

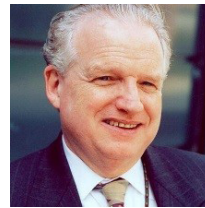
Shared Savings Programs

Lessons Learned from a New York State Community Health Center

A conversation between James R. Knickman, Ph.D., President & CEO, New York State Health Foundation,
and Neil Calman, M.D., President & CEO, The Institute for Family Health



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Introduction

The prevailing fee-for-service payment system pays for the delivery of care rather than outcomes, and more care rather than better care. There is growing consensus that alternative payment methods—ones that move away from fee-for-service reimbursements—will drive meaningful change in health care costs and outcomes. In piecemeal fashion, providers and payers are experimenting with new arrangements to derive more value from care, such as accountable care organizations (ACOs) and innovative reimbursement schemes. A variety of new models of care, many of which focus on the total cost for a given patient population, currently are being tested and refined by networks of providers and payers across the country. It is still to be determined which reimbursement schemes are most effective, most appealing, and most likely to supplant the use of fee-for-service among payers and providers.

Community health centers can be at the forefront of efforts to restructure the delivery of health care and associated spending. If payers want to pay to keep patients healthy, federally qualified health centers (FQHCs) can be a testing ground to pay for value over volume. FQHCs are leading the way on orienting medical practice around patient outcomes. However, FQHC providers cannot curb the most inflationary aspects of the health care system—unnecessary care, over-testing and over-treatment, high utilization—if they do not have access to information regarding their patients' hospitalizations, use of emergency departments, or other medical services outside of the clinic's walls.

Shared Savings Programs *(continued)*

The **Institute for Family Health (IFH)** is a nationally renowned FQHC network serving 95,000 patients annually at 27 locations in New York State. The **New York State Health Foundation (NYSHealth)** is a private, statewide foundation committed to fostering payment reform as part of its mission to improve the health of all New Yorkers. In 2012, with support from NYSHealth, IFH launched an effort to gain access to the broad array of data on its patients held by the insurance companies, and to use the data both to transform patient care and develop new payment arrangements with the plans that would lead to improved outcomes. After receiving the data from the plans and analyzing its patients' total use of care, IFH would be able to target certain patients for more proactive preventive health care and care coordination services to curb their use of hospital services. Ideally, it would fund these up-front care investments by modifying the health plan contracts to explicitly reward patient outcomes. NYSHealth grant funding supported IFH's efforts to develop shared savings plans with multiple payers and to enhance its capacity to analyze data to support improved health outcomes.

Since the project's start, IFH has entered into shared savings agreements with five commercial payers, some of which include more than one product line (i.e., Medicaid, Medicare, and commercial), as well as Medicare. This brief presents a snapshot of the project, including internal and external challenges; lessons for community health centers and health plans; and recommendations for what it is going to take for payment reforms to succeed in improving patient care.

James R. Knickman, Ph.D., is the President and Chief Executive Officer of NYSHealth. Under Dr. Knickman's leadership, NYSHealth has invested nearly \$100 million since 2006 in initiatives to improve health care and the public health system in New York State.

Neil Calman, M.D., is a board certified family physician who has been practicing in the Bronx and Manhattan for the past 30 years. He is a cofounder of IFH, where he has served as President and CEO since 1983.

Shared Savings Programs *(continued)*

Interview

Knickman: What was the project's goal? What did you hope to achieve?

Calman: The end goal remains improving our patients' health. We are an FQHC and mission-driven, so our focus has always been the patient. But despite all of our efforts, we had no access to information about our patients outside of our walls. What other care were they getting or not getting? Were they showing up at the emergency room (ER) or hospital repeatedly? Was there something we could have done to prevent that? We didn't know the answers. Only the payers, both the health plans we contract with and our government payers, have the data on our patients and their use or nonuse of medical services outside of IFH.

Greater and greater accountability is being placed on providers, and we embrace that. But transforming care requires access to the data. Our goal was to persuade the plans to share the data on our patients, so that we could analyze the data and use the findings to better target patient care and reduce their need for hospital care.

By demonstrating improved outcomes, we expected to work with the plans to redesign our contracts to develop payment arrangements that reward us for keeping patients healthy. Plans could help us build our capabilities to act on that data in a meaningful way that improves patient outcomes.

“Greater and greater accountability is being placed on providers, and we embrace that. But transforming care requires access to the data.”

Would you say you achieved your goal?

We now have shared savings agreements with five payers, covering approximately 19,000 Medicare, Medicaid, and commercially insured patients. We have a lot more data. And we have staffed up so that we will have the capabilities to act on data in a meaningful way that improves patient outcomes. The goal is within reach.

But to get the data, we first had to enter into agreements that commit us to different performance metrics, or benchmarks, for each plan. Right now, we're spending too much of our energy trying to act on too many disparate goals. It's an opportunity cost for us: how much more effort could we put into the really hard-hitting, high-impact interventions, if we weren't trying to do so many different things for so many different payers?

Shared Savings Programs *(continued)*

For example, one plan rewards our proficiency at maintaining diabetes composite scoring (including blood sugar levels, lipid levels, eye exams, and nephropathy screening) but does not give us credit for improvement in some measures if we have not improved in all of them, while another is more interested in increasing the nonuser rate for patients who have not been seen for 12 months or more. Working to achieve these disparate goals is not helping us to achieve better outcomes; these metrics are not reimbursing the cost of the real practice transformation required to achieve these payers' goals.

We understand that plans have their own quality goals, based on the plans' initiatives, and that's good. But the danger is that a multiplicity of performance standards means that there are no real incentives. And these standards may not reflect how providers can better care for patients. We want our providers to stay focused on what's best for each patient, not just practice for incentive payments.

Without real provider input, the range of performance metrics we have to meet lack coherence. And, to be honest, it is costing the plans money because they are not enabling providers to redesign care to lower costs.

The providers really need to be the ones driving the train. If we have the right data, we can improve care, outcomes, and costs. We can better tailor interventions to the patient. Providers should be helping to define what success means under these new payment arrangements and what benchmarks we should be striving to achieve.

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How did you settle on shared savings as the right payment reform model for IFH?

Under most shared savings models, providers are financially rewarded if their patients' total cost of care comes out to less than a pre-specified, annual benchmark. But at least at the beginning, there's no downside risk for the provider; we receive a share of any cost savings, but we're not penalized if no savings are realized. For nonprofit, lower-margin providers like IFH, it gives us some time to develop our infrastructure and refine our quality improvement strategies, before we take on the risk of limiting ourselves to a capitated payment model, for example. But make no mistake, the resources we are investing in practice transformation represent a huge financial risk—we need to achieve our goals or we will lose money.

How did you approach your commercial payers about negotiating a shared savings arrangement?

We met with our contacts at the plans and told them we wanted to enter into shared savings agreements. Five of them were interested, and so we reopened our existing contracts to engage in this

Shared Savings Programs *(continued)*

discussion. At the time, most plans did not have a template or a readily available term sheet for shared savings arrangements, which definitely affected the speed of our discussions; it took months to work the new contract terms through their corporate structures. Many admitted that they did not have the administrative infrastructure to support these contracts or the capacity to produce the data we were asking for in a usable fashion.

What are some of the plans' metrics/benchmarks in these payment arrangements? How did you try to put it into practice?

Many of the plans can provide gap reports showing deficiencies in quality benchmarks, but they're not all looking at the same benchmarks. So we're all forced to try to come up with a single list of metrics that will cover all of it, and it gets complicated. As a provider, our top priority is to provide consistent, high-quality care to everyone regardless of insurance status or payer. So our providers are trying to do that while our back-office staff members are spending hours analyzing nonuser rates for Plan A, and diabetes levels, medication adherence, and hypertension for Plan B, and so on. It's very resource-intensive, and there needs to be more synergy.

We've created our own list of 11 measures based on the most frequent metrics from the plans, along with our own priorities, and we monitor those monthly. The metrics were selected based on four criteria, including their ability to improve care for diverse populations; potential for decreasing morbidity and mortality; feasibility; and projected financial impact.

This year, the metrics include colon cancer screening; cervical cancer screening; breast cancer screening; immunizations for children under three years; controlling high blood pressure; depression screening; pneumococcal vaccination for patients older than 65 years; and a diabetes composite measure consisting of eye exam, HgA1C under 8%, LDL control, and nephropathy screening. We track these data and make them available by site and by provider to help identify and spread best practices, as well as have monthly conference calls where changes in Institute-wide performance over the past month are highlighted. Part of the call is spent showcasing a site that has shown marked improvement in recent months and discussing what interventions it has implemented to achieve that improvement.

What are some of the challenges encountered in getting the data?

We learned that plans also need analytic and technological capabilities to share data on a patient's total cost of care. We had a specific list of data we were looking for (drafted by our clinical and IT folks together), aligned with nationally recognized quality benchmarks, like HEDIS [Healthcare Effectiveness Data and Information Set] to measure performance and QARR [Quality Assurance Reporting Requirements]. We sent the request to the plans, and many could not provide the information we wanted in the format requested. Not because they didn't want to, but because their systems weren't set up to report that way. It took three months to get satisfactory ER utilization data from some of the plans.

Shared Savings Programs *(continued)*

Tell me more about data challenges you encountered.

There's a whole array. Some plans can't run certain data extractions. Or they have no way to provide raw data that we can actually manipulate—only fixed reports. Sometimes it's simple formatting, but labor-intensive: things like whether a patient's first and last name are listed in one column or in two. It sounds inconsequential, but it impacts our ability to combine reports and match them in a consistent way to our own electronic health records (EHRs), without doing a lot of data manipulation first. There are also attribution problems: patients assigned to the wrong providers, providers not linked to the right practices. Initially, it seemed that many plans were unable, or unwilling, to provide actionable information about members' use of services or cost of care on a regular basis. And in some cases, the plans' legal counsel raised concerns about sharing data with us for HIPAA reasons.

Eventually, several of the plans were able to provide us with a list of attributed patients who were never seen at the Institute but were incurring medical expenses elsewhere. This allowed us to reach out to those members and engage them in care—critically important when we are responsible for total cost.

Ultimately, all the plans have been able to identify the frequent ER users and the high-cost members, which has permitted us to work with patients to improve care management and follow-up. We've also received use data for specialty referrals, radiology, other outpatient facilities, and pharmacy costs.

Equally important are clinical event notifications provided by the regional health exchanges. We need to know immediately every time one of our patients is in the ER, admitted to a hospital, or discharged.

Your FQHC, along with two other health center network partners, was designated an ACO by Medicare earlier in the year. How has your experience with the ACO program so far shaped your approach to negotiating shared savings contracts with your commercial payers?

Patient attribution is key and incredibly complicated! We're spending a lot of time making sure that our Medicare patients are properly attributed to our Medicare ACO, so that when we improve their health outcomes, we get the credit. The same is true with the commercial plans. The first step is to make sure you and the plan are talking about the same group of people, so you know what the needs are and you know for whom you're accountable. Additionally, it is important that health plan data mirror EHR data, particularly around primary care provider (PCP) alignment. Many times, the PCP recorded by the health plan does not match the PCP who is actually caring for the patient. A big challenge is working with the plans to obtain data that are real and accurate. Otherwise, the data we get include people who are not our patients.

Shared Savings Programs *(continued)*

What do payers need to do to best support providers interested in the shared savings approach?

Invest in their analytic capabilities, for one. The plans want to do this—they just don't all have the systems yet. Like the providers, everything they do is designed to support a fee-for-service model. They have staff to credential clinicians and process claims, but many do not have people available who can process ad-hoc data requests, provide real-time information about preventable service use, or analyze and troubleshoot quality improvement efforts.

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What do providers need?

More than anything, up-front resources to invest in staff, both for analytics and for clinical quality improvement. The resources required to implement and monitor the shared savings agreements, on both the provider and payer sides, are substantial. We're also looking into setting up some kind of data warehouse so we can more easily aggregate, process, and manage all of the data we need from the different plans.

What does it take to actually achieve the quality improvements you'd need to see to achieve cost savings? How do you staff an effort like this?

It's impossible to address the needs of complex patients without substantial changes to practice staffing and workflow. It's a huge undertaking. We've been working toward a real practice transformation across our network: in the past year or so, we hired an administrative director of care management; trained a team of care coordinators and managers; collaborated with staff to integrate care management into daily practice operations; and strengthened relationships with care coordination staff at partner agencies to ensure seamless care for patients. The need for leadership with the skills and time to support these changes is huge. The need for actionable data to inform patient outreach and clinical decision-making is huge.

In addition to hiring all project staff, the Institute established an internal metrics team, consisting of representatives from clinical, operations, psychosocial services, and IT departments to guide selection, definition, and prioritization of performance metrics for tracking and targeted improvement. To support the practice changes and quality improvement, we also established an AO [analytics and operations] team, which meets monthly to review data and develop interventions related to health care plan partnership goals. The AO team is composed of the chief medical officer, senior vice president of clinical

Shared Savings Programs *(continued)*

operations, vice president of quality, lead nurse coordinator, director of care management, coordinator of care management services, data analyst, managing director of strategic initiatives, continuous quality improvement coordinator, and other key staff members as needed.

What's the biggest challenge you face in pursuing your shared savings-related quality improvement goals?

Hiring and training new and existing staff members, building out our EHR to support these new job titles and resulting workflow changes...these are big expenses. The up-front investment is significant. In some of the shared savings models, including Medicare's, there's no up-front funding, although some models do provide care coordination funding to help offset the enormous expense. Providers are expected to make the changes, but we won't see any real revenue increases until later, when they start to have measurable impact on health system utilization. The Institute has been fortunate to receive some private foundation funding to help offset a portion of these costs.

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Can you share more about some of the interventions you developed based on the data?

Analysis of claims-derived data indicated high ER utilization rates among IFH patients in New York City and upstate. In addition, data indicated that more than half of these visits could have been prevented with a timely primary care visit. The Institute administered a patient survey to gain a better understanding of what drives patients to use the ER rather than contacting the PCP to customize interventions that minimize avoidable ER use. We also were able to see how our frequent ER users (those who use the ER three or more times in a year) used our own centers. Surprisingly, we found that the majority of our frequent ER users are also frequent users of our services. To help address this, we have implemented extended hours at most of our sites, including the identification of a hub site in every geographic region that is open 365 days a year, 8 a.m. to 10 p.m. on weekdays and 8 a.m. to 8 p.m. on weekends and holidays. We also are expanding our call center to have a more robust after-hours service.

We have started to identify our frequent ER users in the EHR with a frequent flyer banner that goes across the top of the patient's EHR. A frequent ER user policy also has been created and disseminated to all staff members. It says that when an identified frequent ER user calls into a center, that patient receives a same-day appointment and immediate assistance from a nurse, if appropriate. When this patient is in the office, both nursing staff members and the provider counsel the patient on services that our centers provide, the advantages of seeing one's PCP rather than an ER provider, and appropriate

Shared Savings Programs *(continued)*

reasons to seek emergency services. We currently are building an electronic prompt that will remind providers to review this information with anyone coming in for a follow-up visit after seeking services in the ER.

Using the data also has helped us to identify practice trends and modify referral patterns; for example, we learned that one oncologist was performing infusion services in a hospital setting rather than in his office (resulting in significantly higher cost), so we stopped using that provider. Additionally, we now are reviewing the costs associated with referring patients to stand-alone facilities for radiology vs. hospital settings and will modify referral patterns as appropriate.

Are the plans willing to reimburse for any of the up-front costs, such as care coordination?

We now receive care coordination fees from two payers. One of the plans has tied the care coordination fees to the shared savings outcome, requiring us to remain eligible for a surplus by line of business to retain such fees the following year. We also receive a pre-negotiated administrative fee from a third plan. We do not receive anything from the other two payers, although clearly it would be helpful.

Which of your goals were you unable to achieve?

We had hoped to build a truly robust data warehouse. The inability to link claims data to a warehouse for direct data management has made every stage of the process more difficult. Every data element that arrives from our payers must first be queried to ensure accurate patient attribution and then cleaned and formatted into a standard template for further analysis. This system is further complicated by the individual nature of contracts, with each payer or plan sending different types of data. We are working on a few different solutions for integrating EHR and claims data, but haven't settled on one yet.

What key lessons learned would you highlight for other health centers heading down this road? Lessons for health plans?

The big issue, then and now, is data. When you're talking about a shared savings approach, you're talking about total health system use—and the plans are the only ones that have the cost data on the patient's total use across all settings.

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Shared Savings Programs *(continued)*

Both health care plans and community health centers interested in entering into shared savings or pay-for-performance contracts must have sophisticated data and analytic capabilities. Currently, many of our payers lack the capacity to share information efficiently and easily. Despite many years of experience with custom reports and data mining from the EHR, we also have struggled with the quantity of data necessary to assess population-level health indicators.

We understand that data has power, and plans do not want to give away that information without strings. But it will ultimately benefit payers to be open to provider input and leadership on how to define success for payment incentives to work. We also need real-time notification of clinical events from regional health information exchanges, as well as from the plans.

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What benefits have you seen so far from this effort?

Despite the challenges, we are getting unprecedented access to information about our own patients. All the plans have been able to identify the frequent ER users and the high-cost members, which has permitted us to work with patients to improve care management and follow-up. Additionally, several of the plans were able to provide us with a list of attributed patients who were never seen at the Institute and who were incurring medical expenses elsewhere, so we could reach out and engage them in more effective primary care. That’s a big goal of ours.

We’ve also learned a tremendous amount about structuring the agreements, and we have already seen this process start to improve as both providers and health care plans gain experience with these contracts. These shared savings contracts and agreements, including the ACO, have helped us refine our internal processes for data analysis and programmatic interventions aimed at driving population-level changes in health.

Have you seen quality gains? Better patient outcomes?

We have definitely seen some gains in quality measures. Though we are implementing interventions to address the ER utilization rates, we have not yet seen significant changes.

Shared Savings Programs *(continued)*

I have to ask: Has your organization actually seen any shared savings payments yet?

We've received payments from two payers to date for a total of about \$90,000—just a tiny percentage of what we've invested so far.

Do you anticipate that the structure of your agreements will change over the next several years as you gain more experience and get access to better data?

We expect that plans will continue to hold us more accountable and agreements will be more rigid with more deliverables tied to the surplus, such as improving quality scores, coding to ensure that the patient's risk score accurately reflects the acuity level, and that all patients assigned to us are receiving services. In the meantime, we're trying to learn as much as possible from the process and, most of all, to stay focused on providing excellent care to every one of our patients.

What is your vision for the future?

The Institute, like all FQHCs, wants to be able to deliver superb care. To do so, we must build a truly integrated care delivery system with sophisticated care management capabilities. To be successful, we need payment arrangements that support these efforts and access to comprehensive claims data to evaluate the impact of our interventions. We believe that the system is moving in this direction, but reaching our goals will take time. ■