WHITE PAPER

A Guide to Measure and Predict Economic Performance Under Value-Based Care Models

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Today we know that value and quality are intrinsically linked to reduce healthcare spend, and reimbursement models are changing to reflect this.

The transition to new value-based reimbursement (VBR) is happening whether your organization is ready or not. Government payers are shifting the emphasis to value and commercial insurers are beginning to follow Medicare's lead[1]. Of course, this isn't the first time reimbursement models have shifted. The first major shift, capitation, provided a fixed reimbursement rate at the population level with the effect of reducing costs at the expense of quality. Not surprisingly, it failed. Today we know that value and quality are intrinsically linked to reduced healthcare spend, and reimbursement models are changing to reflect this.

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The challenge, however, is how to measure and forecast economic performance for your organization as reimbursement shifts from volume to value. How can you effectively benchmark and project financial success? How can you measure return on investment (ROI) for value initiatives? What are practical strategies to shift your business models to match new VBR contracts?

Many providers are struggling with the uncertainty around how new reimbursement models will cover lost fee-for-service (FFS) revenue and increased costs related to improving quality. While it's not easy to accurately predict quality performance relative to effort and cost, quality is now being explicitly defined and quantified by payers, giving you the information you need to measure and predict economic performance. As you implement new processes, workflows, and technologies to effect change, you also have the data you need to calculate ROI using our step-by-step process.

STEP 1 QUANTIFY THE PROBABLE REWARD FOR MEETING QUALITY TARGETS UNDER YOUR VBR CONTRACTS

Start by looking at your performance today and define where you can most effectively improve quality measures as defined by your payers, then quantify the probable reward if you meet all your targets based on your organization's specific contract requirements. With that information, you can establish the relationships between those areas and potential loss of FFS revenue.

This can be done by defining value as a proportion of quality with respect to cost, which is most commonly done using clinical quality measures (CQMs). CQMs track health and healthcare outcomes that can be impacted by better population management as a representation of quality performance. These measures may be defined by your contracts or you may have the opportunity to define CQMs to best meet your population needs.

By working to meet appropriate clinical quality benchmarks, you can help close gaps in care within your population and improve quality measures. These are activities that are directly linked to improved current and future reimbursement.

If you haven't yet begun to pursue quality measures that support value calculations, this is the ideal time to begin putting CQM capabilities in place. By working to meet appropriate clinical quality benchmarks, you can help close gaps in care within your population and improve quality measures. These are activities that are directly linked to improved current and future reimbursement. Increased FFS revenue is tied to office visits and ancillary services that are necessary to close care gaps. And the transition allows you to establish competencies for upcoming reimbursement models that link shared savings and incentive payments to established performance targets in value-based contracts.

Depending on your contract mix, shared savings and risk in the context of contribution margin are another element to consider in your calculations. Shared savings puts accountability on your organization for the total cost of care with an upside-risk contractual relationship. If the total cost of care for your population meets the target, saving the payer money, you get a share of the difference with no variable cost increment.

It is important to note, however, that probable reward can be difficult to predict for contracts based on both quality measures and shared savings because you don't know exactly how successful you will be. Spend accountability performance simply has too many variables beyond your control, such as unit cost rates by specialist and utilization of resources such as emergency department and imaging.

An appropriate approach is to calculate the maximum probable reward and adapt your model based on previous performance benchmarks and analysis for your organization.

Software Automates Value-Based Care Contract Analysis and Projects Future Performance

Cedar Gate's Fee-for-Value Modeler is a cloud-based platform designed to enable provider organizations to pursue and maximize value-based care and payment. Insights gained from value-based care analytics allow care teams and patients to address clinical and financial opportunities made actionable through integrated care coordination technology. This enables the finance team to identify risk and opportunities in the population and empowers the care team to address them.

STEP 2 QUANTIFY NEW EXPENSES FOR STAFF AND TECHNOLOGY AS YOU REDESIGN PROCESSES TO MAXIMIZE CQM PERFORMANCE

As you shift to value-based care, staff and processes will also need adjustment toward improving quality metrics rather than increasing patient visit volume. You may need to add care coordination staff for patient outreach between visits, for example. As physicians spend more time with patients to provide more comprehensive care, their capacity for visit volume may be reduced. As a result, you may find you need to add other staff, such as more medical assistants and nurse practitioners, to cost-effectively manage routine patient care and offload physician burden. These staff additions are necessary to support population health management and care-coordination activities that don't exist in a pure FFS world.

In this process, you also need clinical decision-support technology to identify and manage at-risk populations, surfacing quality gaps for patients during office visits and supporting outreach to those who have not sought care. This investment in technology is another important part of the ROI equation. Traditional manual approaches such as spreadsheets and calendars are simply too inefficient and burdensome to maintain, leading to missed opportunities to meet quality targets—not to mention employee burnout. With the right technology and processes in place, the patient becomes an active member of the care team, providers have the tools they need to identify and address patient care needs, and your organization gains real-time data on quality performance.

STEP 3 ESTIMATE ANY ASSOCIATED LOSS OF PROVIDER PRODUCTIVITY DURING THE TRANSITION AND QUANTIFY THE IMPACT ON PRACTICE REVENUE

For many organizations, the immediate concern is that this new approach will slow physicians down and add overhead, but the transition to value requires a new perspective. While quantifying the impact of reduced capacity during the transition is another aspect of the ROI calculation, the key is to focus on improving patient quality metrics rather than visit volume.

In the traditional approach, the doctor was the primary caregiver and filled nearly every medical role in order to avoid additional overhead costs. Today, we believe that's a highly inefficient—and expensive—use of a physician's time and expertise. The doctor's role should be focused on those activities that only she or he is qualified for: making medical decisions, communicating with patients for shared decision-making about their care, and performing hands-on procedures that require a medical license. Any other activities should be performed by the most appropriate member of the care team, working at the top of his or her licensure.

A complete staff may include care coordinators, care managers, medical assistants, nurses, nurse practitioners, as well as educators and behaviorists. Their goal is patient activation—putting patients at the center of the care team so that they are empowered to make significant improvements in their health and improving overall population health outcomes to meet quality targets.

It's important to note that while the extra staff and technology add to overhead, your organization's overall capacity can also increase—without putting the burden of increased productivity on the physician. This requires that you adapt workflows to more efficiently (and cost-effectively) address patient needs.

There is another often-unrecognized element of the ROI calculation as you transition to VBR: Reimbursable quality components associated with patient visits often include activities that have inherently higher margins. For example, testing such as endoscopy can help close gaps in care while supporting revenue. Margins for imaging may be decreasing, but lab work contributes about 33 percent to operating margin while helping to address gaps in care and also satisfying contract reporting requirements. Incorporate these elements into your calculations.

A Simple Guide for Estimating the ROI of Value-Based Care:

Step 1

MINUS **(Step 2** PLUS **3)**

EQUALS **ESTIMATED ROI**

STEP 4 ESTIMATE ROI BASED ON THE RESULTS OF STEPS 1 THROUGH 3

1: Establish where you can most effectively improve quality measures as defined by your contracts. Quantify the maximum probable reward if you meet all your targets. Adjust your model based on previous performance benchmarks and analysis.

2: Research the investments needed for additional staff, technology, and workflow adjustments to support improved quality metrics rather than increased patient visit volume.

3: Estimate reduced physician capacity. Offset this with the increased capacity enabled by additional staff and by patient outreach that increases office visits to close care gaps. Include the potential increase in higher-margin, quality-based activities such as lab work and testing.

What's Next?

Once you've calculated the economic return and implemented new workflows to meet quality targets, you're still not done. Continuous improvement requires ongoing measurements of CQM performance and course-corrections as needed. The resulting improvements can have dramatic impact on revenue and ROI.

Regular analysis can identify when your organization isn't on track to meet a quality measure, allowing you to quickly analyze the barriers and change approach to better meet CQM thresholds. These ongoing reviews and reporting also help reinforce the importance of team-based care and broader practice efficiency for all of your staff members, which can help keep them engaged and active in meeting your organization's goals. ***We're here to help.***

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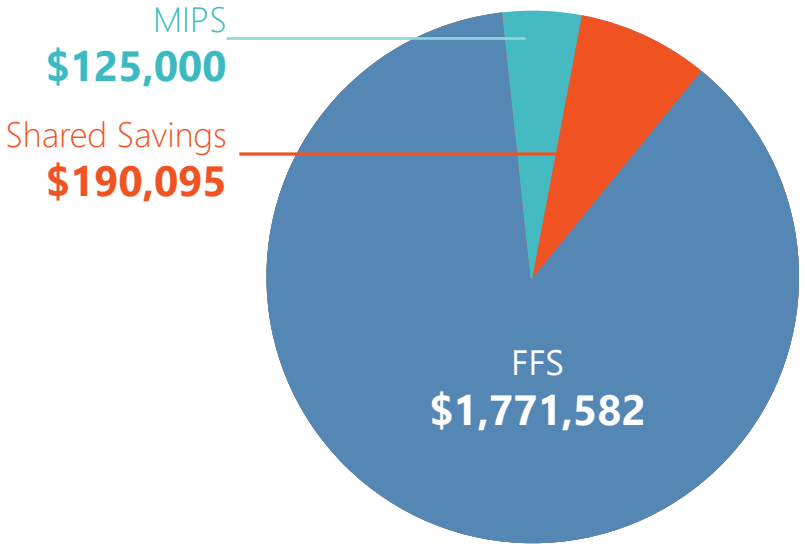
Use Cedar Gate's No-Cost ROI Calculator for an In-Depth Analysis Based on Your Organization's Numbers.

The Cedar Gate ROI calculator is a no-cost service that estimates both cost and reward in value-based contracts, and provides an accurate return on investment customized for the unique operational capabilities of each organization. Components include:

> Provider productivity
> Staffing requirements
> Incremental FFS visit revenue associated with closing care gaps
> Enhanced ancillary revenue (lab, imaging, procedures) associated with care gap closure

Closing Care Gaps Can Boost Revenue by $2.2M

The chart below depicts the incremental APM & FFS revenue of a 50 provider practice when using Cedar Gate technology to pursue value-based care.



Key Assumptions

Organization Size:

> 50 providers

Service Rates:

> Office visit $150
> PAP smear $150
> Urine albumin lab test $50
> A1C lab text $100
> Mammography $100
> Colonoscopy $2,000

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