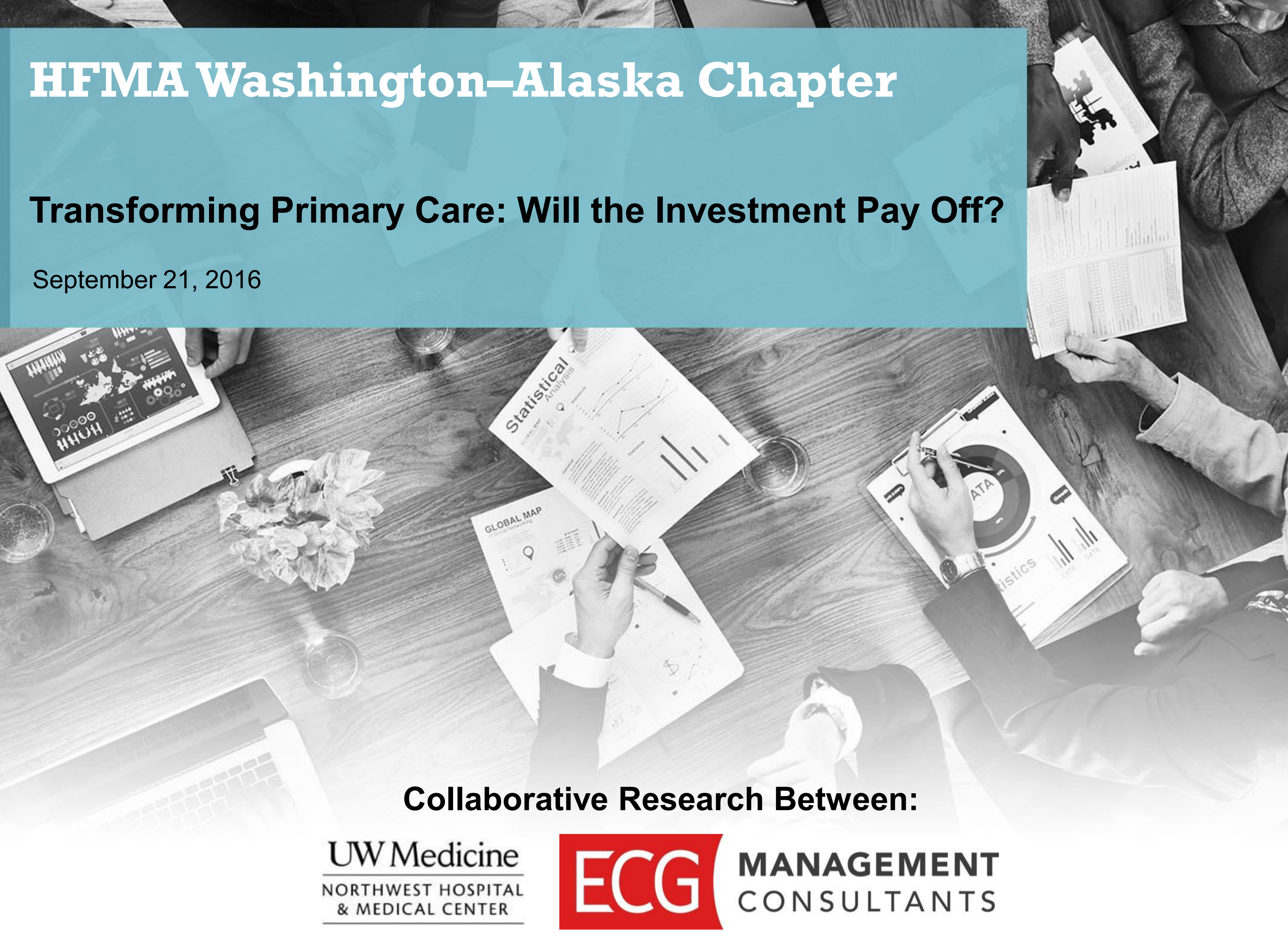

HFMA Washington–Alaska Chapter
Transforming Primary Care: Will the Investment Pay Off?
September 21, 2016
Collaborative Research Between:
UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
ECG
MANAGEMENT CONSULTANTS

Today's Objectives

- Discuss local and national market trends on the transition to value-based care and payment models.
- Present strategic, financial, and operational implications and considerations to support the transformation of care delivery models.
- Define components of the financial framework that are necessary to support the transition and ongoing management of value-based care delivery models.
- Introduce strategies to achieve financial and clinical alignment for primary care models and across the full continuum of care.
- Explore results that support value-based care and payment delivery strategies, including achievement of clinical and financial return on investment (ROI).

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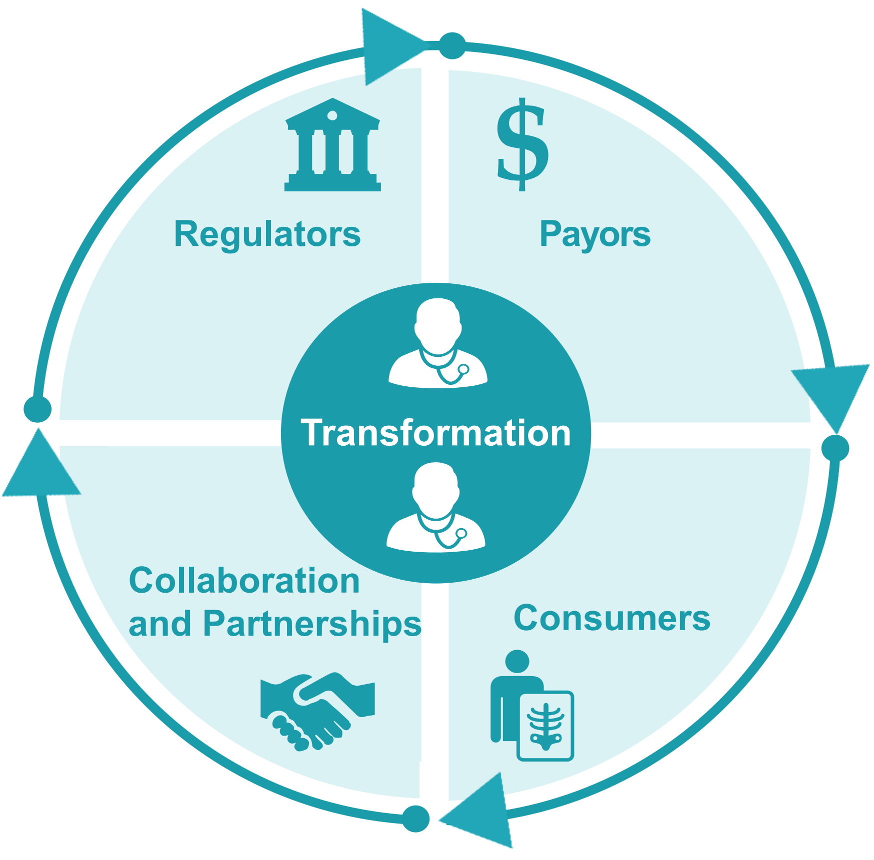
Market Evolution

Drivers of Change in the Market Are Impacting Providers and Practices

The rate of change within the healthcare industry has been consistently accelerating—with emerging value-based payment (VBP) and care delivery models.

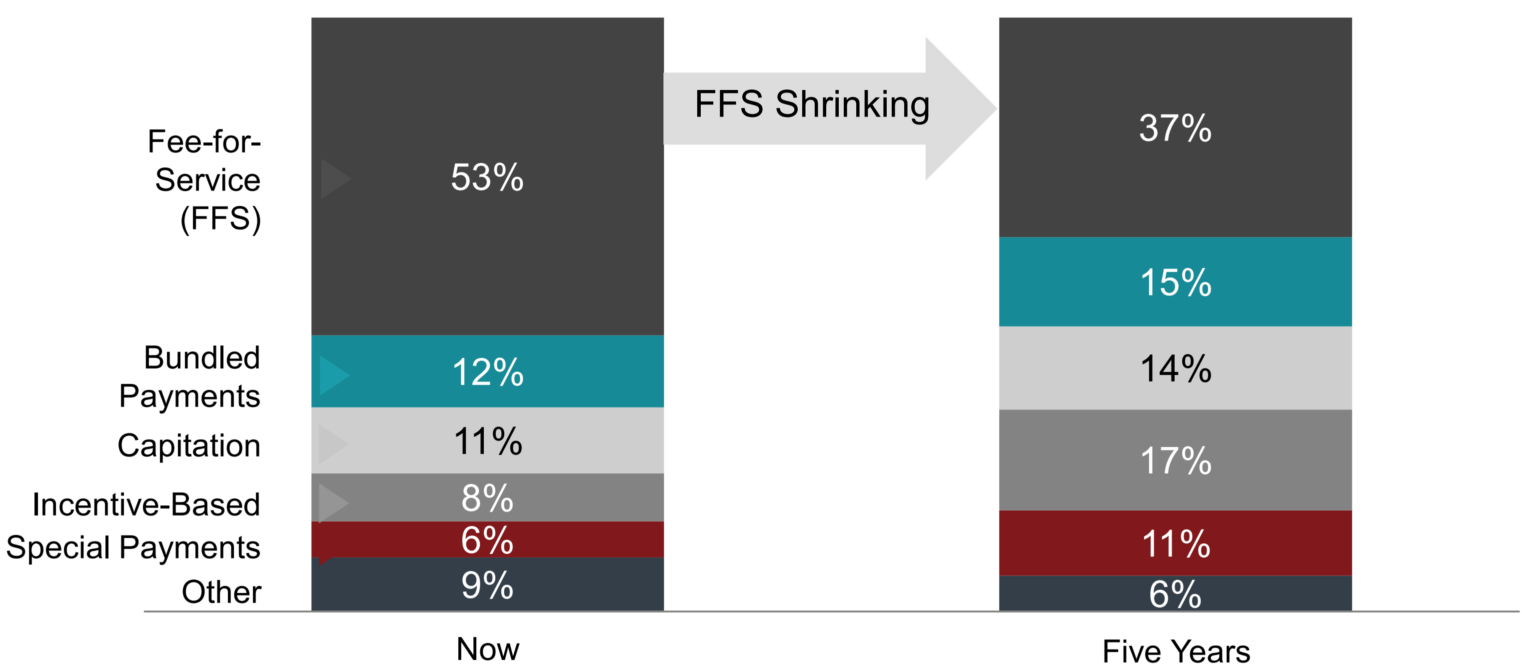


These forces are pushing primary care providers to deliver high-quality care at a lower cost.

Market Evolution

Regulators Are Tying Payments to Value

Recently, CMS set specific goals related to aggressively shifting Medicare payments to alternative VBP models over the next few years.[1]



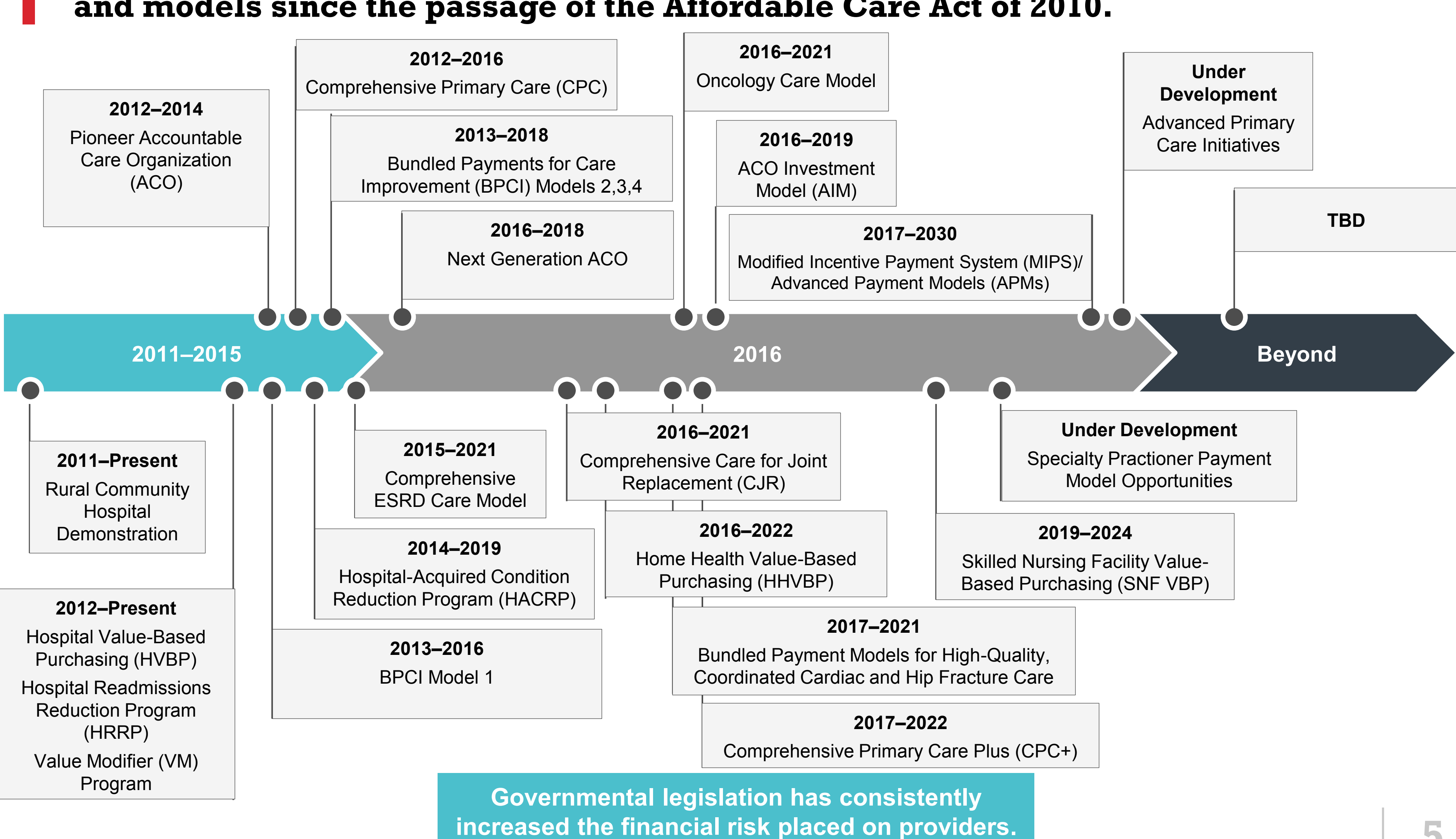
[1] "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," CMS, January 26, 2015.
NOTE: Figures may not be exact due to rounding.

The setting of explicit goals indicates CMS's commitment to making VBPs a permanent component of governmental reimbursement.

Market Evolution

Regulators — Rate of Change

Additionally, CMS has developed and launched numerous value-based programs and models since the passage of the Affordable Care Act of 2010.

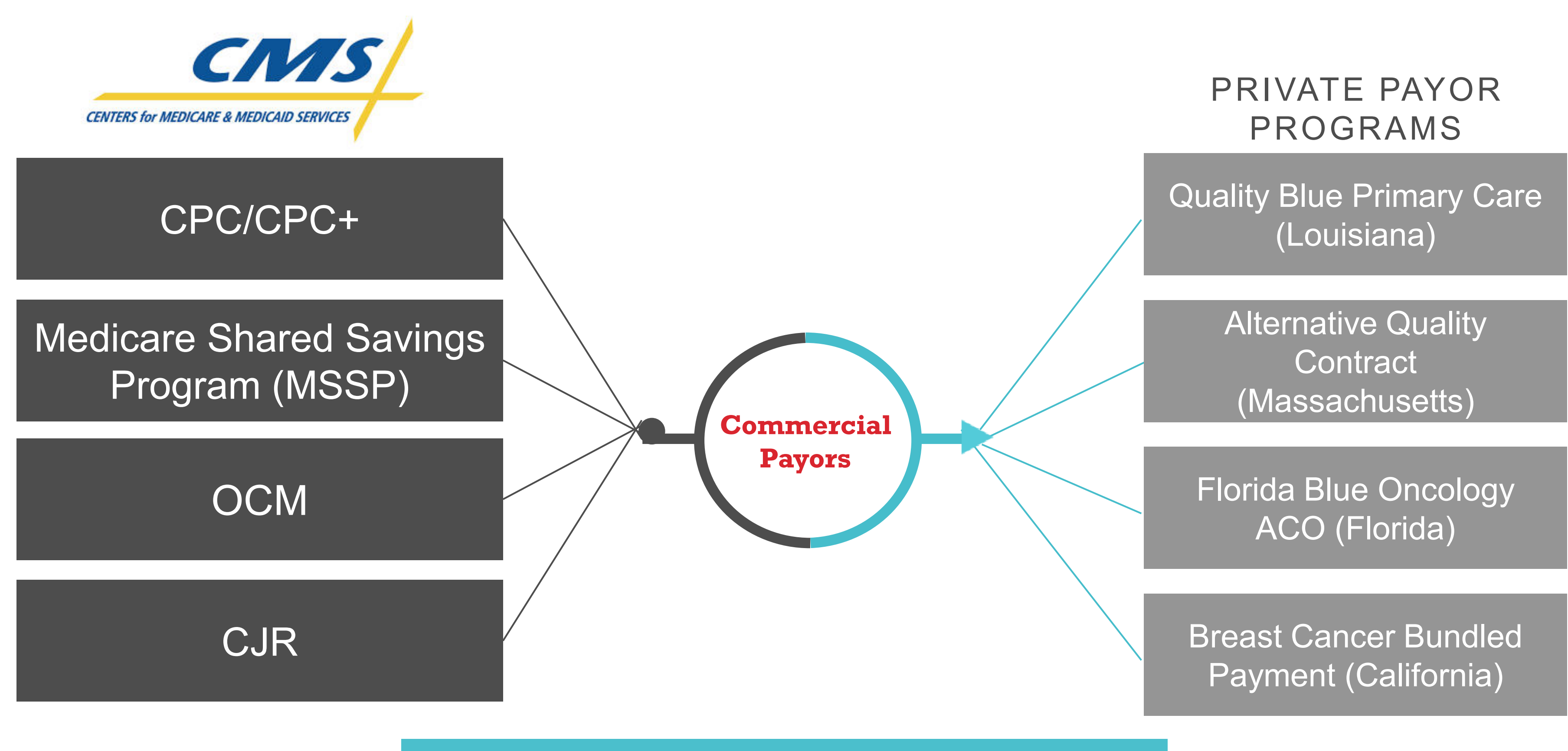


Governmental legislation has consistently increased the financial risk placed on providers.

Market Evolution

Commercial Carriers Are Following CMS

Consistent with historical trends, commercial carriers are following CMS's lead in adopting new reimbursement models and supporting new models of care.

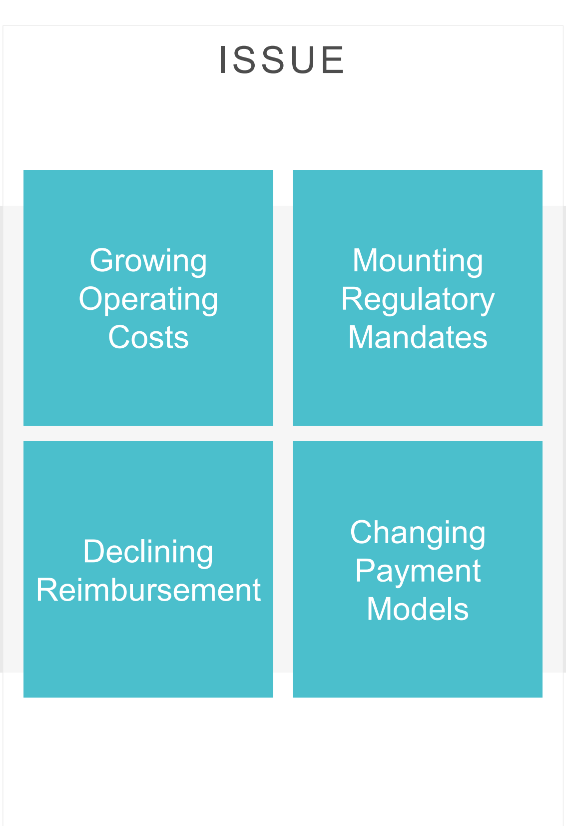


The Health Care Transformation Task Force found that 41% of provider and payor members were in a VBP arrangement at the end of 2015, up from 30% in the prior year.

Market Evolution

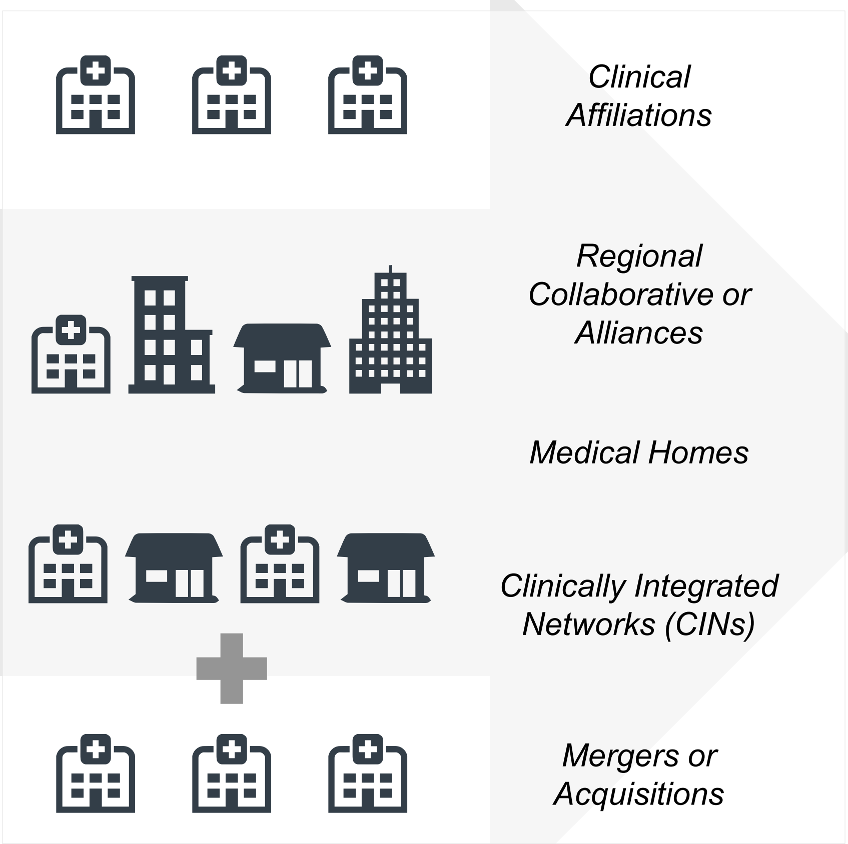
Collaborations and Partnerships Are Increasingly More Common

As providers increase the amount of risk being shared with payors, further collaboration through innovative alignment models among providers has become a key element in both decreasing costs and improving overall health for a population.



SOLUTION (to scale)

- » Increased Collaboration
- » Horizontal Integration
- » Vertical Integration
- » Increased Purchasing Power
- » Coordinated Services
- » Cost Cuts



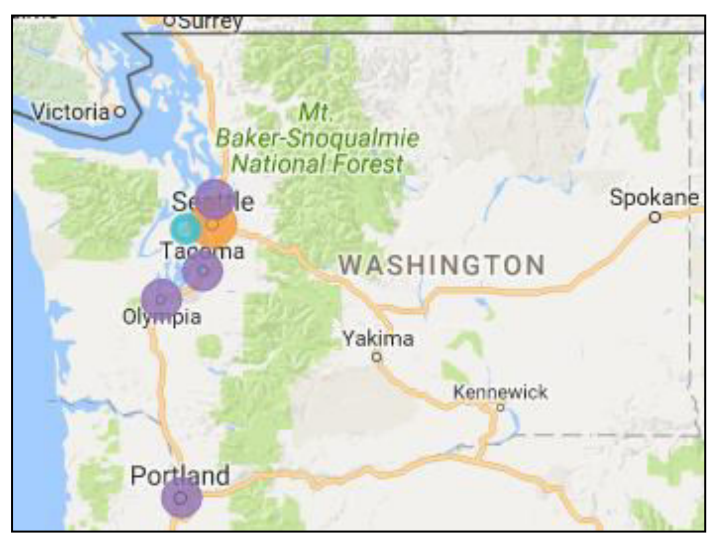
Source: *2015 AHA Environmental Scan.*

Market Evolution

Washington — Transition to Value

As a regional healthcare provider and a growing economy, Washington's integration activity is robust and continuously adapting, though no single model has emerged.

MEDICAL HOME INITIATIVES



Legend

CARE MODEL TRENDS

- 15% to 20% ACO penetration rate compared to 9% nationally
- 15 primary care medical home provider/payor collaborations
- Nearly 250 NCQA-recognized patient-centered medical home (PCMH) clinicians or medical practice sites

PAYMENT MODEL TRENDS

- Large employer partnerships with providers, including Boeing and Expedia
- Shared savings and pay-for-performance models prevalent with Medicare and commercial arrangements
- Medicaid value-based arrangements targeted for 30% in 2017 and increasing to 90% by 2019

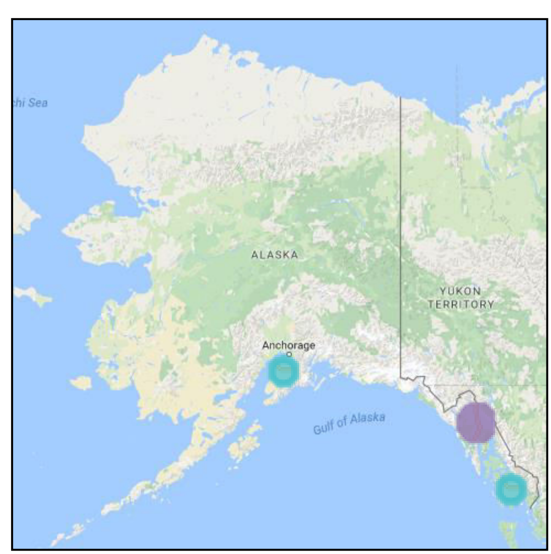
Sources: *http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion*; *https://www.pcpcc.org/initiatives/national*; and HealthLeaders InterQual Study *2015 Health Plan Analysis, Washington*, as of July 2015.

Market Evolution

Alaska — Transition to Value

Alaska's value-based environment is less progressive given its expansive geography with a primarily rural population and higher-than-national-average healthcare expenditures.

MEDICAL HOME INITIATIVES



Legend

CARE MODEL TRENDS

- 10% to 15% ACO penetration rate (compared to 9% nationally)
- Four primary care medical home provider/payor collaborations
- Recent legislative actions that encourage coordinated care demonstration projects, expanded telemedicine capabilities, improved data/analytics, and a primary care case management program

PAYMENT MODEL TRENDS

- Primarily on FFS payment model
- Medicaid expansion that includes implementation of value-based arrangements, with data showing that costs are well above the national average and unsustainable
- Privatization feasibility study for behavioral health services

Sources: *http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion*, *https://www.pcpcc.org/initiatives/national*, *http://www.adn.com/politics/article/walker-administration-proposes-medicaid-reforms-outlined-recent-report/2016/01/28*, and *http://stateofreform.com/news/states/alaska/2016/03/unpacking-alaskas-medicaid-reform-bill-sb-74*.

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Implications and Considerations

Focus on the Certainties

While most primary care providers feel as if they are operating in an uncertain environment, there are a few certainties within the changing landscape that should serve as a framework in positioning yourself for success in the future.

Reimbursement is moving from volume to value—for both government and commercial payors.

The time frame for maximizing/shoring up FFS revenue is dwindling.

Costs must be taken out of the system in order to protect margins in both the near and long term.

New care models (spanning the entire continuum of care) must be adopted to not only successfully operate under changing reimbursement models, but also to meet consumer demand.

Consolidation of providers (or, at a minimum, new collaborative efforts among providers) will continue to emerge.

Investment in IT systems that support new care models and provide insight into performance will be critically important.

These strategies require an investment of resources: time, staff, and financial capital.

Implications and Considerations

It's Time to Optimize and Transform

Furthermore, the current environment necessitates quick action to respond to the changing landscape; optimization and transformation strategies mitigate short-term challenges and position providers for long-term success.

Category	Considerations
Optimization strategies, which are more traditional revenue enhancement and cost-reduction initiatives	» Assessing current operations and defining opportunities for improvement (e.g., revenue cycle management, scheduling, access/throughput) » Creating efficiencies and economies of scale » Developing a culture of continuous improvement
Transformational strategies that are intended to move providers from payments based on volume to those based on value	» Understanding overall readiness for value-based care delivery » Accepting increasing payment risk for quality and cost of redesign and implementation of the incentives across the continuum of care » Developing clinical population health management tools (e.g., optimized EHR, clinical protocols, effectiveness measurements, clinical data at the point of care) » Solidifying a provider network that can go to market though acquisition or clinical integration

Optimization and transformational activities will also allow organizations to further evaluate potential ROI and achieve it.

Implications and Considerations

Understand the Financial Investment

As part of these optimization and transformation activities, conducting an ROI analysis will further help organizations prioritize efforts and understand the investments they need to make.

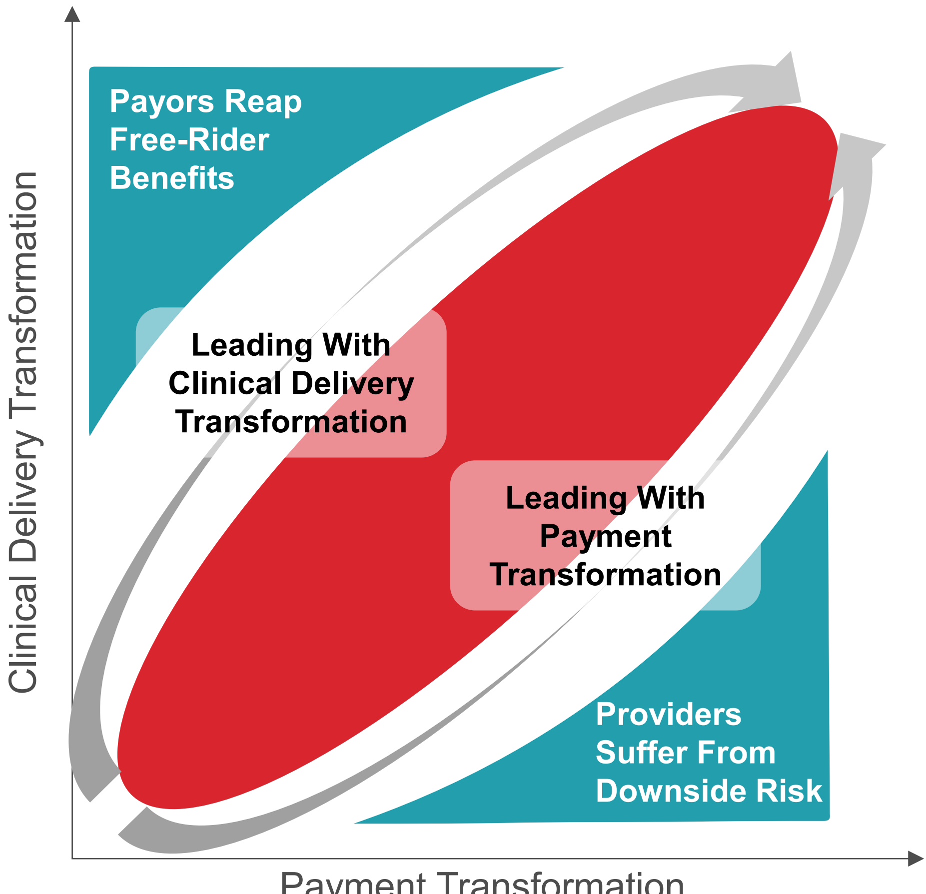
Category	Description
Reimbursement Opportunities	» Provider contract reviews to identify value-based incentives, such as care coordination fees, quality incentives, or transition support payments » FFS opportunities for annual wellness visits, transition of care codes, and expanded telehealth or virtual visits
Clinical and Administrative Resources	» Interdisciplinary, team-based staffing models » New roles or redefined job descriptions for care coordinators/managers, social workers, clinical/quality analysts, and other administrative support
IT Infrastructure	» EHR improvements, including care management/coordination modules, health information exchange tools, and disease registries » Data analytics to support clinical and business operations
Facility Improvements	» Improved patient throughput through facility expansions or upgrades » Increased level of care coordination with team-based work spaces
Other Expenses	» Certification/accreditation, marketing, education, and consultant/vendor fees » Incremental expenses to align provider/staff compensation plans » Offsets through operational efficiencies, such as enhanced work flows

A financial model provides a baseline comparison to measure and assess progress, as well as revise tactics as you go.

Implications and Considerations

Pacing Is Critical

Effectively synching the pace of an organization's clinical and financial transformation activities underpins the sustainability of its efforts.



Leading too far with either clinical or financial innovation can prevent organizations from realizing the full benefits of transformation.

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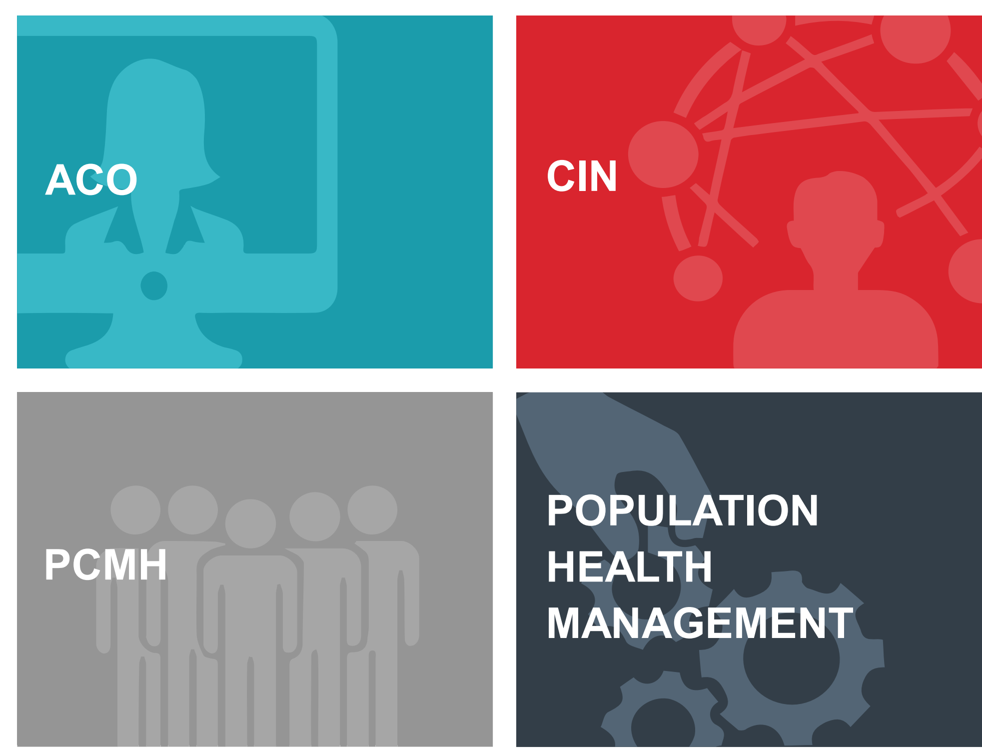
Optimization and Transformational Strategies

Value-Based Care Delivery

Whether it's to fix "old cracks" in the care continuum or prepare for today's value-based environment, organizations are pursuing new models of care delivery to support VBP models.

Care Delivery
Transformation

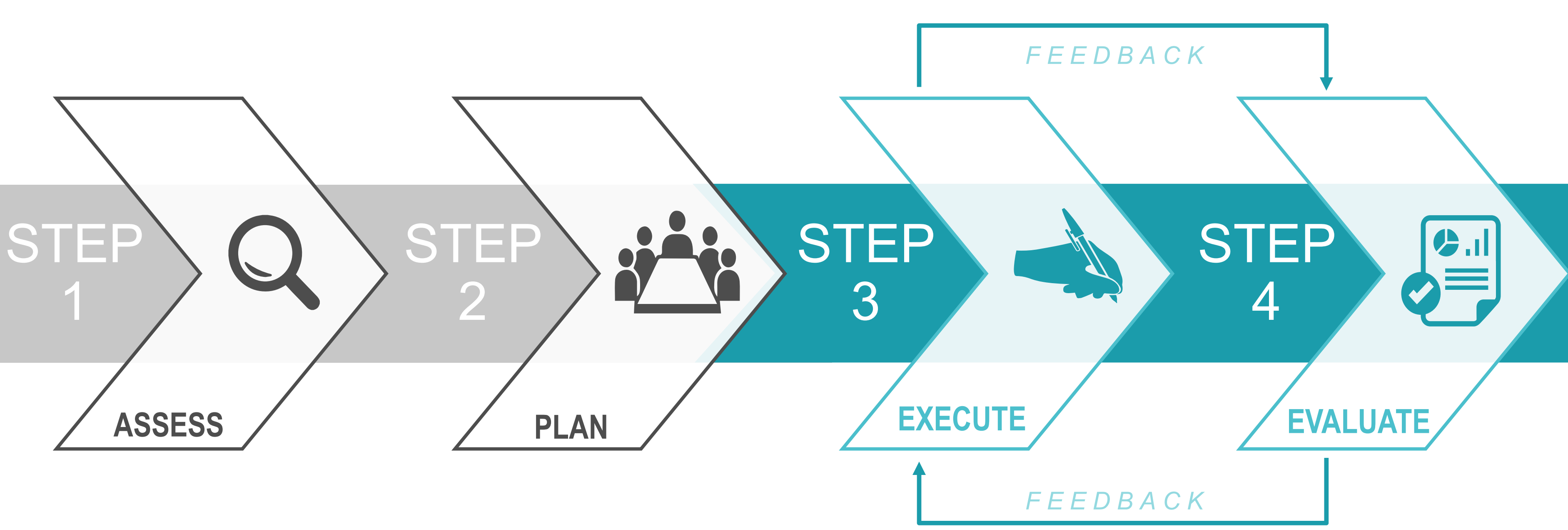


These four value-based care delivery models are the most prevalent and begin with primary care—building a foundation for integration and coordination.

Optimization and Transformational Strategies

Setting the Pace and Maintaining Momentum

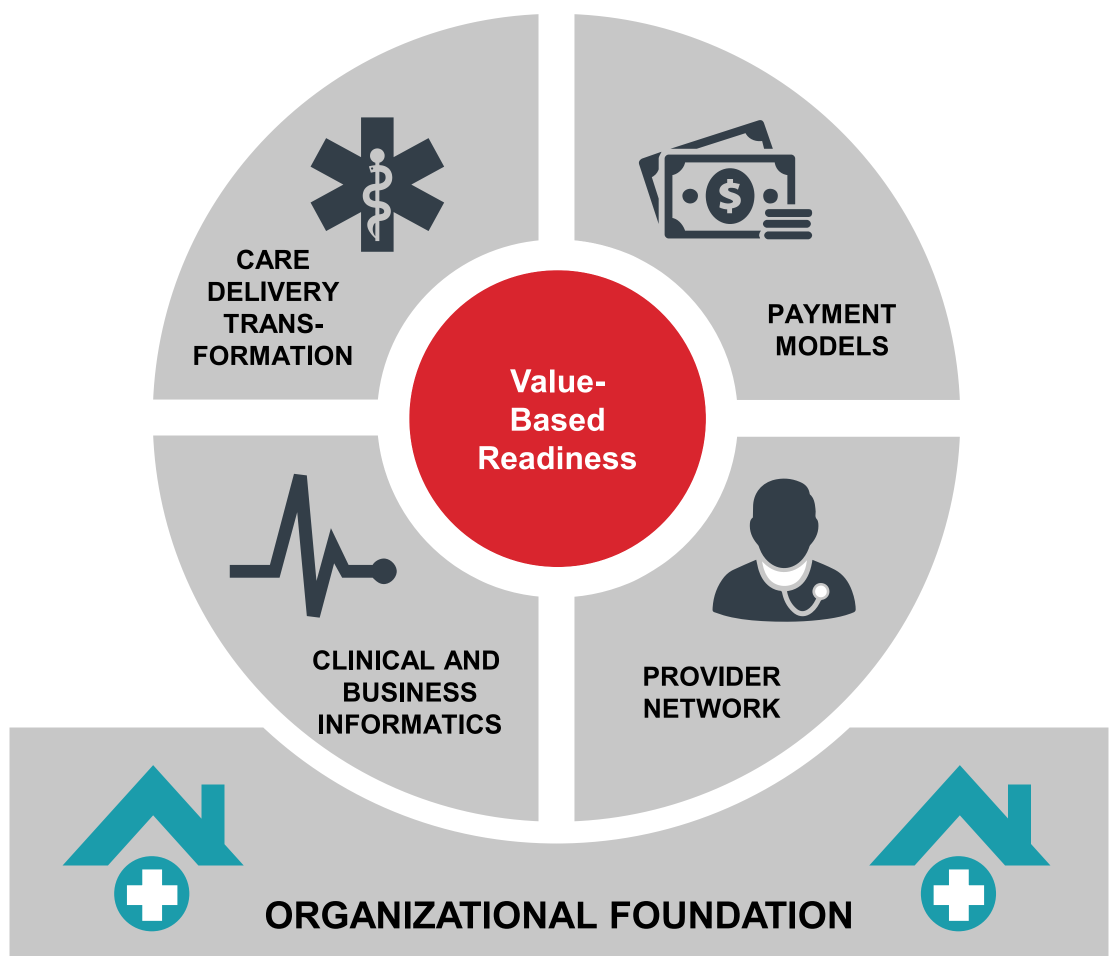
In order to best position themselves for a successful transition to these models, providers should deploy a structured approach to assess, plan, execute, and evaluate their efforts.



Optimization and Transformational Strategies

Value-Based Readiness Is a First Step

As a first step, providers must determine their level of readiness to be able to simultaneously evolve operationally, strategically, financially, and technologically.



Optimization and Transformational Strategies

Step I — Assess

Determining the required scope and feasible rate of an organization's care delivery transformation requires an assessment of five critical factors.

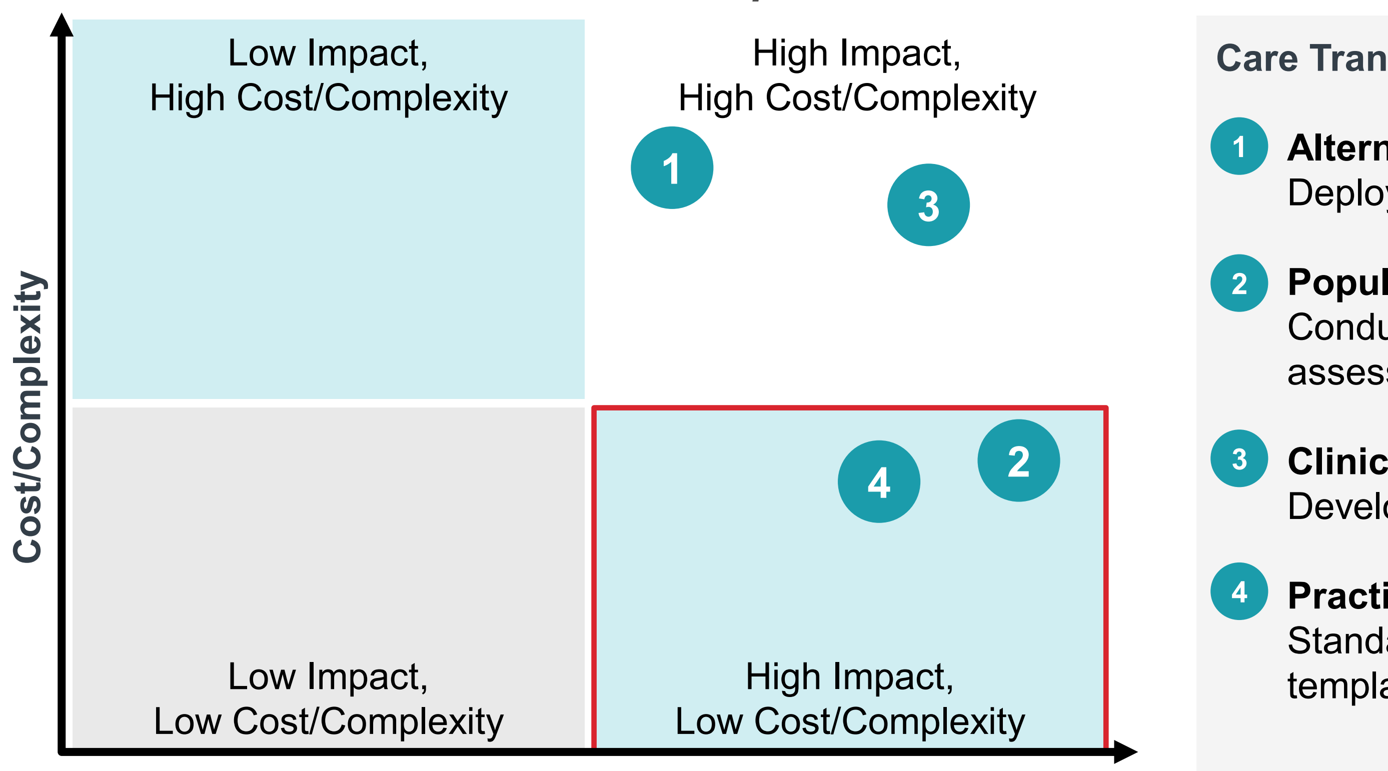
	TRADITIONAL	VALUE-BASED	ASSESSMENT
CARE DELIVERY	Fragmented, focused on acute needs, physician-centric, dictated by individual provider experience	Coordinated, comprehensive, patient-centered, evidence-based	» Care coordination » Standards and protocols » Patient engagement » Clinical innovation
PROVIDER NETWORK	Built on referral relationships, dominated by specialists, located adjacent to hospitals, legally accountable	Built to meet population needs, primary care–driven, community-based, financially accountable	» Comprehensiveness » Level of integration » Extent of alignment » Provider accountability
CLINICAL AND BUSINESS INFORMATICS	Decentralized, not reasonably comparable, Microsoft Excel–based, run as needed, retrospective, internally compared, statistics-based, narrowly distributed, informative	Centralized, commensurable, automated, strategic, prospective, externally compared, trend-based, widely disseminated, actionable	» Infrastructure and support » Data integration » Analytic competencies » Reporting capabilities
PAYMENT MODELS	Predominantly FFS, volume-based, adversarial payor/provider relationships	Increasingly risk-bearing, value-based, collaborative payor/provider relationships	» Market opportunity » Payor readiness » Employer relationships » Risk-sharing experience
ORGANIZATIONAL FOUNDATION	Segmented leadership, cost-conscious, reactionary, departmental, resistant to change, physician-informed	Cross-continuum leadership, margin-conscious, visionary, multidisciplinary, supportive of innovation, provider-led	» Financial feasibility » Structural compatibility » Cultural tolerance » Leadership commitment

Optimization and Transformational Strategies

Step II — Plan

Activities (i.e., identified gaps) should be prioritized and translated into a detailed implementation plan based on a practical transition timeline.

Prioritization Example



Care Transformation Objectives

1. **Alternative Access** Deploy the patient portal.
2. **Population Health** Conduct health risk assessments.
3. **Clinical Integration** Develop ACO, PCMH.
4. **Practice Redesign** Standardize the scheduling templates.

Focusing on the care transformation activities that will result in the highest impact but require minimal cost will help organizations achieve an ROI sooner.

Optimization and Transformational Strategies

Step II — Plan *(continued)*

Developing an ROI analysis in conjunction with the care model provides a barometer to assess whether or not the selected strategy will be financially sustainable in the near- and long-term.

Determine Care Model Strategy

- Define care delivery model
- Identify system and community partners
- Conduct readiness assessment
- Outline financial requirements to support care model

Develop Timeline

- Assess care model certification/accreditation process, if applicable
- Determine near-term and long-term goals and priorities
- Establish a multi-year timeframe and consider a phased approach for transition
- Identify clinical/financial metrics and targets to establish a baseline of progress

Define the Investment

- Estimate the initial investment, including capital and incremental operating costs
- Assess EHR capabilities and identify costs for required upgrades
- Review human resources to support transition and evolution into steady state
- Define ongoing operating expenses required post implementation

Assess P&L Strategies

- Determine reimbursement strategies that align with care model
- Assess external market for transition funding opportunities
- Review provider compensation arrangements to ensure alignment
- Consider other operational efficiencies to reduce other expenses

A robust financial model provides an opportunity to assess various scenarios and illuminate the unknowns that will be of highest impact.

Optimization and Transformational Strategies

Step III — Execute

Realizing the vision of care and payment delivery transformation will require an approach to execution that mitigates potential risks and enables smooth transitions.

Execution Success Factors

ENGAGE RELEVANT STAKEHOLDERS

» Multichannel communication
» Relevant and timely education
» Motivation

ASSEMBLE HIGH-FUNCTIONING TEAMS

» Executive sponsors
» Physician leaders
» Relevant staff

ALIGN FINANCIALLY

» Align with value-based payor contracts
» Manage costs
» Develop financial model
» Determine ROI

INSTILL ACCOUNTABILITY

» Clear responsibility
» Regular cadence
» Reinforcing incentives

MONITOR AND EVOLVE

» Meaningful metrics
» Stretch performance targets
» Reports/dashboards

DEDICATE ADEQUATE RESOURCES

» Required financial capital
» Appropriate human capital
» Sufficient time and energy

Optimization and Transformational Strategies

Step III — Execute *(continued)*

A critical component of the execution step is to align clinically and financially. Executing the financial plan includes engaging with payors to determine VBP arrangements, implementing new or revised coding/billing practices, and initiating operational efficiency projects.

Opportunity	Description	Examples
Transition support fees	Payments offered by states or payors that help to offset the initial investment required to transition	» Provided through a lump sum up front upon agreement to meet certain criteria » Provided through PMPM fees
Care coordination or care management fees	Payments offered by states or payors that support proactive management of a defined patient population for care management and coordination efforts	» CMS chronic care management PMPM fee ($40 PMPM) » Anthem Blue Cross Enhance Personal Health Care Program PMPM care management fees for participating in patient-centered care models » New York's $6 to $8 PMPM fees for Medicaid managed care plans and $20 to $29 add-on per visit payments for its FFS plans for PCMH participation[1]
FFS Revenue Enhancements	Codes that provide higher relative value unit (RVU) values for ensuring efficient transition of care for patients discharged from an acute care facility and preventive services	» Transitions of care management codes » Annual wellness visits » Advanced care planning (new in 2016)
Shared savings	Payor (government and commercial) arrangements offering an opportunity to share in any savings generated from more efficient and effective operations and clinical care delivery	» MSSP » Medicaid managed care organizations » MACRA — MIPS
Operational efficiencies	The identification and execution of process and operations improvements, resulting in cost, quality, or clinical care efficiencies	» Lean processes » Reduce unnecessary steps, utilization, supplies

1 New York State Department of Health, statewide PCMH program, April 2015 update.

Optimization and Transformational Strategies

Step IV — Evaluate

Care and payment delivery transformation is a journey that requires its leaders to continuously monitor progress, navigate obstacles, and course-correct.

- Identify and prioritize key performance indicators (KPIs).
- Categorize leading and lagging indicators.
- Define meaningful and ambitious yet achievable performance targets.

- Prioritize areas for improvement.
- Establish causality (i.e., root causes).
- Utilize proven PI methodologies (e.g., PDSA, Lean, Six Sigma).

- Determine reporting venues and stakeholders.
- Determine indicator relevance by stakeholder class.
- Determine reporting needs/preferences by stakeholder class.

- Identify optimal data sources and establish reporting cadence.
- Develop, automate, and distribute intuitive and actionable reports.
- Monitor investments and develop pro formas.

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Results

Achieving an ROI — A Review of the Evidence

Reaping the clinical and financial returns in today's value-based environment is achievable with a carefully executed strategy over the long term.

Select Results

Metric	UnitedHealthcare Medical Home Evaluation[1]	WellPoint's Colorado PCMH Pilot[2]	WESTMED's Commercial ACO[1]	WA-Managed FFS Demonstration[3]
Cost Savings	Third year net savings of 6.2%	5% increase for PCMH sites compared to 12% increase for traditional practices	1.3% reduction in costs per member per year	Achieved $21.6 million (6.6%) in total savings
ROI	6 to 1	Ranged between 2.5 to 1 & 4.5 to 1	Not reported	Not reported
Emergency Department (ED) Visits	Not reported	15% reduction compared to 4% for control group	8% reduction in utilization	3% reduction compared to baseline data
Inpatient Admissions	Not reported	18% decrease compared to 18% increase for control group	5% decrease in costs	13% reduction in admissions compared to baseline data
Patient Satisfaction	Not reported	» 95% reported care setting was well organized and efficient » 97% reported recommending practice » 90% reported it was easy to speak to a physician	Not reported	>50% of participants reported significant improvement in their health or quality of life

1 *https://www.uhc.com/content/dam/uhcdotcom/en/ValueBasedCare/PDFs/UNH-Primary-Care-Report-Advancing-Primary-Care-Delivery.pdf.*
2 *http://content.healthaffairs.org/content/31/9/2002.full.pdf.*
3 *https://innovation.cms.gov/Files/reports/fai-wa-prelimppone.pdf.*
4 *https://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf.*

A study of Pioneer ACOs found it can take up to three years to achieve an ROI.[4]

Results

Minnesota's Health Care Homes Initiative

SITUATION

Minnesota's Department of Health and Department of Human Services partnered with providers and payors from 2010 to 2014 to create Health Care Homes (HCHs), which included 42% primary care clinics. The HCH model included standards that were derived from the standards and goals of the NCQA PCMH model. More specifically, the standards focused on an interdisciplinary team that provides comprehensive, coordinated, and accessible healthcare services. Additionally, emphasis was placed on cultural transformation into a "learning organization," with a strategic focus on empowering staff to encourage shared decision making and separating planning processes and execution tactics.

ACTIONS TAKEN

- The state provided financial incentives, learning collaboratives, certification standards, and transformation assistance to align with medical practices.
- Practices implemented team-based care models, improved EHR capabilities, developed care plans, provided 24/7 access to care, and integrated with system and community partners.
- PMPM care coordination fees were defined based on a tier system corresponding to patient risk and payor.

CLINICAL OUTCOMES

- Quality of care scores improved between 2% and 20% for HCH practices compared to non-HCH practices for five medical conditions.
- Health disparities were narrowed on race/ethnicity measures for HCH practices compared to non-HCH practices for Medicare and Medicaid patients.
- There was no impact to patient experience or Medicare/Medicaid quality metrics (reported by CMS) for HCH practices compared to non-HCH practices.

SAVINGS AND ROI

- HCH practices saved $1 billion on medical costs for Medicaid, Medicare, and dual eligible populations, representing 2.6% of Minnesota's total healthcare spend.
- Savings is attributed to fewer hospital admissions, hospital outpatient visits, skilled nursing facility admissions, and prescription medications with reductions ranging between -9.0% to over -30%.
- However, ED visits increased by 10% but only contributed to a 3% cost increase.

Source: *http://www.health.umn.edu/sites/default/files/UM%202015%20HCH%20Evaluation%20Final%2007Feb2016.pdf.*

Results

Confidential East Coast Health System

SITUATION

A fairly progressive and innovative East Coast health system is currently expanding its population health capabilities, including continued build of its team-based care model. As part of this process, this client has defined two additional roles—care guides and health advisers—that are being piloted, both centrally and locally, to support all of its value-based payor, governmental, and internal efforts. Moreover, these roles are being funded for the first six months by the health system for both its employed and affiliated practices. Thereafter, the funding will shift to practices supporting the roles. Thus, a critical component to the success of these roles was the development of a pro forma that defined potential clinical and financial ROI.

Health Adviser Role

- Embedded in primary care practice
- LPN or entry-level RN
- Performs AMW visits, CCM calls, nursing visits for care gap closures, counseling visits, immunizations, and pre-visit planning
- Supports five providers
- Seamless transitions with network and hospital-based care management

Health Adviser Revenues

- Full-time clinical provider
- Performs AMW visits, CCM calls, nursing visits for care gap closures, counseling visits, and immunizations
- Improves HEDIS scores and Star Ratings
- Impacts Medicare Risk Adjustment Factor scores
- Direct income from care gap closure incentive programs
- Reduction of readmissions
- Care plan adherence

Health Advisors Prototype

Operational Income Statement Review	Year 1 Site 1 Based On Annual Operations	Year 1 Site 2 Based On Annual Operations	Year 1 Total Based On Annual Operations
REVENUES			
Gross Patient Charges			
AMW visits (2/day)	141,960	141,960	283,920
Nursing visits (2/day)	31,200	31,200	62,400
Counseling visits (2/day)	136,800	136,800	273,600
Immunizations increase	33,211	33,211	66,422
Total Gross Patient Charges	343,171	343,171	686,342
Contractual Adjustments	(196,916)	(196,916)	(393,832)
Net Collections	$ 146,255	$ 146,255	$ 292,510
Total Operating Revenues	$ 146,255	$ 146,255	$ 292,510
OPERATING EXPENSES			
Staff Salary Expense	53,383	53,383	106,766
Staff Fringe Benefits	14,413	14,413	28,827
Supplies	6,750	6,750	13,500
Operational Expenses*	28,667	28,667	57,333
Total Operating Expenses	$ 103,213	$ 103,213	$ 206,427
EXCESS OF REVENUES OVER EXPENSES	$ 43,042	$ 43,042	$ 86,083

Results

Atrius Health

SITUATION

Atrius Health, a large provider organization located in Massachusetts, provides care to more than 675,000 patients across 29 clinical locations and includes 50 specialties and 750 physicians. Atrius is one of the original CMS Pioneer ACOs and has been able to succeed in this program, which has seen nearly two-thirds of its members leave. The Atrius clinicians participating in the Pioneer ACO serve more than 25,000 Medicare beneficiaries and have successfully developed a clinically and financially aligned model. Atrius has been invested in population health for more than a decade, combining care coordination with analytic tools and financial tracking to reduce the cost of care.

ACTIONS TAKEN

- Developed a value-based strategy that supports clinical and financial alignment
- Worked in a value-based environment for many years
- Focused on population health management, which is the overarching model within which Atrius has been successful
- Transitioned the majority of its private payor contracts to value-based arrangements
- Developed a supporting value-based care delivery model that provides payor- and program-agnostic, consistent care

CLINICAL OUTCOMES

- Achieved a 95% quality score
- Saved Medicare $6.8 million, returning $4.4 million in savings to the organization
- Out of the six Pioneer ACOs, distinguished itself as the only one to attain savings
- Achieved a score above the mean on 30 of the 33 select measures
- Performed over the 90th percentile benchmark on several measures across all care domains

SAVINGS AND ROI

- $4.4 million in savings went back to the organization and was achieved through optimization and transformational efforts.
- These savings helped support population health management efforts and value-based care delivery.
- These savings also supported the additional staff needed to provide value-based care delivery, such as care managers.
- Atrius made significant up-front and ongoing investments to support efforts.

Source: *http://www.healthcare-informatics.com/article/payment/medicare-acos-trenches-how-survive-healthcare-s-changing-world-part-1*

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Key Takeaways

Value-based care and payment delivery continues to be an increasingly prevalent trend, but it is going to take time before there is enough consistency to realize the full potential.

1 Ambiguity

There is no algorithm that can be written for determining success in today's value-based environment.

2 ROI

Achieving an ROI requires a long-term commitment to truly reap the benefits. Thus, financial modeling is critical and will also serve as a tool to monitor progress and reassess strategic priorities.

3 Attributable Results

Simultaneous initiatives may create difficulty in crediting clinical or financial success to a particular model without a clear baseline.

4 Alignment

Aligning the care delivery model with a financial strategy supports a value-based approach and achieves the goals of the Triple Aim.

5 Infrastructure

There will always be necessary costs, both initial and ongoing, which if not carefully planned, may not be financially sustainable.

6 Physician Leadership

Physician engagement is a critical success factor to any care and payment delivery transformation.

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For additional information on this topic, please refer to the article titled "Producing an ROI with a Patient-Centered Medical Home" in the April 2016 edition of *hfm* magazine.