WHITE PAPER

Powering VBC Performance with Advanced Analytics

Value-based care (VBC) models that focus on improving care outcomes and reducing the total cost of care are on the rise, and provide tremendous opportunity for payers, providers, and self-funded employers looking to stem the tide of rising healthcare costs and premiums.

The goal is clear: improve care quality and patient outcomes while driving down costs. But achieving that goal – and proving the return on money and time invested in these efforts – is anything but simple. Fragmented data, attribution challenges, and the complexity of defensible benchmarking methodologies make it difficult to track the true impact of VBC initiatives, especially as healthcare organizations and self-funded employers juggle multiple wellness programs and point solutions.

This white paper explores common obstacles in forecasting and quantifying success across various VBC models, and how Cedar Gate's advanced analytics tools – specifically the Impact Tracking and Contract Modeling modules – provide the clarity and confidence needed to move from educated guesswork to data-driven decision-making.

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VBC Performances Goal: Tracking Initiatives & Impacts

THE CHALLENGE

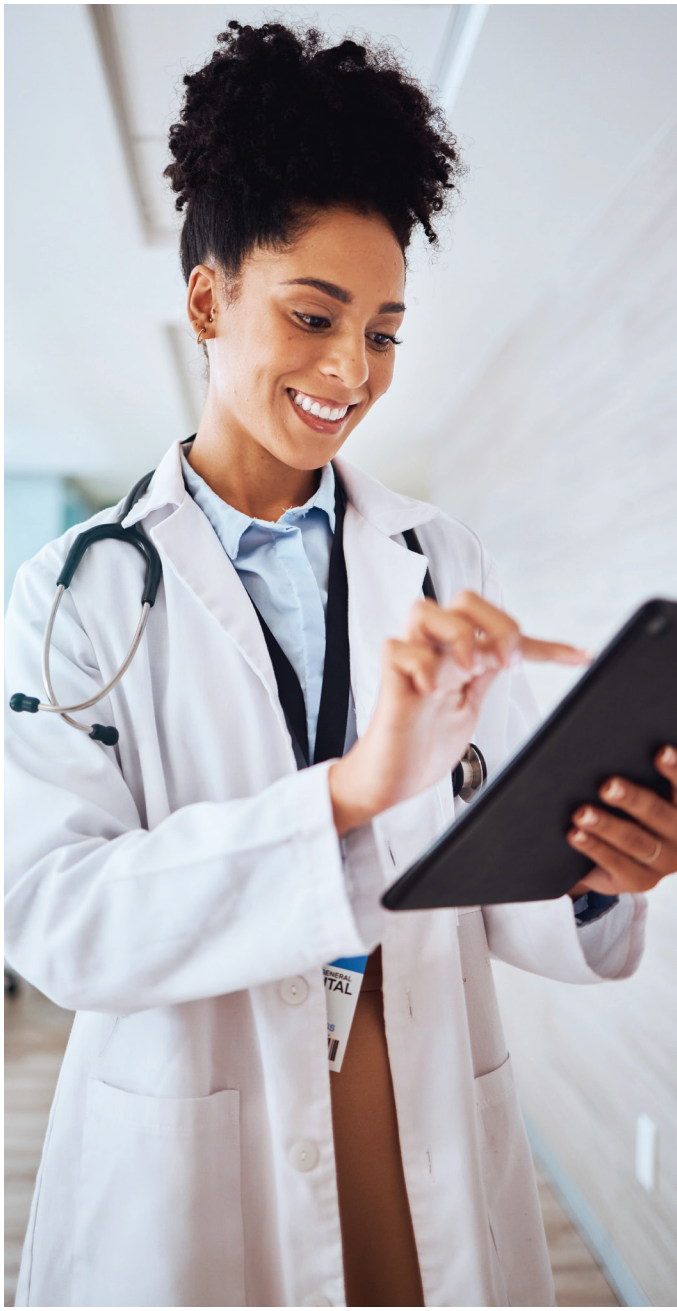
QUANTIFYING THE IMPACT OF COST, QUALITY, AND WELLNESS INITIATIVES

As more healthcare payers, providers, and self-funded employers engage in VBC initiatives and models, there is mounting pressure to prove that these efforts are worthwhile. While there is near-unanimous agreement that a fee-for-service model doesn't work, there is still a lot of debate about exactly *what* model (or models) should replace the old way of doing things.

Value-based care models – from primary care attribution and upside-only programs to prospective bundled payments and capitation with downside risk – all share the goals of lowering total cost of care while improving care quality and patient outcomes. Many commercial payers and their provider partners are engaging in these models in innovative ways to drive down costs for members and patients. Employers and health plans, meanwhile, are continually bombarded with sales pitches on the latest point solutions promising to improve employee health and wellness.

The common denominator among all these programs, payment models, and point solutions is the question everyone wants to answer: ***Is this actually achieving the outcomes we want, need, and expect?***

If answering that question were simple, every payer, provider, and employer would already have a streamlined tech stack and simple reports showcasing the impact of each initiative and program. They would be able to easily identify the most beneficial programs and point solution investments, and could eliminate the ones that were not providing adequate return on time and money invested. Unfortunately, many organizations still lack the tools to make a compelling case for or against their VBC initiatives and point solutions.



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Common Hurdles in Measuring Program Impact

FRAGMENTED DATA LANDSCAPE

Healthcare and patient data remains fragmented and siloed, and most organizations lack the ability to bring it all together – claims, EHR, pharmacy, social determinants of health, and more – into a single, streamlined data source. Without tools to seamlessly integrate the information, staff are forced to utilize incomplete datasets or spend significant time compiling data to even begin to analyze the impact on various programs or initiatives. Without a single data lake, healthcare organizations lack the full picture of patient, member, or employee health and the ability to track a person's journey.

PROGRAM ATTRIBUTION & CAUSALITY

When organizations implement new payment models, cost and quality initiatives, or point solutions for health and wellness, they aren't operating in a vacuum. They are influenced by other programs, patient behaviors, social determinants of health, and other societal trends and factors. That makes it challenging to attribute specific outcomes to individual VBC initiatives, programs, or point solutions.

STATISTICAL SIGNIFICANCE & VALIDITY

In any effort to measure outcomes, participant organizations must contend with the question of whether the outcomes – either positive or negative – are the result of specific actions taken, or are simply due to random chance. Additionally, organizations must be able to measure statistical significance, ensuring that the results come from a VBC program or initiative, and not just data variation.

NUANCES IN COST & QUALITY MEASUREMENT

Quality metrics in VBC programs and models are complex. Today's efforts and investments may take years to manifest in measurable outcomes for a patient or member, making them hard to track for organizations that often can only look at data for only a limited time period. These metrics also must be standardized and tracked appropriately so organizations can analyze the effects.

Unique Challenges for Self-Funded Employers: THE POINT SOLUTION PREDICAMENT

Employers of all sizes face significant burdens as the cost of healthcare continues to rise. Scaling back on benefits or passing on the costs puts companies at a disadvantage in hiring and employee retention, but absorbing the ever-rising costs puts a strain on employers' bottom lines.

Many self-funded employers turn to point solutions – programs targeted at specific health and wellness needs, such as diabetes or mental health – with the goal of improving overall employee health and lowering healthcare costs in the process. HR departments are bombarded with hundreds of options for point solutions. Many of them tout promising studies and data backing up their claims to lower costs and improve employee wellness.

But quantifying the actual impact on employee populations remains a serious issue due to:

- **Fragmented data** makes it difficult to get the full picture of employee health, particularly when point solutions come from a third-party vendor that doesn't play well with your existing core administrative processing systems.
- **Inability to isolate trends** (positive or negative) or attribute success to a single point solution or program since many employees engage with multiple point solutions and programs simultaneously – from EAPs and wellness challenges to telemedicine services and chronic disease management tools.
- **Challenges reconciling data** collected from third-party vendors on engagement, usage, and outcomes with claims data from your health plan, making financial ROI difficult to measure.
- **Confusion about exactly what you should be measuring.** Just because a point solution vendor tracks and reports on a metric doesn't mean it's having a measurable impact on your healthcare costs or employee wellness – for example, a high volume of sign-ups doesn't mean much if those employees never engage with a point solution to see the benefits.
- **Variability in employee populations** can also impact program success. A point solution vendor may have impressive case studies showing success, but variations in employee demographics, job functions, geographic regions, and other variables could render that data meaningless in your situation.

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The Traditional Approach:
GUESSING GAMES, MANUAL WORK, AND WASTED TIME

Nearly every healthcare organization today is dealing with the pressures of shrinking budgets, hiring freezes, and increased demands on existing staff members. Employer HR departments are no different. Those pressures make it extremely challenging to divert enough resources from critical daily tasks to compile reports on the impact of specific cost, quality, or wellness initiatives. For most organizations, the time it takes to pull the information together manually makes it impossible to achieve, so they simply cannot do it.

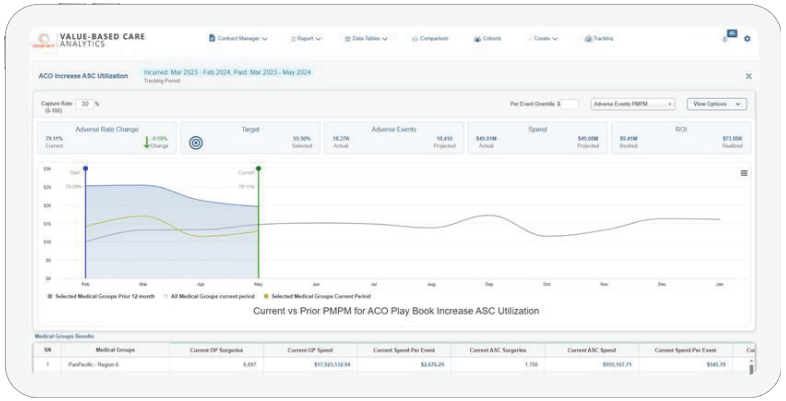
That leaves everyone trying to figure out which initiatives and tools they should keep, and which ones could go. It's a costly guessing game for organizations that want to spend limited dollars wisely to improve individual and population health. But without the tools, and the underlying data to make sense of the metrics and information available, it's the only option for many payers, providers, and self-funded employers.

Those who do try to quantify the results often have to devote significant time and resources to compiling the information manually. Staff must bring together volumes of data (usually into a spreadsheet), attempt to normalize the information from multiple sources into a single, usable format, and then analyze and make sense of the results. In the end, the time it takes to quantify the impact of programs and initiatives negates the savings organizations may have achieved.

The High-Performance Approach: CEDAR GATE'S IMPACT TRACKING MODULE

It's time for a better approach. Cedar Gate's Analytics products (including Value-Based Care Analytics for payers and providers, and Healthcare Benefits Analytics for employers) includes the new Impact Tracking module. It's an industry-leading tool that allows you to go beyond tracking point solutions and measure the success of any value-based care cost or quality initiative, care management program, health and wellness program, or point solution applications.

Upon setup, all the data collection and analysis happen automatically, eliminating manual work to track your programs and freeing up staff to focus on activities and actions that will improve population health.



HERE'S HOW IT WORKS:

1 CREATE THE OPPORTUNITY

When your organization identifies a specific behavior, metric, or program to track, the first step is creating a new opportunity template. Opportunities can include:

Behavior Switch measures the impact of initiatives that encourage a change from one behavior to another. For example, are you effective in your efforts to shift appropriate care from high-cost settings like a hospital to lower-cost settings like a clinical outpatient facility or an ambulatory surgical center?

Behavior Stop measures progress toward goals of stopping behaviors that lead to higher costs or poorer outcomes. For example, how well are you reducing the number of potentially preventable emergency room visits for your patients, members, or employees?

Population Management measures efforts to move members of your population from one cohort to another. For example, how many of your employees with a diabetes diagnosis enroll in and engage with a diabetes management point solution?

2 CONFIGURE THE GOALS

Within each opportunity, you can set up specific KPIs to track, such as the number of events per 1,000, the cost per event, or a target compliance rate for events like preventive screenings. Adjust the parameters to meet your specific needs based on your unique VBC contract, cost savings goals, quality targets, and care management outcome goals.

3 TRACK THE IMPACT

Now the fun part begins – time to track how well your programs are working, and whether you are meeting your goals. Cedar Gate's interface makes it easy to view each opportunity, the tracked parameters, and a chart showing progress over a specified period of time. You can drill down into any data point to see more detail, helping you better understand what's happening and improve programs and initiatives over time. Additionally, since you can see data in near-real time throughout a performance year, you can identify trends (both positive and negative) and adjust to hit year-end goals or improve outreach and other strategies.

Cedar Gate's capabilities also include two critical features to ensure the integrity and validity of any analyses:

- Automatic "zero-day" setting for reports, which aligns data based on a specific trigger event, such as the day someone enrolls in a smoking cessation program. This normalizes reporting along a continuum of activity, rather than showing just a single point in time (since progress can vary widely based on how long they have been in a program).
- Tools to create control groups with demographics similar to members you are analyzing, providing an important check to ensure that results are not random chance.

VBC Performances Goal: Modeling Risk-Based Contracts

THE CHALLENGE

FORECASTING PERFORMANCE IN RISK-BASED MODELS

Risk-based models represent a fundamental shift in healthcare – moving away from fee-for-service payment models that incentivize care volume over outcomes toward models that incentivize high-quality care, cost-effective care. But these models represent a new layer of complexity for participants – both payers and providers – that are now required to take on risk for clinical and financial performance.

Many healthcare organizations have operated in a fee-for-service world for long enough to feel comfortable forecasting financial performance based on historical care volumes. Few have the tools and expertise to confidently forecast performance in a value-based model. Among the challenges that organizations face when trying to negotiate effective contracts or select the most beneficial risk-based model are:

- **Data quality and availability:** Fragmented, low-quality data is at the heart of many issues in healthcare today. Accurately forecasting performance in new payment models requires comprehensive, timely, and accurate data from a wide variety of disparate sources, and the ability to aggregate all that information into a single data source for analysis. Payers and providers often have limited resources to share information, so it remains siloed in claims data (for the payers) and EHR data (for the providers), both of which limit the ability to anticipate population risks, patient needs, and financial performance.
- **Accurate risk stratification:** Entering into alternative payment models (APMs) means taking on risk for the care and outcomes of a patient or member population. Succeeding in these models requires the ability to identify high-risk patients, anticipate healthcare needs, and respond with actionable care team workflows. To generate meaningful insights requires the ability to bring together multiple data sources – including claims, EHR data, social determinants of health, and pharmacy data. Unfortunately, most legacy software designed to optimize fee-for-service simply cannot bring all of that information together in a useful way.
- **Behavioral uncertainty:** Succeeding in VBC models requires buy-in and engagement from everyone – including provider partners and patients. Organizations new to risk-based contracts have no framework to determine the level of risk in their population from patient noncompliance, or estimate how well providers will respond to initiatives and incentives.
- **Incentive alignment between payer and provider partners:** To achieve the performance goals of VBC contracts, payers will often incentivize providers to document risk and close care gaps. Identifying what to do is one thing, but making the data and insights actionable through provider partners is not possible without integrated analytics and care technology that leverages data from a common source.

The Traditional Approach: MANUAL WORK FROM A TEAM OF ACTUARIES

Payers and providers considering – or already engaged in – risk-based and advanced alternative payment models need an understanding of how they might perform in order to choose the best APMs, negotiate contracts, and optimize performance. Typically, payers would need an advanced team of actuaries to:

Analyze historical claims data

Identify trends and patterns in areas of utilization, cost, and outcomes

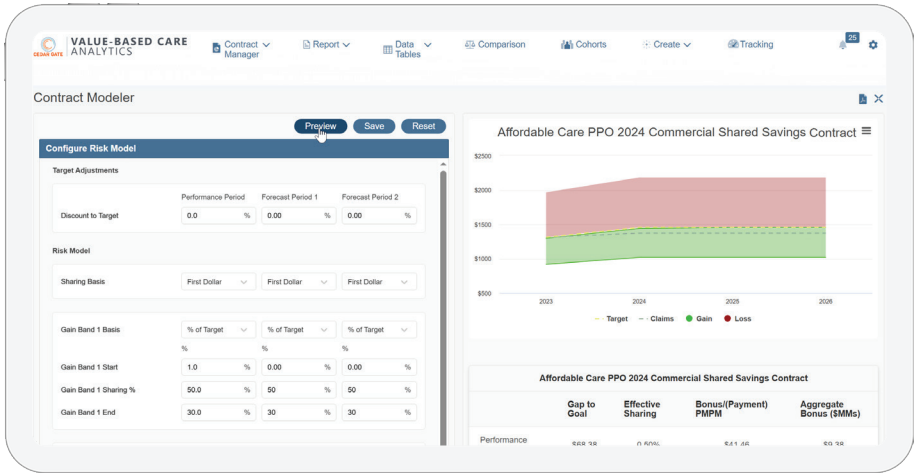
Employ statistical tools that estimate how factors like age, gender, and diagnosis could impact performance in a risk-based model

Model various scenarios and outcomes to assess VBC financial performance

This labor-intensive manual process requires significant human resources with advanced actuarial expertise, which is a substantial investment for any payer considering VBC models. This approach is also limited in its ability to scale as participation in risk-based contracts expands and covered populations grow.

The High-Performance Approach: CEDAR GATE'S CONTRACT MODELING MODULE

Cedar Gate's Contract Modeling module is an advanced capability within our Value-Based Care Analytics platform, designed to completely support the actuarial and financial management of VBC arrangements. It enables users to configure, simulate, and operationalize settlement logic for any APM. The end result is accurate and efficient VBC contract settlement with lower administrative costs, and a tool that is highly configurable to adapt to emerging value-based care models.



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HERE'S HOW IT WORKS:

Advanced data aggregation tools ingest and validate data from CMS files, claims files, enrollment files, risk scores, and quality reports.

Excel-based templates, agnostic to specific contract language, provide complete flexibility to customize based on unique contract parameters and reuse for any future contracts.

Modeling capabilities perform advanced actuarial and financial analysis to estimate contract costs and utilization, as well as identify cost drivers and potential interventions that could bring costs down.

Target tracking monitors cost and utilization targets for providers and ACOs, ensuring accountability throughout a contract lifecycle.

Performance reporting provides regular progress updates throughout the contract period, giving everyone an opportunity to adjust and achieve performance goals.

Settlement and reporting tools facilitate end-of-period contract settlement, reconciliation, and optimization for future improvements.

Users can apply these tools in various scenarios, such as:

- Estimating the financial impact of various VBC contract structures
- Identifying benchmarks and stop-loss thresholds for existing and future contracts
- Negotiating optimal contracts with providers in your network
- Developing effective incentive models for provider partners
- Establishing risk-adjusted cost and utilization benchmarks
- Assessing provider performance across the network to optimize cost and quality
- Reconciling payments at the end of a contract period
- Analyzing trends and modeling various interventions or cost containment strategies to optimize VBC performance over time

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Highly Scalable & Exceptionally Accurate Contract Modeling

What sets Cedar Gate apart from the manual approach, and from other contract modeling software currently available, is our:

SCALABILITY

We tested our software with a large regional payer operating 45 ACOs and more than 100 value-based care contracts, and the tools could easily accommodate all the contract variations with minimal user input.

FLEXIBILITY

The software can be configured based on the unique needs of any organization, accounting for differences in geography, VBC model, population demographics, and more.

ACCURACY

Our software provided accurate settlement reports to within less than 0.2% of a test client's actuarially-derived settlement results.

SELF-SERVICE CAPABILITIES

The robust data foundation and simple user interface make Contract Modeling a user-friendly tool for organizations interested in boosting the productivity of their actuary teams.

Cedar Gate's Contract Modeling is the ideal tool for actuary teams at healthcare delivery organizations who need a self-service tool to manage the entire VBC contract lifecycle, and want to manage it efficiently and accurately with minimal manual work.

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Boost Your VBC Performance WITH THE RIGHT TOOLS

The transition to value-based care demands more than good intentions – it also requires evidence. Unfortunately, the challenges in accurately measuring the impact of VBC programs and forecasting performance in risk-based models have left many healthcare organizations and employers trying to figure it all out on their own. Manual processes, disconnected systems, and limited analytical capabilities make it hard to identify what's working, what's not, and where to invest next.

Cedar Gate's Impact Tracking and **Contract Modeling** modules offer a path to accelerate VBC performance. By automating data integration, enabling real-time performance tracking, and delivering self-service contract modeling for actuary teams, these tools empower organizations to measure and validate success, optimize strategies, align incentives, and achieve sustainable outcomes. In a landscape defined by care model complexity, Cedar Gate delivers clarity – and with it, the ability to lead with confidence in the era of value-based care.

About Cedar Gate Technologies

Cedar Gate enables payers, providers, employers, and service administrators to excel at value-based care with a unified technology and services platform delivering analytics, care, and payment technology on a single data management foundation. From primary care attribution, to bundled payments, to capitation, Cedar Gate is improving clinical, financial, and operational outcomes for every payment model in all lines of business.

To learn more, visit cedargate.com.

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