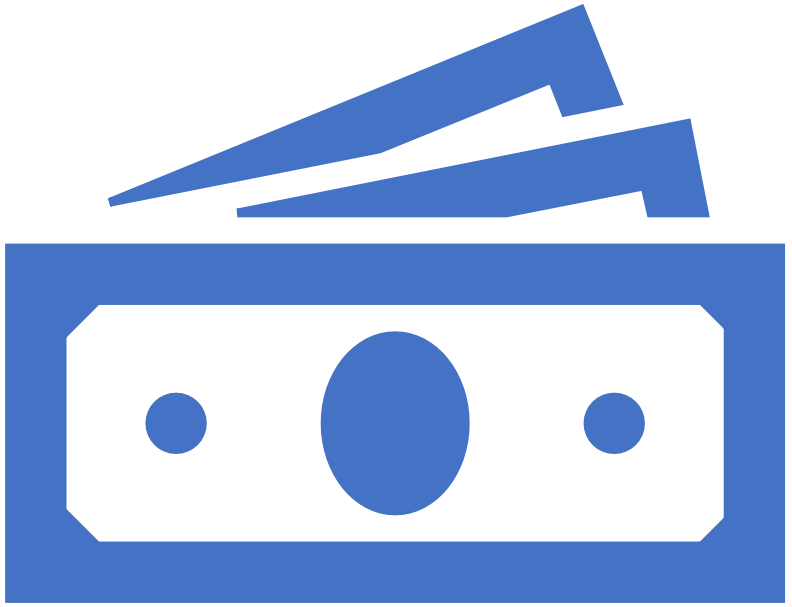


Technical Assistance: Cost & Savings Analysis

Melissa Rowan, Partner, Wertz & Rowan

Olinda Harbaugh, Transformation Initiatives Director, Hamilton Healthcare System

Belinda Reininger, Professor of Health Promotion and Behavioral Sciences, University of Texas School of Public Health

Today's Goal

Share different approaches to approaching financial sustainability and cost and savings analysis

Starting in October 2021, the current DSRIP program will be zero funded.

Cost and Savings Analysis	Understanding HHSC's requirement for Cost Savings analysis is important for DSRIP reporting
Long-term Financial Sustainability	Thinking about financial sustainability post-DSRIP requires providers to complete a thorough review of costs, financing options through multiple payers, consider programmatic restructuring

Costs and Savings

Hamilton Healthcare System
Hamilton, TX

Olinda Harbaugh MPH RDN CDE

Diabetes Retinal Screening Prevention

How and why we chose the ROI Forecasting Tool

Challenges: Data Sources that align with tools

http://www.chcsroi.org/Welcome.aspx

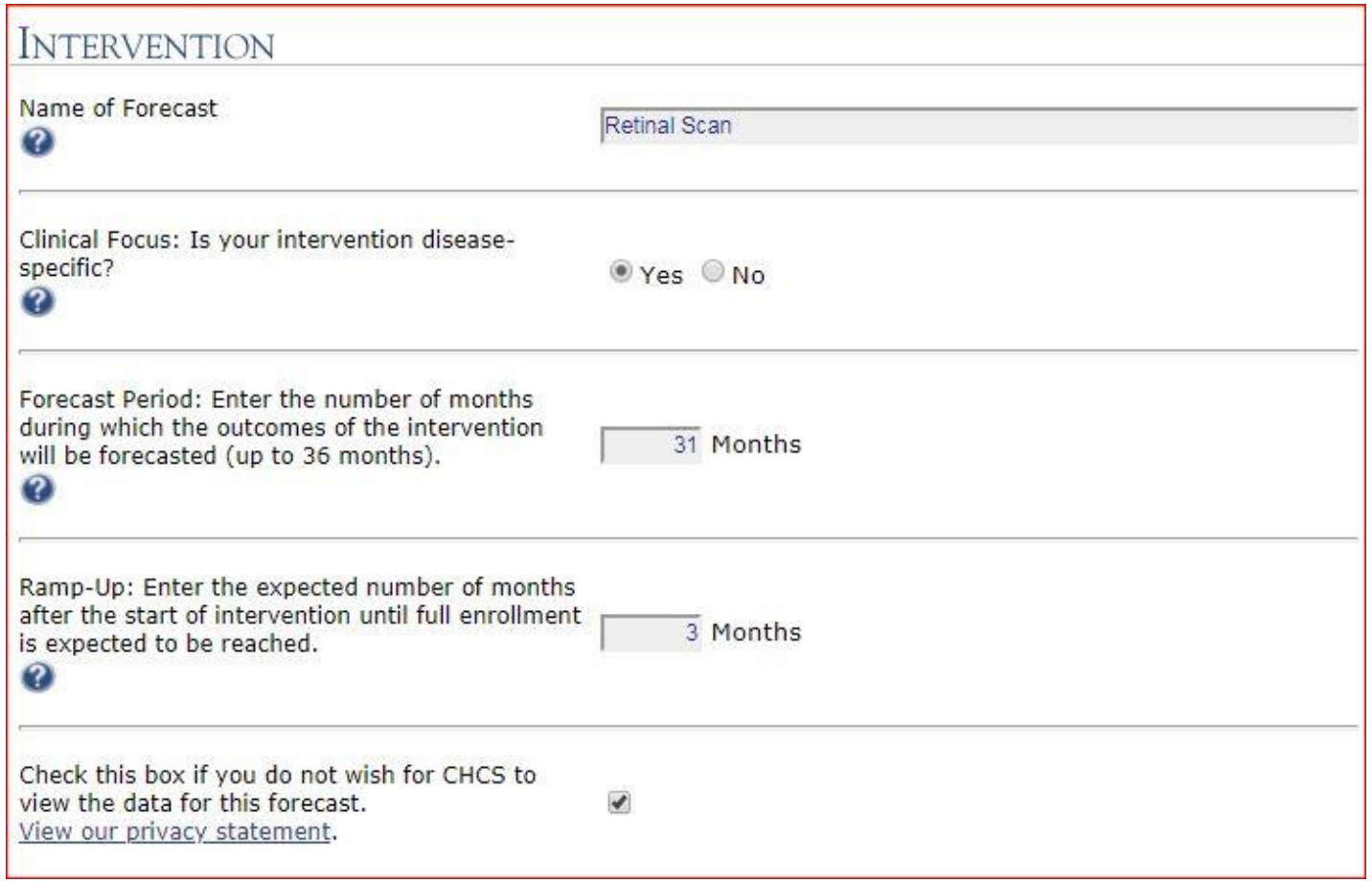
To complete an ROI forecast, you will need to provide the following information:

Intervention	• Clinical focus • Intervention strategies • Timeframe/duration of initiative
Target Population	• Targeted population subgroups • Disease prevalence among target groups • Expected enrollment rate • Risk stratification
Utilization	• Average 12 month baseline costs for intervention group members • Trend (expected growth in claims costs) • Anticipated utilization changes resulting from initiative
Program Costs	• Estimated costs of launching and operating the initiative
Discount Rate	• Organizational cost of capital

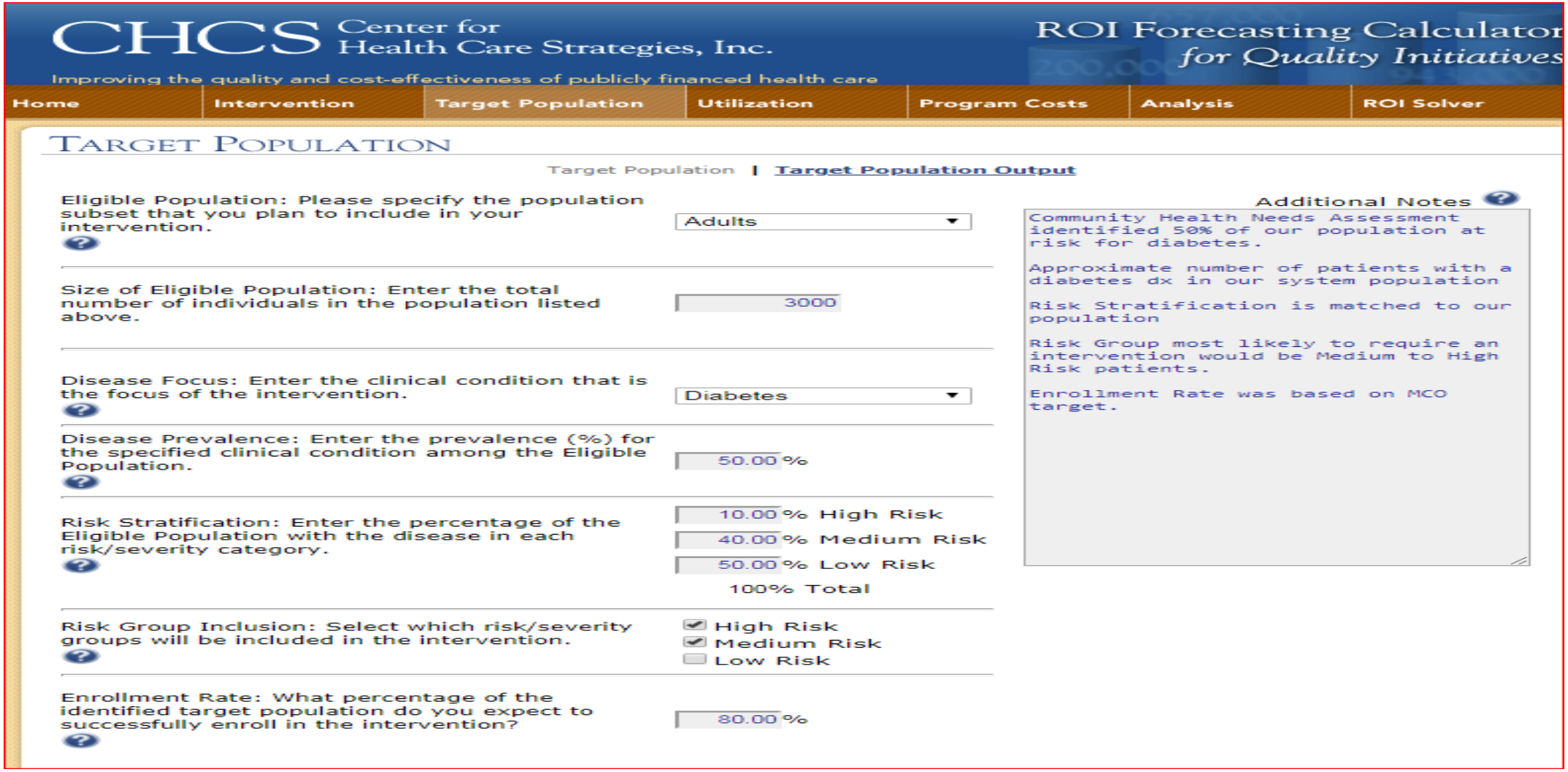
Core Activity and Literature Review

- Core Activity Utilization of care management and/or chronic care management services, including education in chronic disease self-management
- Chronic Care Management Services- Complications of Diabetes
- Probability of retinal complications increases with increasing duration of disease. In up to 50% of patients with type 1 diabetes and 30% of those with type 2 diabetes potentially vision-threatening retinal changes develop over time, while early retinal changes are not noticed by the patients. World J Diabetes. 2015 Apr 15; 6(3): 489–499.

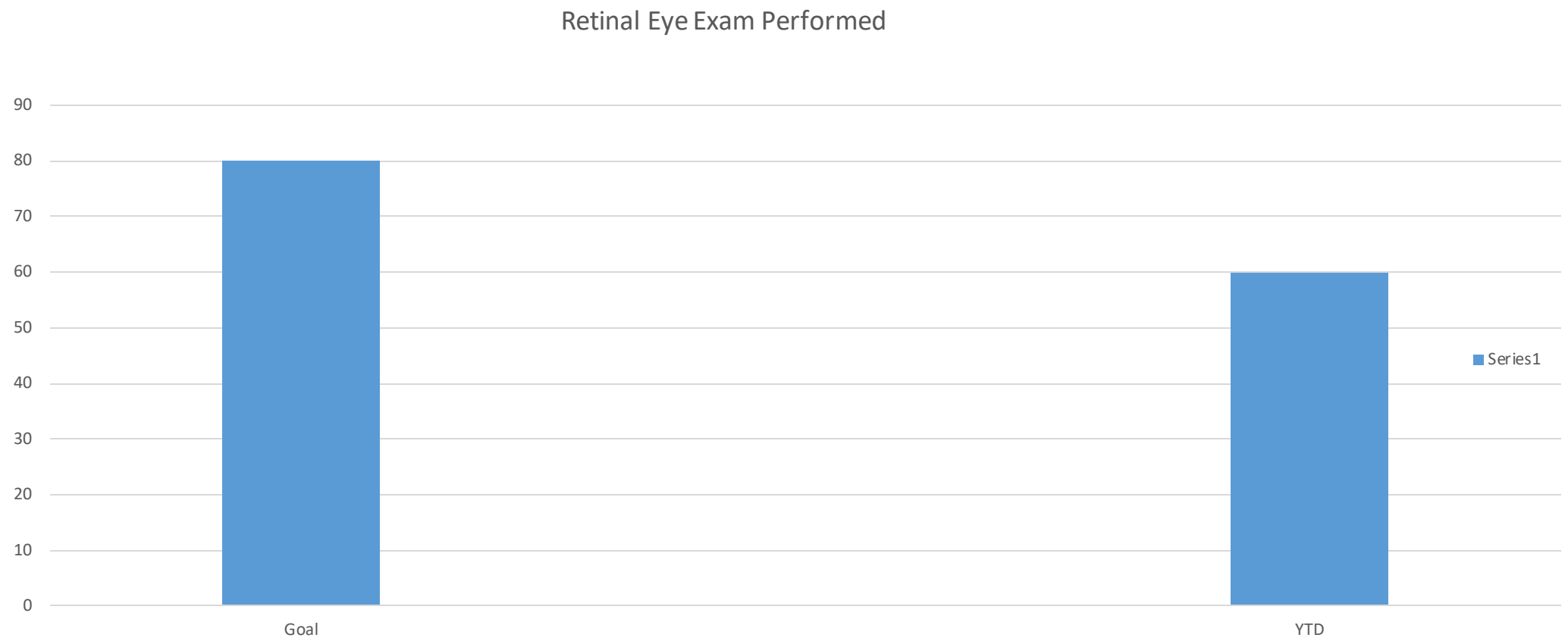
Important Aspects of the Tool



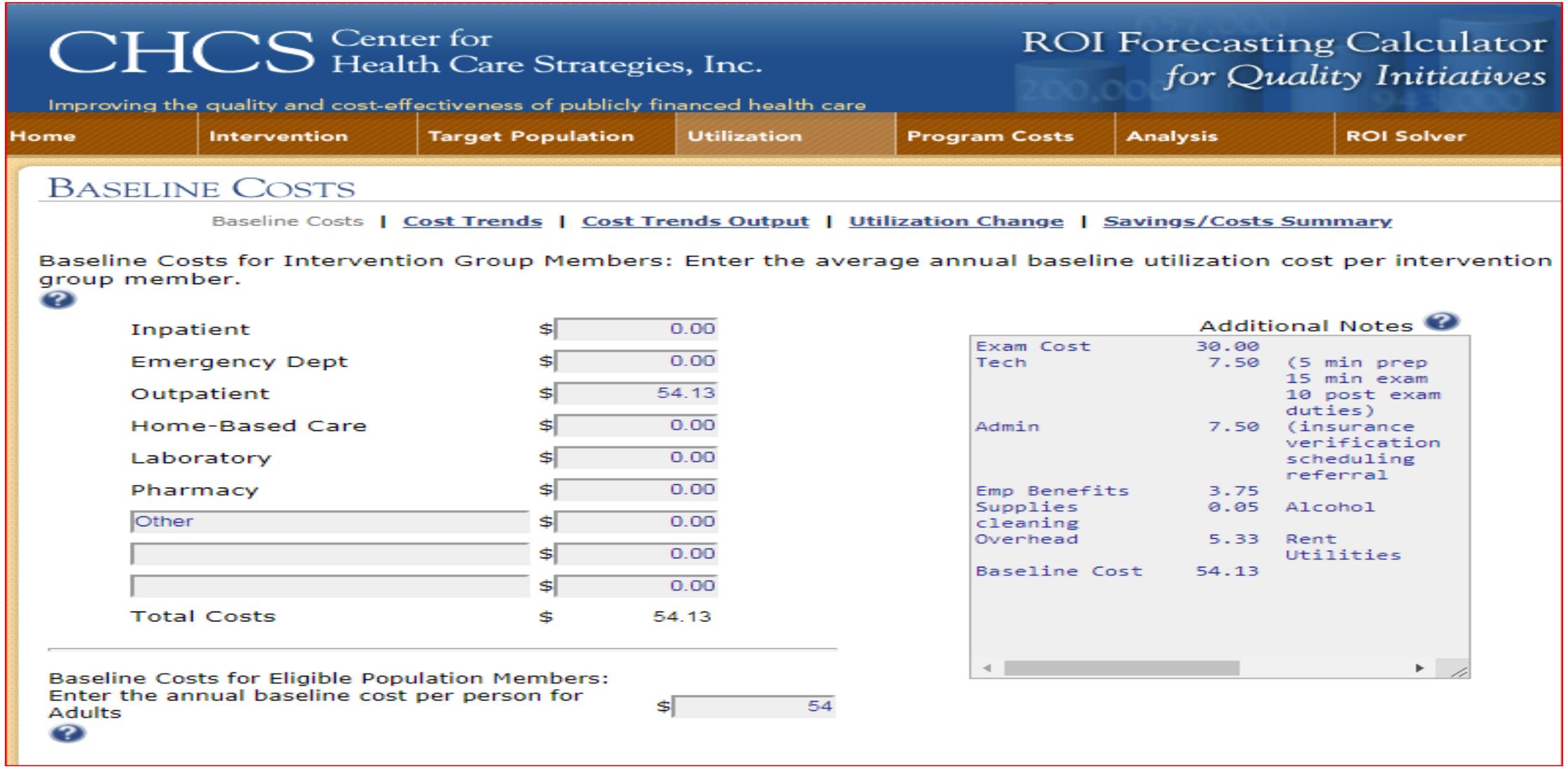
Target Population



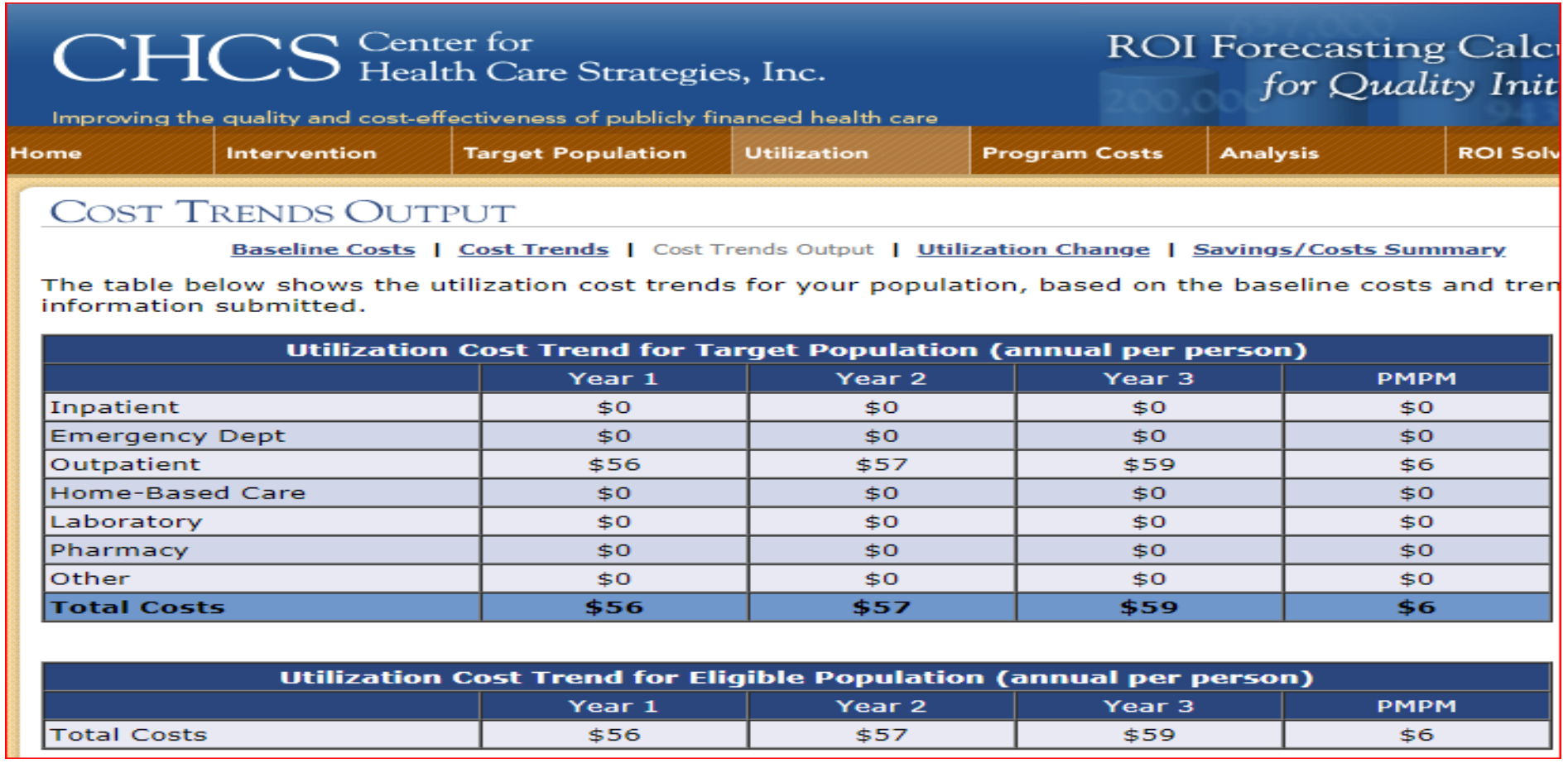
Opportunity- Incentive for Improving Screening



Baseline Costs



Cost Trends Output



Program Costs

ROI

Forecast Name: Retinal Scan

Utilization Change Assumptions Used: No article selected, manual inputs used.

Target Population	
Eligible Population	Adults
Total Membership in Eligible Population	3,000
Clinical Focus	Diabetes
Target Strata	High Risk, Medium Risk
Outreach Goal	80.00%
Ramp-up Period	3 months
Total Target Population Members	750
Total Intervention Group Members	600

ROI			
	Year 1	Year 2	Year 3
Cumulative ROI	-0.02x	-0.03x	-0.04x
Cumulative ROI Captured Internally	0.00x	0.00x	0.00x
Cumulative ROI if Savings are 3.00% Lower	-0.02x	-0.03x	-0.04x
Cumulative ROI if Savings are 3.00% Higher	-0.02x	-0.04x	-0.04x
Net Present Value	($42,975)	($54,597)	($66,947)

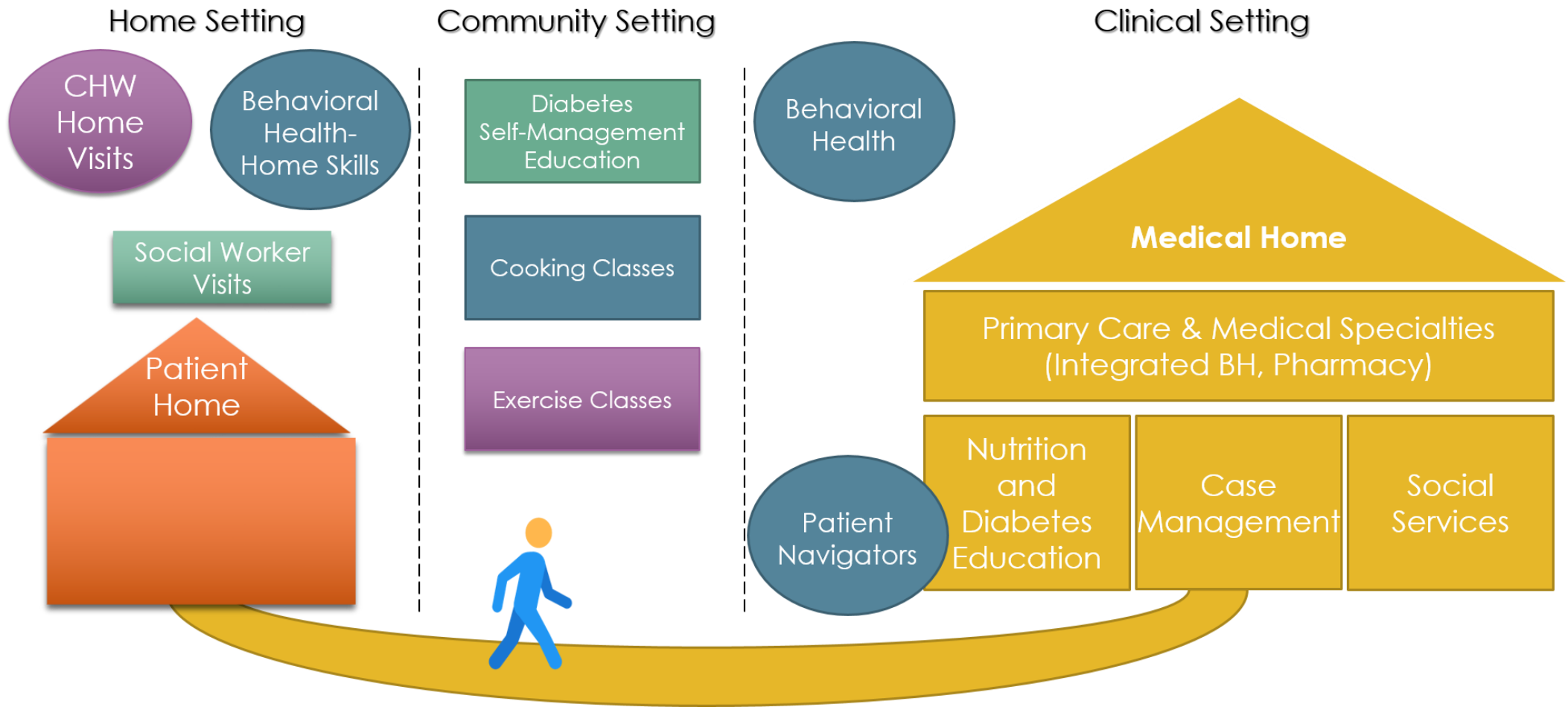
How will we approach VBP?

- Payout for retinal interventions from MCO is not available
- 20% of allowable charge for Medicare of $4000 is $800
- Assumption is that we are saving the MCO $800 per treatment intervention.
- Using the numbers from the tool 300 High Risk persons are at risk for an intervention.
- 30% or 100 would have an intervention costing the MCO $80,000.
- Payment for screening averages $55.00 which is less than cost
  - Incentive to improve screening numbers
  - Share the cost savings based on preventing costly interventions.

Sustainability for a collaborative chronic care management program

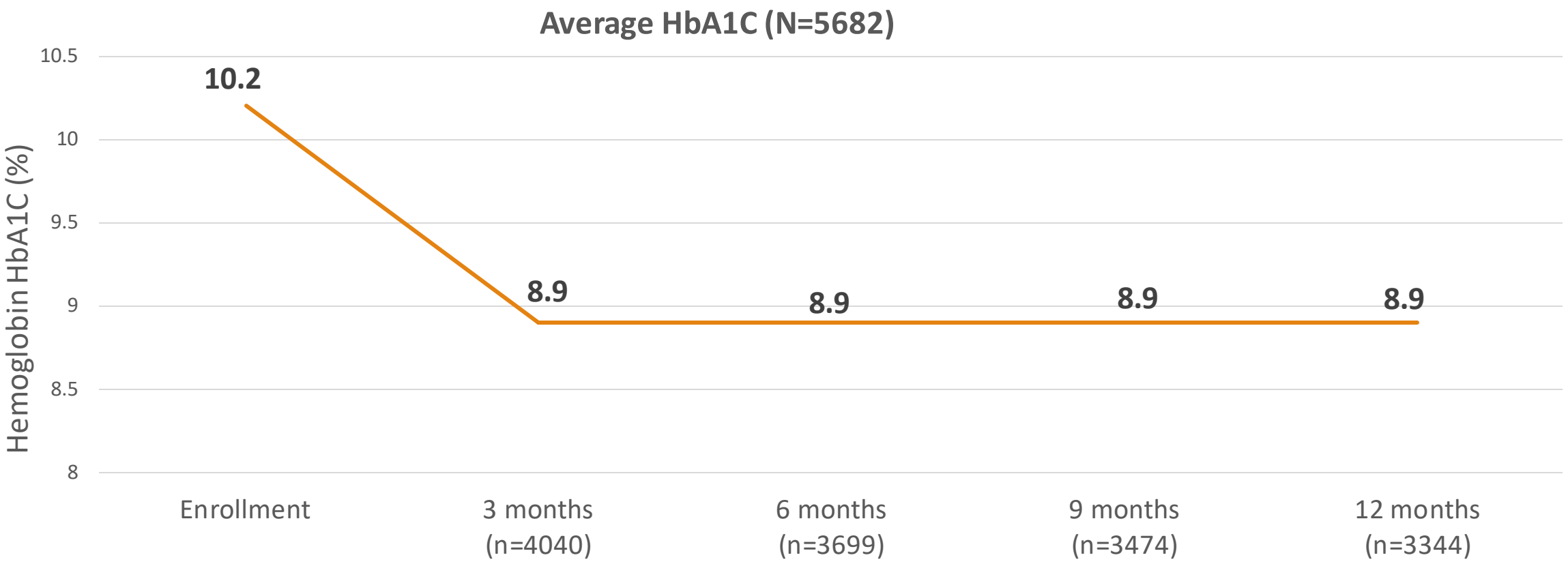
Belinda Reininger, DrPH, Regional Dean

Salud y Vida – Care beyond the clinic

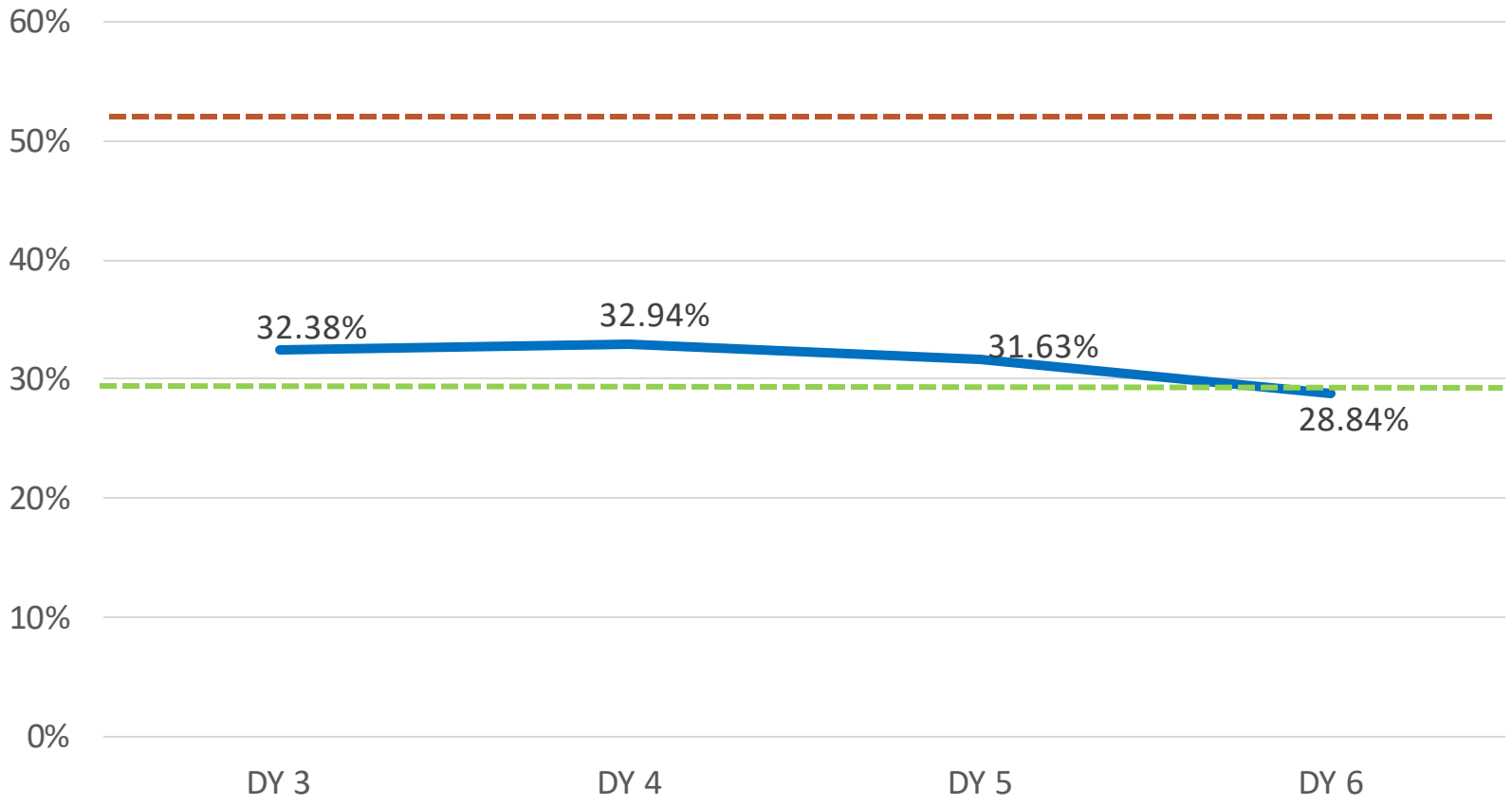


How do we fund a collaborative care model transcending all patient settings?

Mean HbA1c of Salud y Vida Participants 2013-2018



Overall Rate of HbA1c Poor Control in 4 Clinic Partners Implementing Salud y Vida



Minimum Performance Benchmark = 52.2%

High Performance Benchmark = 29.36%

NCQA NQF 0059 guidelines were used to assess HbA1c Poor Control

Who will fund a collaborative care model transcending all patient settings?

Participant Baseline Demographics

High rates of uninsured individuals = No payers

Table 1. Demographic and Baseline Characteristics of Salud y Vida Participants, 2013-2018 (N=5,678)

	N	%		N	%
Gender			**Educational attainment**		
Female	3893	**68.5**	8th Grade or less	2363	**48.1**
Male	1788	31.5	Some High School	916	18.6
Language			High School Graduate/GED	855	17.4
English	1775	31.3	Some college	634	12.9
Spanish	3889	**68.7**	College degree (BA/BS)	126	2.6
Health Insurance			Graduate Degree	23	0.5
Yes	1228	22.6	**Employment status**		
No	44211	**77.4**	Employed	1456	28.5
Income level			Disabled	307	6
$0	694	28	Student	242	4.7
From $1 - $500	430	17.4	Employed	23	0.5
From $501 - $1,000	717	**28.9**	Unemployed	2475	**48.5**
From $1,001 - $2,000	432	17.4	Other	603	11.8
$2,001 or more	206	8.3			

*Information not reported or missing was excluded from this demographic table

How do we sustain a program serving the sickest patients and who are uninsured?

Sustainability Initiatives

1. **DSRIP Cost Benefit Analysis:**
   Using the Center for Health Care Strategies ROI Forecasting Calculator (still underway)

2. **Assess cost effectiveness using economic models:**
   Lifetime Cost Savings:
   QALY 0.2 Yrs: $10,000
   Cost Aversion: $1,429
   $14,429

   Program Costs:
   Per member per year: $1,287.29

   The Salud y Vida program is considered Cost Effective

3. **Sustainability evaluation by consulting agency to explore reimbursement opportunities:**
   Recommendations included scenarios by uninsured, Medicaid, Medicare, and insured covering options such as state and federal funding lines, grant funding through state, federal and local foundations, reimbursement for Diabetes Self-Management program

4. **Alternative payment models:**
   Lack of interest due to small number of MCO patients served
   MCOs are testing their own chronic care management models

Barriers with Current Financing Structure

BILLING IS BASED ON SINGLE PROVIDER MODEL NOT COLLABORATIVE, MULTI-ORGANIZATION MODEL

PROGRAM SERVICES COMPLEMENT THE CLINICAL SERVICES BUT DO NOT CONFORM TO THE BILLING STANDARDS

THERE IS NO REIMBURSEMENT FOR ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN COMMUNITY SETTINGS

Long term impact on low income uninsured individuals

We know that there are disparities in health outcomes for the uninsured when compared to insured patients. The lack of accountability for improving outcomes in the uninsured (value based models are not incentivizing for uninsured pts) may result in increasing these disparities once DSRIP goes away.