operational costs not directly attributable to physician services
- Build rapport and trust among physicians about the value of ACO program participation

Challenges

- **Data usability:** Obtaining/converting beneficiary claims into usable forms was a challenge since ACMG's initial shared-savings agreement with CMS
- **Care Coordination throughout the Patient Experience:** ACMG needed to ensure timely notifications of acute care experiences, coordinate care in post-acute settings, and provide chronic care management services to mitigate risk.

Solution

- ACMG selected HealthEC's PHM platform after many assessments of competitive solutions.
- Leadership wanted a vendor partner that would provide the ability to modify and adapt the platform to the evolving needs of the organization.

Results

HealthEC helped ACMG save more than $9 million annually on an assigned beneficiary population averaging 8,000 people, including an average annual savings of $1,250 per beneficiary

29%	20%	17%	14%
Reduction in ER visits	Reduction in hospital admits	Increase if PCP visits	Reduction in PMPM

Case Study: AICNY

The Alliance for Integrated Care of New York, LLC (AICNY) oversees the healthcare needs of individuals with intellectual and developmental disabilities (IDD). Comprising ~350 healthcare providers, AICNY cares for over 6,000 dually eligible Medicare and Medicaid beneficiaries and is the only MSSP-approved ACO of its kind in the U.S.

Goals

- Identify and implement technology to create a centralized view of the patient's data, regardless of the originating system or setting of care
- Engage the physician community and illustrate opportunities for improved quality of care
- Manage care coordination and personalize patient communication for social determinants
- Reduce overall cost to serve a growing beneficiary population and geographic region

Challenges

- Integrating care solutions
- Alternative care setting dynamics
- Delivering proactive, personalized care
- Considering social determinants while maintaining privacy

Solution

- HealthEC's PHM platform was implemented within 6 weeks of contracting.
- HealthEC included two care mgmnt. team members to augment AICNY's provider team to coordinate care for at-risk patients.
- Within 3 years, AICNY integrated 7 CHCs and 25 licensed private practices, completing the GPRO group reporting process.

Results

$2.4 million reduction in total costs	Data used to risk-stratify patients resulted in a $2.4 million reduction in total costs.
6% reduction in expenditures	Over three quarters of 2018 inpatient expenditures saw a 6% reduction.
ER visits dropped by 11% and admits dropped by 7%	As a result of teletriage kiosks installed in IDD group homes, ER visits dropped by 11% and admissions dropped by 7%.

Questions and Discussion


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