Valence Health | Solutions For Value-Based Care

From Bundles to Global Capitation: Aligning Care Models to Payment Models

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The 16th Annual Population Health Colloquium

Philadelphia, PA

March 8, 2016

The U.S. Payer Market is Committed to Dramatically Increasing VBC Reimbursement.. Real Risk Still Coming

GOVERNMENT PLEDGES

Health and Human Services (HHS) Announcement

- HHS announced goals for shifting Medicare business to value-based care payment models - 30% payments by the end of 2016 and 50% payments by the end of 2018
- Medicaid Agencies in numerous states expand managed care options for different populations

ALLIANCE PROMISES

Health Care Transformation Task Force (HCTTF)

- Several major providers and payors formed a nonprofit coalition called the HCTTF
- Each member of the HCTTF has committed to shifting 75% of their business to value-based care

COMMERCIAL COMMITMENTS

United Healthcare

- Made ~$36 billion in value-based care payments in 2014
- Announced plans to increase value-based payments to providers by 20% in 2015 (more than $43 billion)

Blue Cross Blue Shield

- Currently pay $1 out of every $5 of medical claims to value-based programs (~$65 billion)
- Engaged with ~350 local value-based programs nationwide
- Saved ~$500 million as a result of value-based care in 2012

Humana

- 75% percent of their 2 million Medicare Advantage members are cared for through value-based reimbursement models by 2020

Source: Valence Health summary of public statement's and press release from each named organization

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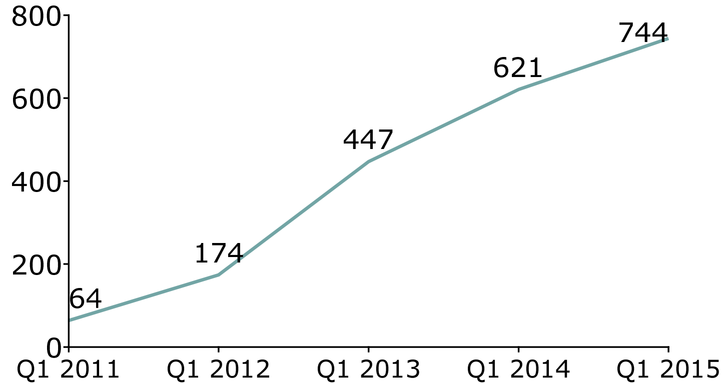
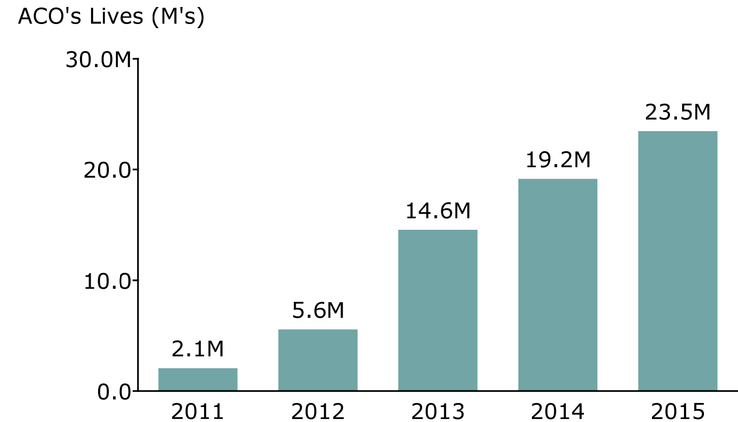
…Resulting in Multiple Different Payment Models

Increased number of ACO's formed each year

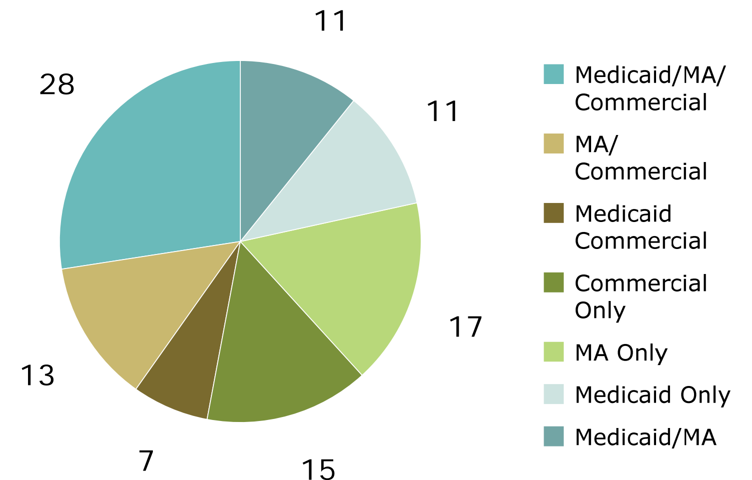


Covering over 23M lives



~2000+ Providers in CMS Bundled Payments Pilots

PSHP's taking many flavors



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Yet, Only One-Third of Providers Are Currently Taking Risk

What types of arrangements or models does your hospital or your owned medical groups currently have in place? In two years?

Category	Model	Currently	In 2 Years	Total
Medicare	Pioneer ACO	5	1	6
Medicare	MSSP	32	33	64
Medicare	Bundled Pymnts	13	37	50
Medicaid	Medicaid contract	60	37	98
Commercial	Bundles	12	44	56
Commercial	Ins prod - ins admin	32	31	62
Commercial	Ins prod - Shared risk	25	44	69
DTE	Bundled Pymnts	18	55	73
DTE	Direct contract	28	54	81
PSHP	Ins prod - Own ins license	15	15	30

The level of risk for the 1/3 today is low, but growing

Source: AHA 2015 Data Review

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Why?

- **Once you have seen one health system or provider organization, you have (really) only seen one…**
- **There are incredible differences within these organizations in the following areas:**
  - Resources
  - Competitive factors
  - Risk management experience
  - Market payor characteristics
  - “Attitude”
- **And…**
  - Optimization of CARE DELIVERY

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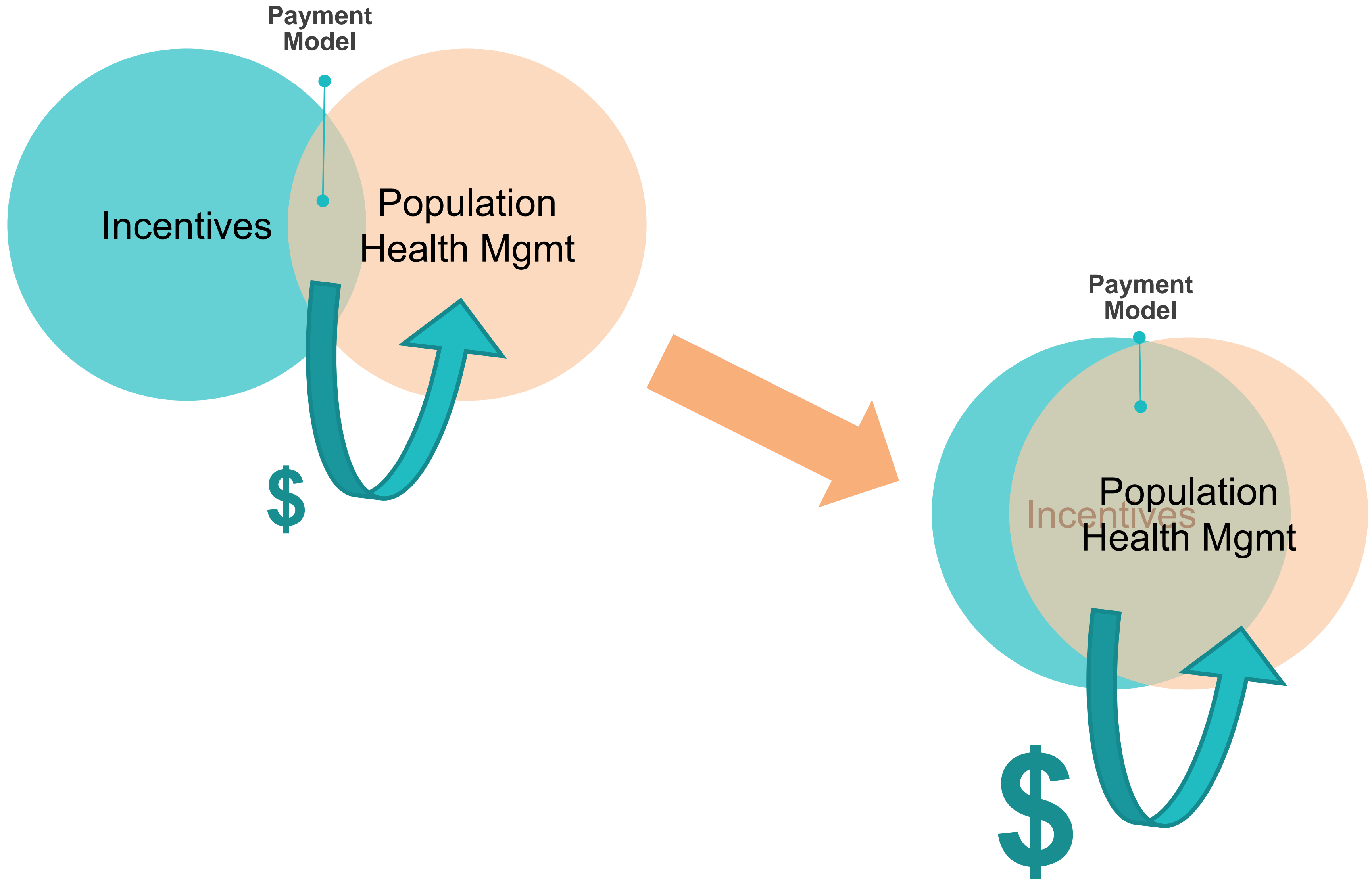
Moving Providers To More Risk

How Can Clinical Care Models Be Optimized to Encourage?



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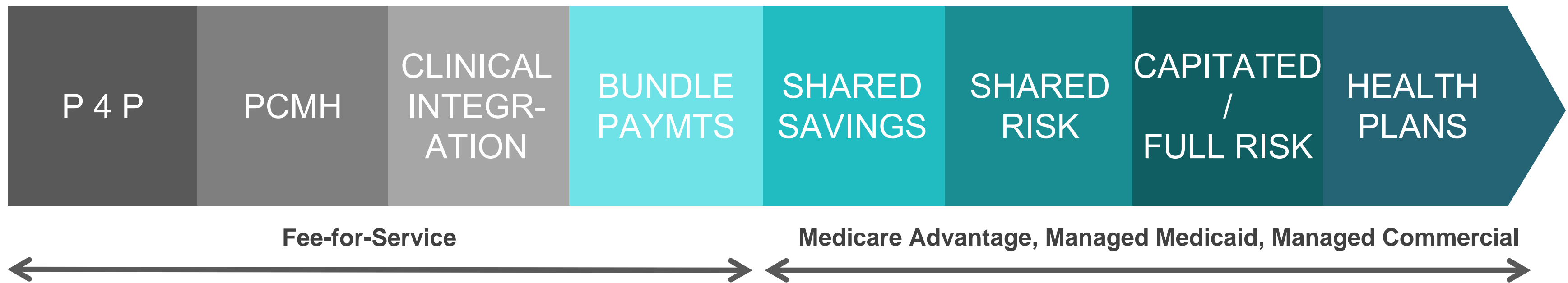
As the Shift Plays Out, Providers Will Continue To Exist Along a Spectrum of Models



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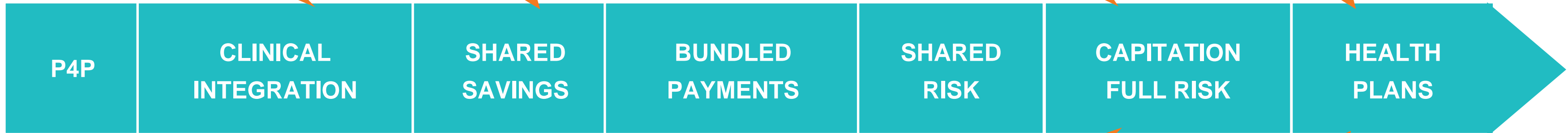
- 8 Hospital, 2500 physician CIN
- Two provider town
- Valence provided CIN technology, Care Manager technology, Advisory Services

- 4 Hospital system
- MSSP participant
- Competitive urban/ suburban market
- Valence provides Advisory Services

- Dominant pediatric institution in multi-state region
- Fully delegated rick via sub-capitated Medicaid
- Valence provides Care Management and Interim Executive

- 300 Bed, Single Hospital IDN in Dalton, GA (rural setting)
- 50% Owner commercial health plan with local IPA
- Valence provides technology, Health Plan Services



- 3 hospitals, 75+ practices, 500 physician CIN
- Valence provides CIN technology

- Single hospital system, semi-rural setting
- 100+ physician CIN
- Recently approved MSSP
- Valence provides technology and Health Plan Services

- 4 Hospital IDN
- 500 Physician CIN, Delegated Medicaid and Commercial Risk
- Valence provides technology, Advisory Services, Interim Executive, Health Plan Services

- Standalone pediatric hospital, Corpus Christi, TX
- 130,000 live Medicaid Plan, $300+ million
- Valence provides, technology, Advisory Services, Health Plan Services

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Moving To The Right

Structure

Ambulatory

Inpatient & Interventional

Care Continuum

P 4 P
PCMH
CLINICAL INTEGR-ATION
UNDLEPA
SHARED SAVINGS
SHARED RISK
CAPITATED/ FULL RISK
HEALTH PLANS

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Moving To The Right

Structure

- Primary care?
- Popuations? Market? Payors?
- Compensation system?
- Provider structure governance?
- What's my footprint?
- What types of facilities?
- Current risk programs?

Ambulatory

- Platform tech (EHR, Analytics…)
- Disease or efficiency mgmt tools?
- Do I know how to care manage?
- PCMH or similar?
- Care management personnel?
- How are my quality outcomes?

Inpatient & Interventional

- Specialists practicing EBM?
- Have I eliminated variability?
- Can I manage LOS?
- Am I managing discharge and F/U?
- How are my quality outcomes?
- Can I manage patient satisfaction?
- Supply chain optimized?
- Facility, infrastxr, maint costs?

Care Continuum

- What influence or control do I have over…
  - Home health
  - LTACH
  - Rehab
  - SNF
  - Complex institutional care
  - Elderly care
  - Community (church, school, other)

P4P

SHARED SAVINGS

SHARED RISK

CAPITATED/ FULL RISK

HEALTH PLANS

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Up Front Statements

- Employing dramatically different types of care management based on payment model has not served us well.
- There are a number of basic competencies that are needed no matter the payment model.
- As you move from isolated pay-for-performance arrangements to full risk, there is a need to be working more effectively in "all four boxes"

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Basic Competencies Every Payment Model Needs

1. **Effectively Engaging Patients**
   - Effective "traditional" (top of the triangle) care management
   - Reaching "deeper into the triangle"
   - Primary care is the coin of the realm
   - New technologies MUST be leveraged

2. **Effectively Engaging Clinicians**
   - **The Last mile is the first mile**
   - Analytics and reporting approaches – "providers are the effector arm"

3. Effectively **Targeting Both Condition Specific And Operational Challenges** providers and patients face

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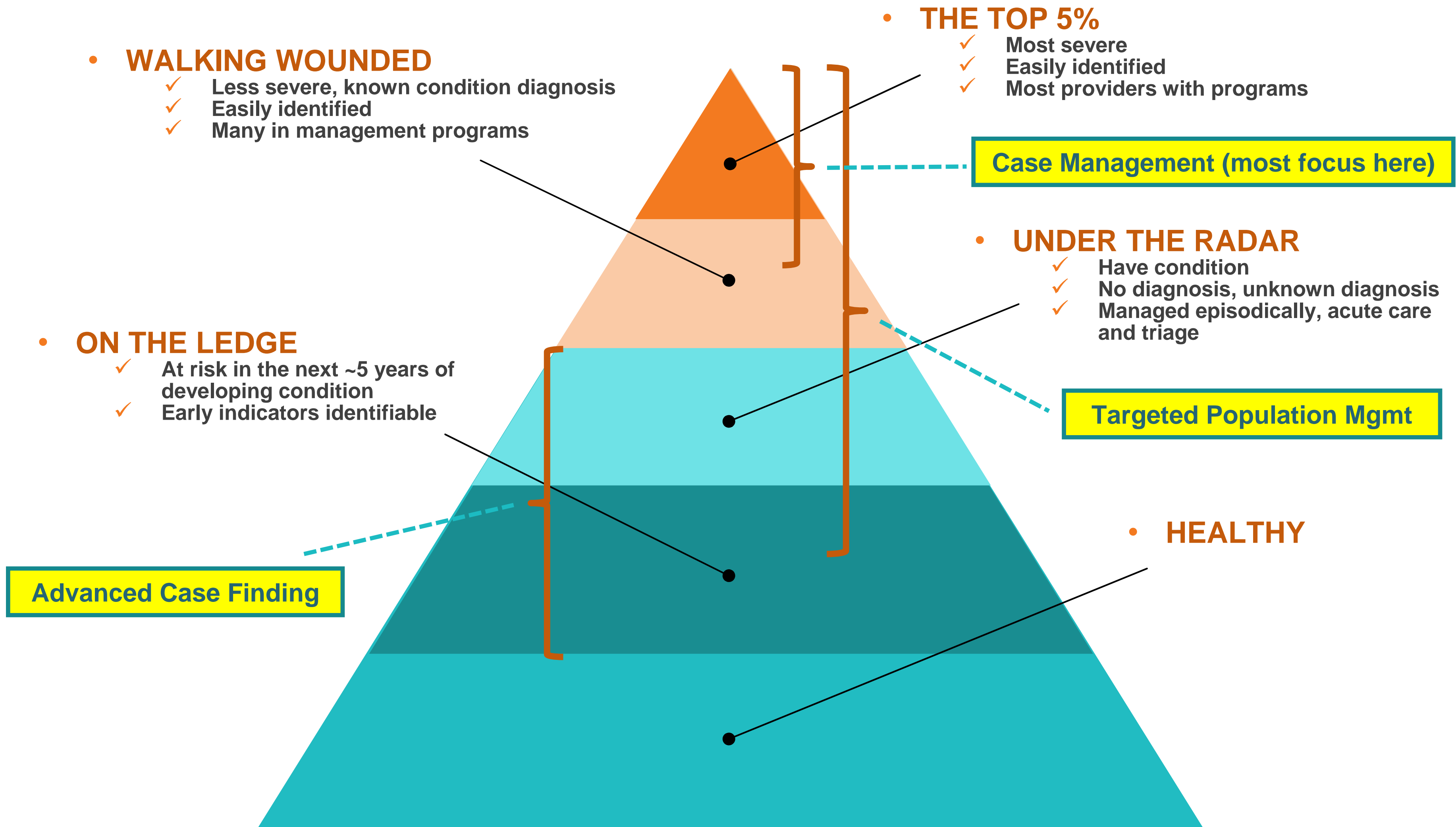
Effectively Engaging Patients

Not Just Those At The Top Of The Pyramid



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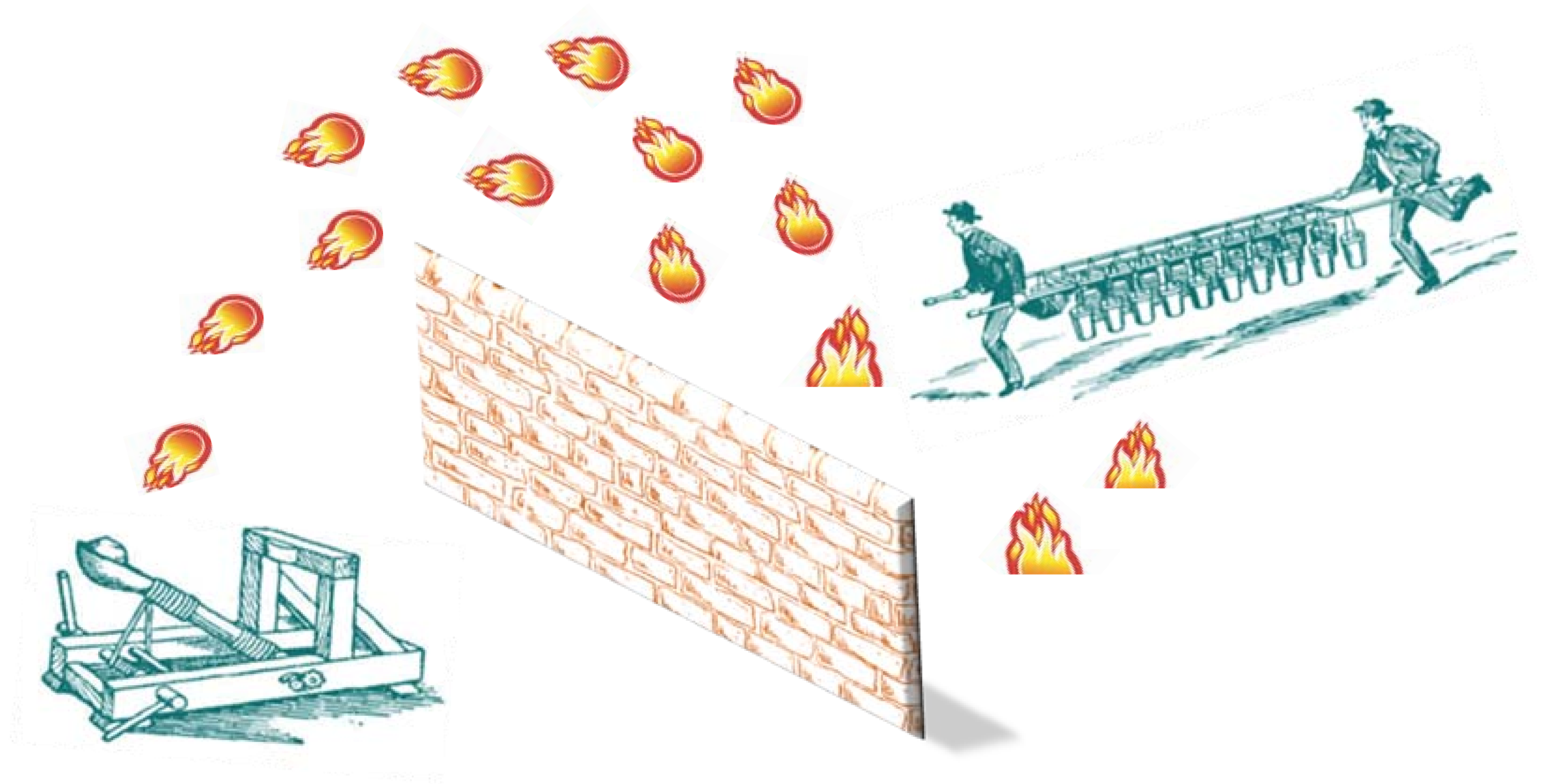
Effectively Engaging Patients

Not Just "Putting Out Fires"



Advanced Care Management

- Prevent patients from becoming expensive
- Prevent operational challenges
- *Shutting down the catapult*

Conventional Care Management

- Case managing the most expensive patients
- Identifying operational challenges
- *Putting out fires*

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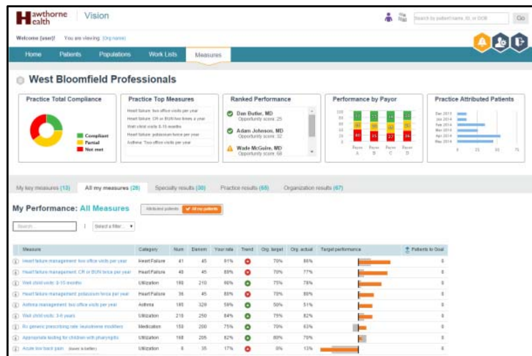
Effectively Engaging Clinicians

Comprehensive Analytics Are No Longer Optional

Clinical Quality

(Vision)

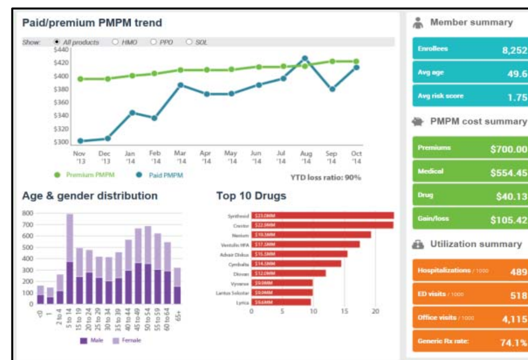
- Clinical integration
  - Aggregate data
  - Physician attribution
- Patient care
  - Risk stratify populations
  - Identify care gaps
  - Build registries
- Provider performance
  - Benchmark performance measures
  - Stratify by location, specialty, practice, etc.
- Campaign outreach



Analysis and reporting

(vQuest)

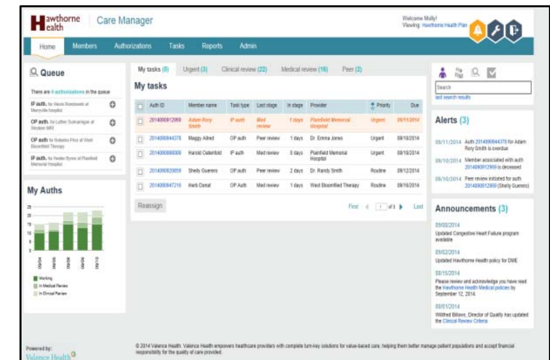
- Analyze medical costs and trends
- Stratify and prioritize patients
- Predictive modeling
- Tracks medical expense across major categories
- Measure provider performance on cost and utilization
- Supports delegated Risk and health plans



Care Management

(vCare)

- Workflow solution for medical management
  - Utilization Management
  - Case Management
  - Disease management
- Designed to support URAC and NCQA standards
- Drives patient engagement
- Analytics align with Vision and vQuest
  - Embedded care guidelines



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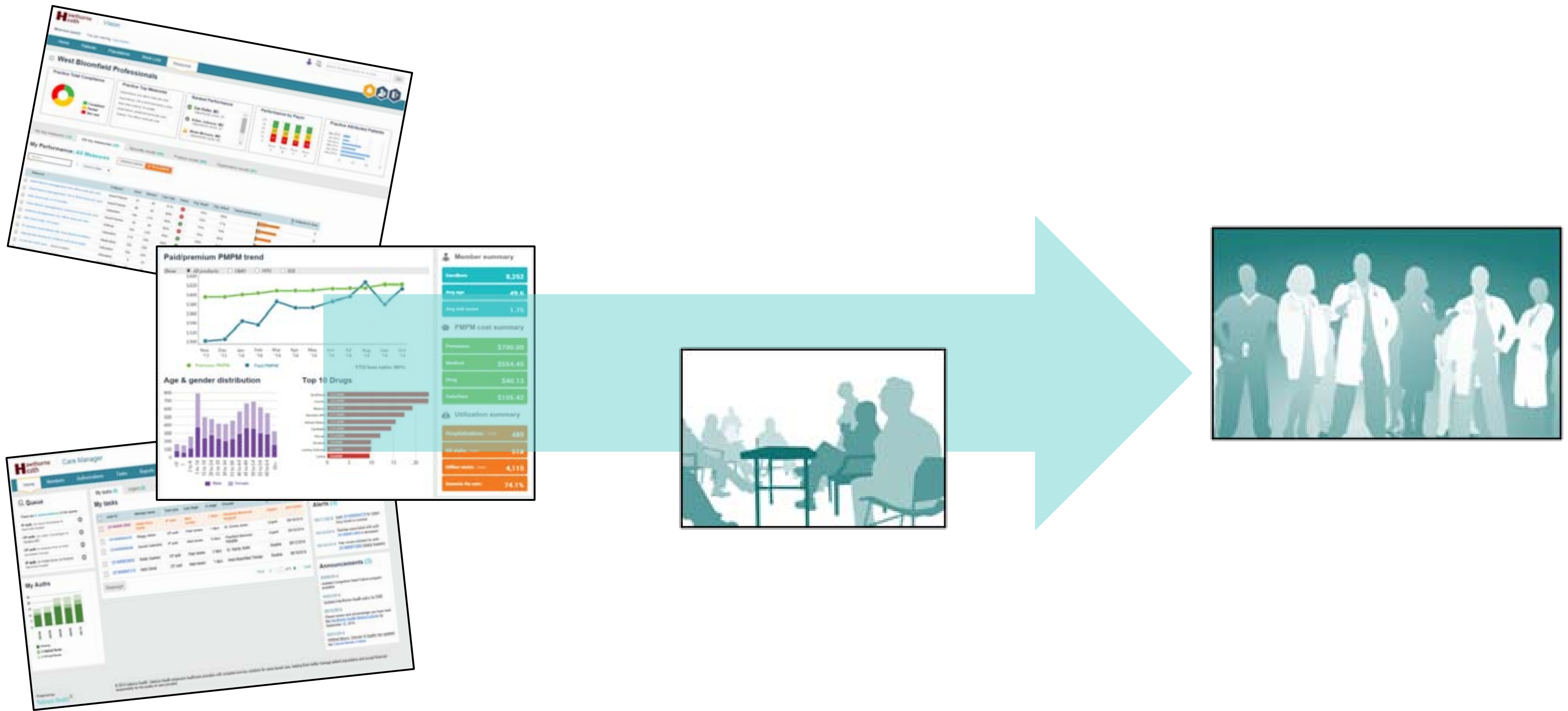
Effectively Engaging Clinicians

Without Effective Governance and Reporting, Little Action



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Pediatric Medicaid Targets
Condition and Utilization

Driver	Cost PMPM ($)	Goal / Solution Examples
Physician Office Visits	20.32	Virtual or telemed care
Outpatient ER	15.07	Triage tech – app level of care
Single Live Born	10.09	Shared Decision Making, Prevention undesired preg
Acute Inpatient Surgical	7.63	Encourage outpatient surgery, Education
Health Supervision Child	5.16	Virtual or telemed care
Asthma	1.45	Disease Management Technologies
Acute URI	1.40	" " "
Vaccination	0.38	Vaccinate home / convenient care
Drug Costs	?	Equivalencies, generics, incentives
Nutritional Deficits (A)	?	Dz Management Technologie
Trauma (A)	?	Education, resources
Care Gaps (A)	?	Vision, Emmi, CVS

A = Aggravating or proximate cause

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Adult Medicaid Targets

Condition and Utilization

Driver	Cost PMPM ($)	Goal/Solution Examples
Inpatient Maternity	62.43	Shared Decision Making, Prevention undesired preg
Outpatient ER	28.08	Virtual or telemed care, Triage tech – app level care
Normal Pregnancy	24.01	Shared Decision Marking, Prevention undesired preg
Office Visits	21.77	Virtual or telemed care, Triage – app level care
Inpt Surgery - Maternity	19.76	Shared Decision Makring, Prevention undesired preg
High Risk Pregnancy	9.86	Shared Decision Making, Prevention undesired preg
HTN	9.58	Dz Management technologies
Sickle Cell	8.43	Augmented case management
Drug Costs	?	Equivalencies, generics, incentives, formulary
Behavioral Health (A)	?	Less intensive / virtual platforms
Renal Failure / Dialysis	?	Shared Decision Making (perit dialysis), Case finding
Smoking (A)	?	Cessation Adjuncts
Alcoholism (A)	?	Moderation Adjuncts? Case finding?
Care Gaps (A)		Vision, Emmi, CVS

A = Aggravating or proximate cause

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Medicare Targets

Condition and Utilization (Medicare Cost Report, 2013)

Driver	APC/DRG	HCPCS	Goal / Solution Examples
Clinic (I, II)	$1.1B	$11B	Virtual care, triage platforms – app level care
Inpatient physician care		$7.0B	EBM, Reduce Variability, Clinical pathways, shared decision making
Joint replacement	$5.0B		Shared deicision making, EBM
Heart Failure (cc and mcc)	$3.5B		Dz management technologies
Nerve Inj / Spinal Fusion	$2.0B		Shared decision making, EBM
Ambulance Transport		$2.0	Tiered transport options
Cataract Surgery		$1.7B	EBM
PCI	$1.2B		Shared decision making EBM
COPD	$1.1B		Case finding, Dz management technologies
Renal Failure	$1.1B		Case finding, shared decision making (peritoneal dialysis)
Echo / Cardiac Imaging	$1.1B		EBM
Medical Eye Exam		$1.0B	EBM
Inpatient Critical Care		$900M	EBM
Therapeutic Exercise (Rehab)		$900M	Virtual rehab platforms
Hip and Femur (replace)	$900M		Shared decision making
ER (III, IV)	$600M		Triage platforms – app level of care
MRI	$423M		EBM
Sleep	$267M		Mobiel sleep study technologies
Medication			Equivalencies, generics, incentives, formulary
Behavioral Health (A)			Less intensive / virtual platforms
Care Gaps (A)			Vision plus partners
End-Of-Life	Big		Shared decision-making, intense education, hospice services

A = Aggravating or proximate cause

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Working in all Four Boxes

Ambulatory

P 4 P	PCMH	CLINICAL INTEGR-ATION	BUNDLE PAYMT	SHARED SAVINGS	SHARED RISK	CAPITATED / FULL RISK	HEALTH PLANS

Structure

Care Continuum

Inpatient & Interventional

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Structure

- **As you go from Left to Right…**
  - More “organized” primary care structures
  - More formal provider governance
  - Compensation models that increasingly reward VBC activities
  - More lives / More market share
  - Willingness or ability to “take on” commercial payors
  - More comprehensive clinical care offerings – inpatient and ambulatory
  - Willingness to regionalize expensive interventional services

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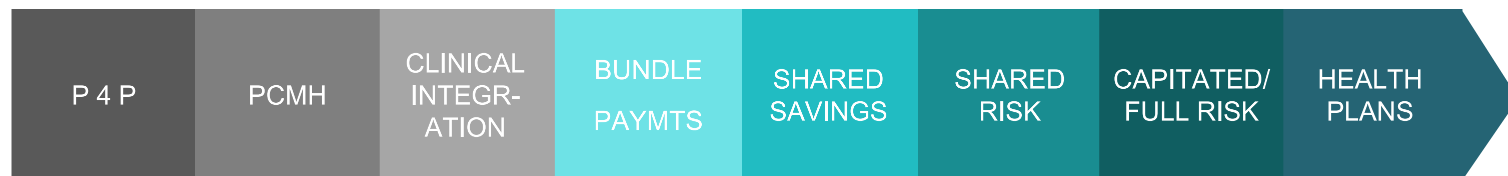
Ambulatory



- **As you go from Left to Right…**
  - Optimized use of the EHR
  - Analytics increasingly important
  - PCMH or similar structures needed
  - Case and Disease Management capabilities needed
  - Quality and clinical outcomes measurement, actionable reporting
  - Patient engagement
  - The use of digital and other tools

- ***Wellness***
- ***Engagement***
- ***Case Mgmt***
- ***Disease Mgmt***
- ***Triage***

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Interventional and Inpatient Care

- **As you go from Left to Right…**
  - More formal provider governance
  - Evidence based practice
  - Elimination of variation
  - Vendor and supply chain control (minimization of "physician preference")
  - Quality and clinical outcomes measurement, actionable reporting
  - LOS / Discharge management
  - Integration with primary care (F/U)

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Care Continuum

- **As you go from Left to Right…**
  - Close integration with or ownership of…
    - LTACH
    - Rehab
    - Home Health
    - SNF
    - Elderly care
    - Complex institutional care
    - Community care (schools, churches, NGOs
  - Coordinated care, communication and payment technology platforms

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Summary

- More important to consider optimization of clinical programs to encourage risk management

- More provider risk creates resources to reinvest in population health management

- As you move from P4P to full risk you must work in "all four boxes"
  - Structure and Strategy
  - Ambulatory Care
  - Inpatient and Interventional Care
  - Care Continuum

- No matter where you are on the spectrum
  - Engage providers and patients
  - Target difficult disease and operational problems with new approaches

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