
THE GOVERNANCE INSTITUTE
A SERVICE OF
nrc HEALTH
The Details of The Business of Disease, Illness & Wellness
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PREPARED FOR:
The Governance Institute Leadership Conference
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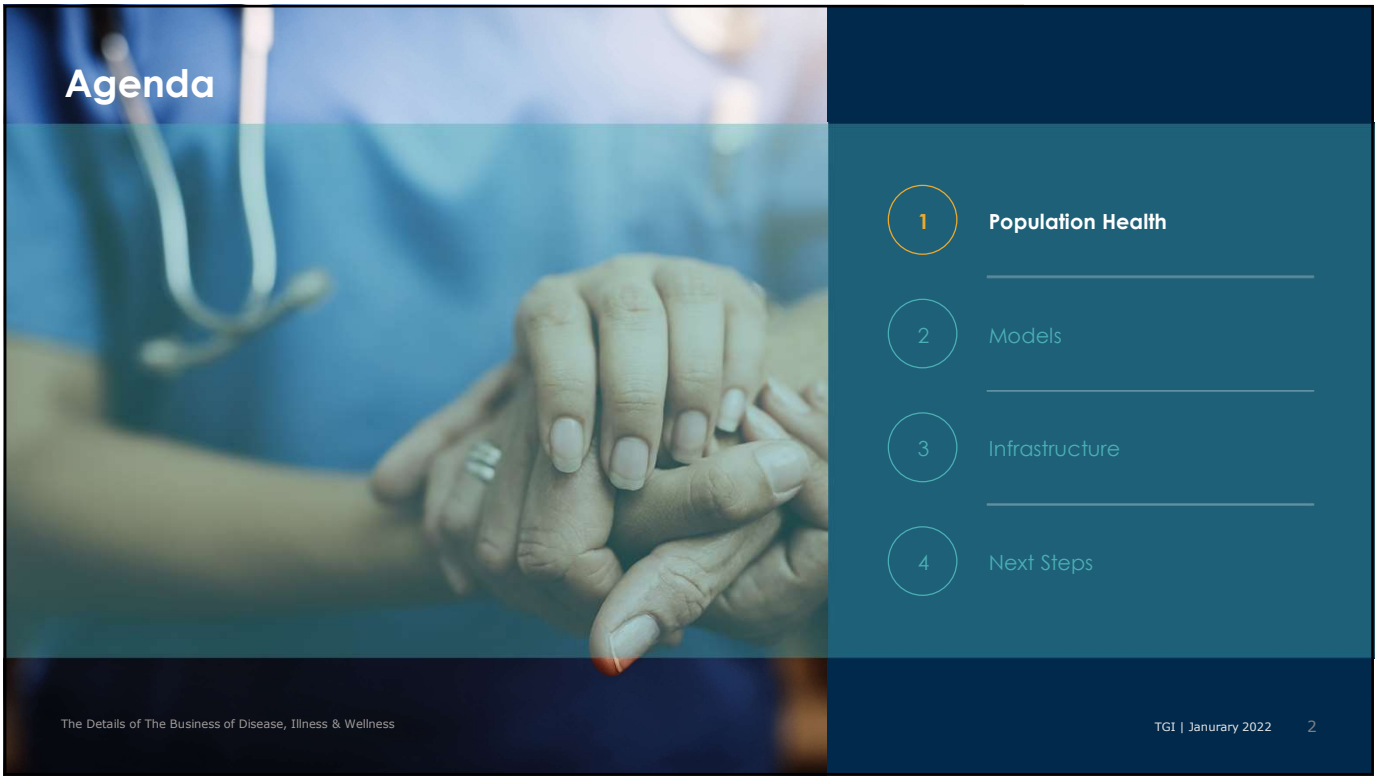
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Population Health Is A Different Philosophy Than Public Health

FIELD	PUBLIC HEALTH	COMMUNITY HEALTH	POPULATION HEALTH
WORKING DEFINITION	Building partnerships that draw on the perspectives and resources of diverse communities and actively engage them in health action	A field of public health which focuses on the study and improvement of the health characteristics of biological communities	The study of the characteristics, activities, and behaviors that lead tend to promote the healthiness of a defined population

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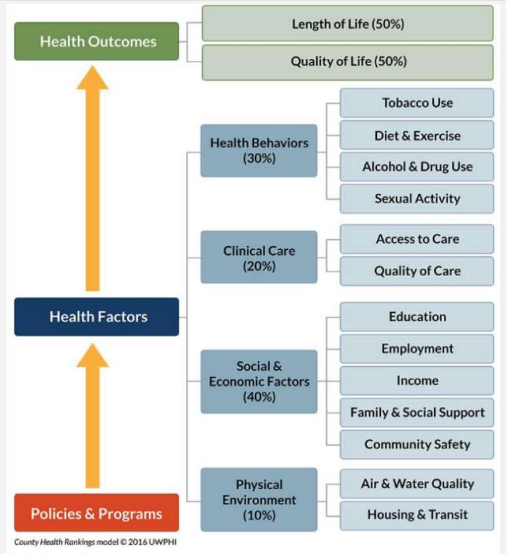
The Data Behind Social Determinants' Contribution to Health



Many analyses and studies have showed that factors other than clinical health care contribute to health[1]

An analysis done with the County Health Rankings model found that the relative contribution of clinical care to health outcomes was less than 20%[2].

If community benefits are intended to serve the underserved and improve the health of communities and populations (emphasized through policies in the ACA), then we should be addressing the other contributing factors, not just subsidizing clinical care.

It remains up for debate who should be responsible for tackling the non-clinical drivers – health care providers, community-based social service organizations, government, individuals, etc.

Sources: 1. CDC Research on Social Determinants of Health; 2. County Health Rankings Model, and Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

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Population Health Management Operations = Value Care Delivery

Identify Population and Create Registry
- Risk Contract (Medicare Advantage, Commercial, Medicaid, Employer)
- Fee For Service with Attribution (Medicare, Commercial)

Perform Meaningful Analytics
- HRA
- Claims Data
- Clinical Data
- Lab Results
- Pharmacy

Create Functional Segments
- Preventive Screenings
- At Risk
- Chronic Disease Gaps in Care
- High Cost

Stage and Target Interventions
- Case Management
- Care
- Management
- Social
- Workers
- Medication Reconciliation
- Transitions In Care
- Referral Management
- Remote Monitoring

Measurement and Monitoring
- Quality
- Cost

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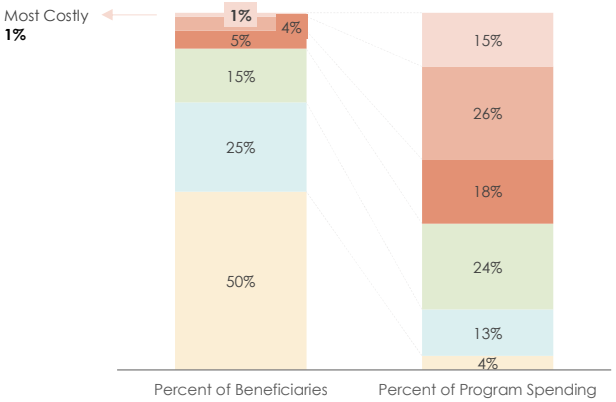
A Small Portion of Patients Are Responsible for Outsize Costs

Medicare Spending by Fee-For-Service Beneficiary Segment, 2014



Source: 1. MedPAC Analysis, 2014 2. Powers, B.W. and S.K. Chagaturu, "ACOs and High Cost Patients", New England Journal of Medicine, Jan 2016 CareFirst Book of Business 2010, CareFirst Health Care Analytics

Of the **costliest 1%*:**

88%
have hypertension

67%
have chronic kidney disease

64%
have ischemic heart disease

61%
have congestive heart failure

60%
have hyperlipidemia

On average, have **8**
co-occurring chronic conditions

*Data on right-hand sides applies specifically to Medicare patients seen at Partners Health Care in 2014, whereas left-hand side applies to all Medicare beneficiaries

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Key Insights To Operationalize Population Health Management

- Accurately assess population health market opportunity
- Develop clinical leadership
- Contracting expertise including alignment of incentives across contracts
- Functional IT system including analytics and workflow
- Effective patient segmentation and interventions
- System of care designed around the patient (vs. office transformation)
- Engaging and activating patients
- Identify and foster a performance network
- Strategic selection of partners including community organizations
- Incentives aligned with transparent clinical and financial performance metrics

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The Shift To Value

Traditional Care		Value-based Care
Complicated healthcare system confuses and frustrate consumers	**Consumer experience**	Consumers are at the center of the healthcare system, empowered with more information and support
Reactive, transactional care delivered in response to an injury or illness	**Care delivery**	Proactive, preventive care, with an emphasis on keeping people healthy
Lack of technology and incentives for physicians to coordinate patient care	**Care coordination**	Physicians empowered by new technology, data and financial incentives to coordinate care
Data trapped inside massive repositories; lack of sophisticated analytics	**Data and information**	Data can be mined to identify patient health risks, improve care coordination and enhance efficiency
Costs climb without corresponding health improvements	**Costs**	Insurance companies and care providers are paid based on quality and patient health improvements

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CMS Is Taking a Multipronged Approach

HHS

- Reducing and preventing healthcare associated infections
- Reducing and preventing adverse drug events
- Community living council
- Multiple chronic conditions
- National Alzheimer's project act
- Partnership for patients
- Million hearts
- National quality strategy
- Data.gov

CMMI and Medicaid

Pay bonuses when providers demonstrate improvements in quality care and cost-effectiveness; while providers continue to be paid on a FFS basis, they also are paid a bonus when they meet or exceed certain goals or benchmark

Program Integrity

Shared Savings Model: provider / payer share episodic risk model where gains / losses are shared

Prospective Risk Model: provider takes on 100% risk for full episode

Coverage

Allows providers to share in healthcare savings if providers perform services at cost below established benchmarks

Rewards mgmt. of overall costs and reductions in spend below an expected level set by the payer (e.g. target MLR)

Quality and Public reporting

Participate in HC savings, but are also liable to refund services if expenses exceed agreed-upon costs

Paid as FFS until year-end true-up: savings bonus if cost / quality goals are met, at risk for a portion of spend that exceeds cost targets

Clinical standards

Fixed amount of money per service

Payment per service provided; incentivizes quantity of procedures over quality of care

Quality improvement

Pay bonuses when providers demonstrate improvements in quality care and cost-effectiveness; while providers continue to be paid on a FFS basis, they also are paid a bonus when they meet or exceed certain goals or benchmark

Value-based purchasing

Shared Savings Model: provider / payer share episodic risk model where gains / losses are shared

Prospective Risk Model: provider takes on 100% risk for full episode

Payment

Allows providers to share in healthcare savings if providers perform services at cost below established benchmarks

Rewards mgmt. of overall costs and reductions in spend below an expected level set by the payer (e.g. target MLR)

Survey and Cert.

Participate in HC savings, but are also liable to refund services if expenses exceed agreed-upon costs

Paid as FFS until year-end true-up: savings bonus if cost / quality goals are met, at risk for a portion of spend that exceeds cost targets

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Multiple Payment Models

LEVEL OF FINANCIAL RISK & DEGREE OF CARE PROVIDER INTEGRATION AND ACCOUNTABILITY

		FFS	FFS + Incentive	Bundled Payments/ Episodic Care	Upside-Risk Model	Full-Risk Model	Capitation Model
	Key Delivery Model Elements/ Contracting Structure	Fixed amount of money per service Payment per service provided; incentivizes quantity of procedures over quality of care	Pay bonuses when providers demonstrate improvements in quality care and cost-effectiveness; while providers continue to be paid on a FFS basis, they also are paid a bonus when they meet or exceed certain goals or benchmarks	Shared Savings Model: provider / payer share episodic risk model where gains / losses are shared Prospective Risk Model: provider takes on 100% risk for full episode	Allows providers to share in healthcare savings if providers perform services at cost below established benchmarks Rewards mgmt. of overall costs and reductions in spend below an expected level set by the payer (e.g. target MLR)	Participate in HC savings, but are also liable to refund services if expenses exceed agreed-upon costs Paid as FFS until year-end true-up: savings bonus if cost / quality goals are met, at risk for a portion of spend that exceeds cost targets	Fixed amount of money per patient per unit of time (e.g. PMPM) Provider takes on insurance risk for covered lives Fees are adjusted to reflect the acuity or risk level associated with the patient population
	Typical Providers/ Examples	Majority of provider organizations (e.g., Dental, Dermatology, Vision, Autism, etc.)	Performance-based programs include primary care incentives, as well as hospital and physician performance-based contracts	CMS BPCI OB / GYNs Orthopedics, incl. Optum Center of Excellence Model for Hip / Knee Cardiology	MSSP ACOs Large, integrated MSGs	MSSP ACOs Large, integrated MSGs	Medicare Advantage Primary Care Physicians
Situation Analysis: Impact of Population Utilization Changes to Provider Profits	Utilization Increases	↑	↑	↓	↔	↓	↓
	Utilization Decreases	↓	↓	↑	↑	↑	↑

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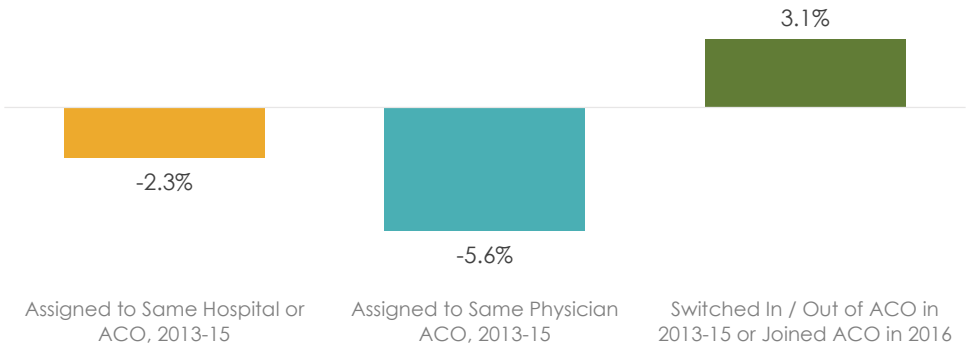
It takes time for an ACO to decrease spending on patients; initially, ACOs increase spending

Spending Growth Relative to the Market Average: Percentage Point Difference
2012-2016



Source: MedPAC, 2017

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ACOs' Strategies for Transitioning to Value-Based Care Lessons From the Medicare Shared Savings Program

U.S. Department of Health and Human Services
Office of Inspector General

- Focused on better supporting physicians
- Improved patient relationships, including increasing the number of annual wellness visits
- Doing a better job of managing beneficiaries with costly or complex care needs
- Managing hospitalizations, working to reduce avoidable hospitalizations, and finding alternatives to the emergency department
- Managing relationships with skilled nursing facilities and home health by creating lists of preferred providers and doing warm handoffs into and out of post-acute care
- Working to address behavioral health needs and the social determinants of health
- Using technology to improve care coordination and overcome interoperability issues.

https://oig.hhs.gov/oei/reports/oei-02-15-00451.pdf

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CMS & CMMI Have Evolved Their Models

MSSP BASIC Tracks | MSSP ENHANCED Track | Next Generation ACOs | Direct Contracting Entity ("DCE")

Direct Contracting Overview

- **The Direct Contracting Model** builds upon the Next Generation ACO Model and elements of MA, offering higher levels of risk and reward than the MSSP
- DCEs will have a 5-year payment model starting in 2021, with the following types:
  - Standard: organizations with experience serving Medicare FFS populations, including traditional ACOs; minimum of 5,000 beneficiaries
  - New Entrant: entities with limited historical experience serving Medicare FFS patients; minimum patient count of 1,000, increasing each successive year by 1,000
  - High Needs: organizations that focus on high-needs individuals, including significant disabilities / chronic illness; minimum patient count of 250, increasing by 250 — 450 beneficiaries each successive year
- DCEs will earn savings or pay losses based on their performance compared to a prospectively set financial benchmark
- CMS will apply risk bands, which have cutoffs for the proportion, but not the absolute limit, of savings or losses the DCE earns / pays

DCE Payment Models

Professional
- Lower-risk model option that will provide a capitated payment for enhanced primary care services
- 50% shared savings / losses
- Will capitalize on MA risk adjustment rate calculations

Global
- Offers greater risk sharing, and provides two payment options: Primary Care Capitation and Total Care Capitation
- 100% shared savings / loses
- Will capitalize on MA risk adjustment rate calculations

Geographic
- Open to health plans and entities interested in taking on financial responsibility for all FFS patients in a region
- 100% shared savings / loses
- Will capitalize on MA risk adjustment rate calculations

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The Quality Payment Program: MIPS and Advanced APMs

There are two ways to participate in the Quality Payment Program (QPP) in Medicare; one entails a payment adjustment through Merit-based Incentive Payment System (MIPS) and the other rewards participation in an Advanced Alternative Payment Model (APM)

There are 2 ways to take part in the Quality Payment Program

MIPS
CMS.gov

MERIT-BASED INCENTIVE PAYMENT SYSTEM

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS

A rare perfect MIPS score is estimated to return a **4.7%** payment adjustment

OR

Advanced **APMS**

ADVANCED ALTERNATIVE PAYMENT MODELS

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model

Qualifying providers (QPs) receive the **5%** lump sum bonus* automatically

Advanced **APMS**

- Bundled Payments for Care Improvement - Adv. (BPCI-A)
- Comprehensive ESRD Care (two-sided) (CEC)
- Comprehensive Primary Care Plus (CPC+)
- MSSP 1+/2/3 (old), Basic-E/ Enhanced (new)
- Next Gen ACO Model
- Oncology Care Model (two-sided) (OCM)
- Complete Joint Replacement Payment Model (CJR)
- VT/MD state programs

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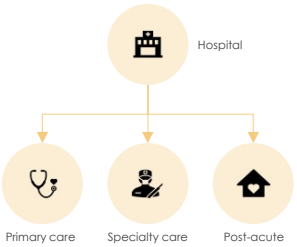
Form Follows Function – Infrastructure Needs to Be Aligned With Strategy

HOSPITAL-CENTRIC

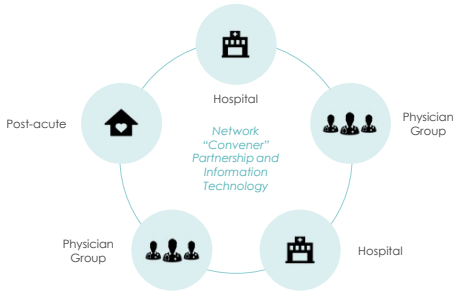
Success requires developing and aligning with referral networks to drive inpatient volume to centralized hospital facilities



Ambulatory network ownership and clinical program development

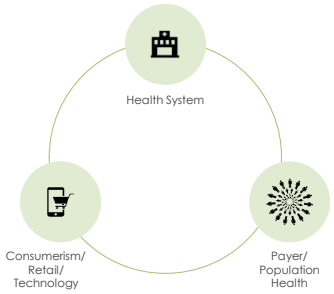
NETWORK-CENTRIC

Success requires participating in heterogeneous networks, consisting of aligned, un-aligned, and competitive members, to improve the health outcomes of populations



HEALTH-CENTRIC

Success requires caring for the whole patient through expansion into businesses beyond the core provider business such as payer, technology, retail, etc.



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Distinct Capabilities Required for Value Care Delivery

A. Network Management
- Community, primary, specialty, acute and PAC network
- Performance expectations required to optimize patient health, care value creation, and contract performance

B. Clinical Management
Provider accountabilities specific to care delivery, including:
- Panel management
- Care planning, coordination and oversight
- Adherence to clinical pathways

C. Care and Service Management
- Capabilities required to optimize health, provider care delivery and contract performance;
- Wraparound services to align care value with contract performance

D. Utilization Management
Capabilities to:
- Minimize clinical variation
- Evaluate medical necessity, appropriateness, and efficiency of the utilization

E. Data, Analytics, and Reporting
Population analytics to provide insights and optimize patient health:
- Cohort segmentation
- Risk stratification
- Performance reporting to provide insight into contract performance

F. Contracting
Contracting strategy to align incentives and promote capabilities that create value

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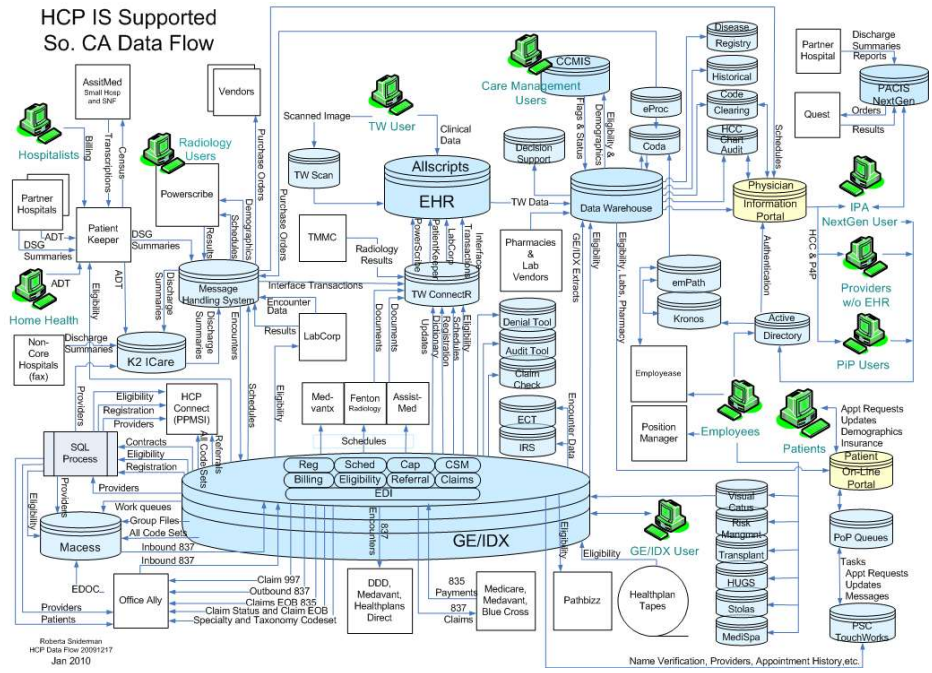

Source: ACHE Presentation Silverstein and Margolis

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Initiatives across the care continuum will have different payoff periods

Time To Impact

- **3-6** Months
- **6-12** Months
- **12-18** Months
- **2-5** Years

- Pharmacy management
- Preventative care; screening; lifestyle; wellness
- Interventions for low-risk chronic disease: disease registries, chronic disease case optimization
- Case management for high-risk chronic patients with targeted conditions (e.g. CHF, COPD)

- More efficient specialists and ancillary providers
- High-end imaging
- Manage transitions of care
- Nursing home management

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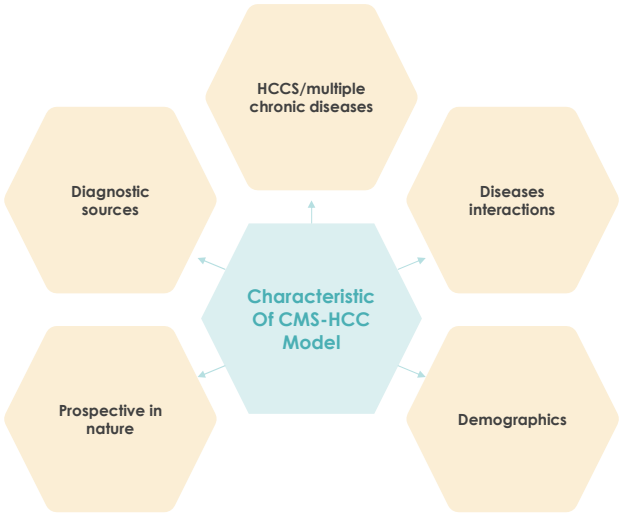
Risk Adjustment Matters—5 Characteristics of CMS-HCC Model



1. Prospective in Nature

Diagnosis from base year used to predict payment for next year

New Enrollee vs. Existing Enrollee

2. Diagnostic Sources

CMS Will Only Consider Diagnoses from IP & OP Hospital & Physician Data

3. HCCS/multiple chronic diseases

Base payment for each member based on HCCs and Influenced by Medicare Costs for Chronic Diseases

4. Diseases Interactions

Additional factors applied when hierarchy of more severe and less severe conditions co-exist

5. Demographics

Final adjustment due to: age, sex, original medicare entitlement, disability & Medicaid status

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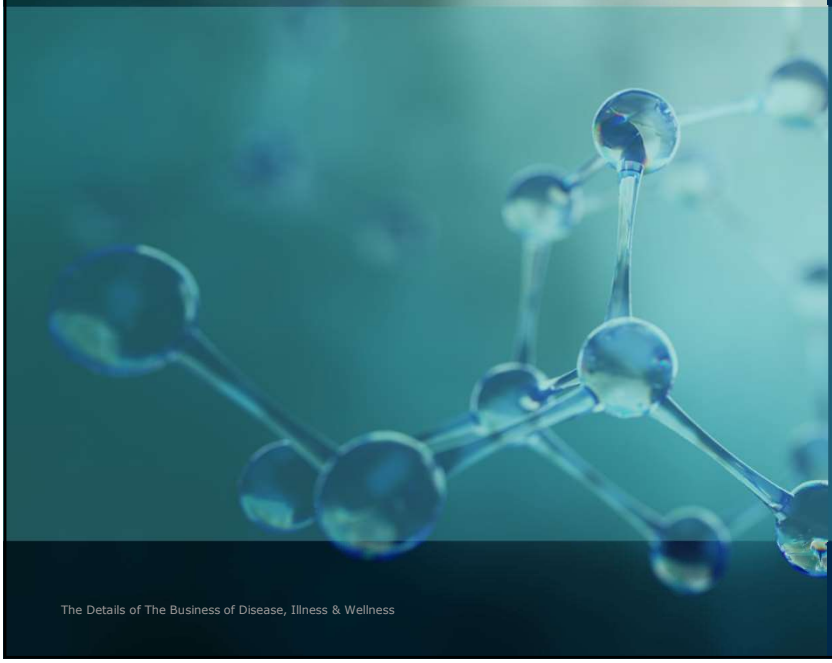

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Summary: COVID-19 affected hospital adequacy indicators, but they remained generally positive

Beneficiaries' access to care	Quality of care	Hospitals' access to capital	Medicare payments and hospitals' costs
• Excess capacity in aggregate • Fewer closures • Decline in volume reflects PHE • Positive marginal profit	• Measure changes not indicative of changes in quality or payment adequacy	• All-payer total margin remained strong, due to substantial federal support • Near record high margin for rural hospitals	• Medicare margin still negative but remained steady • Relatively efficient hospital margin 1%

Note: Provider Relief Funds (PRF).

MEDPAC

Results are preliminary and subject to change

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Summary of our assessment of the adequacy of payments for physicians and other health professionals

Beneficiaries' access to care	Quality of care	$ Clinicians' revenues and costs
▪ Beneficiaries' care experiences are comparable to privately insured people and to pre-pandemic years ▪ Number of clinicians stable ▪ Volume of clinician encounters per beneficiary declined in 2020 due to pandemic	▪ Wide variation in rates of ambulatory care-sensitive hospitalizations and ED visits ▪ Patient experience scores remain high	▪ Medicare payments to clinicians declined by $9B in 2020, but clinicians received tens of billions of dollars in relief funds ▪ Medicare payments per beneficiary decreased during 2020, then rebounded ▪ MEI expected to grow 1.8% in 2023 ▪ Commercial payment rates exceed Medicare's rates ▪ Physicians' compensation increased from 2019 to 2020 despite the pandemic

MEDPAC

Note: ED (emergency department), (MEI) Medicare Economic Index. Data are preliminary and subject to change.

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Considerations for the Chair's draft recommendation

- Maintain payments high enough to ensure beneficiaries' access to care
- Maintain payments close to hospitals' cost of efficiently providing high-quality care
- Maintain fiscal pressure on hospitals to constrain costs
- Minimize differences in payment rates for similar services across sites of care

➔ *To the extent coronavirus public health emergency continues, any needed additional financial support should be separate from annual update and targeted to affected hospitals that are necessary for access*

MEDPAC 22

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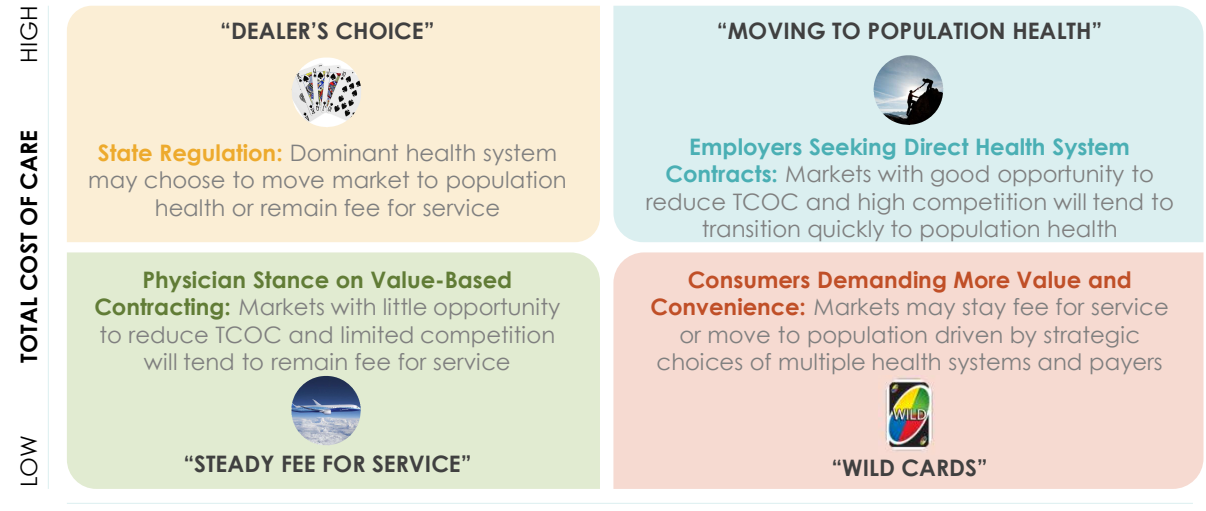
Population Health Uptake Varies by Market



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Balance between proactive or reactive path in transition to value

Health systems must strike a balance between moving too fast and moving too slowly in the transition towards risk/value

Capabilities for Value-Based Care

Value-Based Contracts

TIMING MATTERS

Premature

Contracts before sufficient capabilities to be successful on new arrangements

Well-Timed

Transition contracts strategically while building capabilities.

Lagging

Delay building capabilities and focus on fee for service – and risk being caught unprepared

Risks with Moving Too Fast

- Reduced reimbursement rates
- Lower utilization driven by own organization
- Limited gains in market share for being low cost/high quality relative to market
- Unnecessary infrastructure investment

Risks with Moving Too Slow

- Lost market share through tiered/narrow networks
- Reduced utilization driven by other organizations
- Inability to capture dollars for reduced utilization
- Limited leverage for aligning other providers
- Allowing others to dictate your future

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The role of Consumers and Disruptors

Physicians (and traditional acute care providers) will need to determine how to address increasingly demanding consumers, as well as the market 'disruptors' seeking to meet consumers' demands. Getting leap-frogged will lead to a decline in practice activity and erosion in positive financial margin.

- Rapid access
- Efficient service
- Convenience
- High-value (low cost, high quality)
- Price transparency
- Sophisticated electronic patient portal or platform

- Urgent care, retail clinics, telemedicine, e-visits, mobile health
- Low-cost diagnostic centers or devices
- Price transparency platforms
- Integrated narrow networks, direct-to-employer

POTENTIAL STRATEGIES TO AVOID BEING 'LEAP-FROGGED':

Partner with Disruptors	**Offer Similar Services/** Compete with Disruptors	Form a **High-Value Narrow Network** to Enhance Patient Retention

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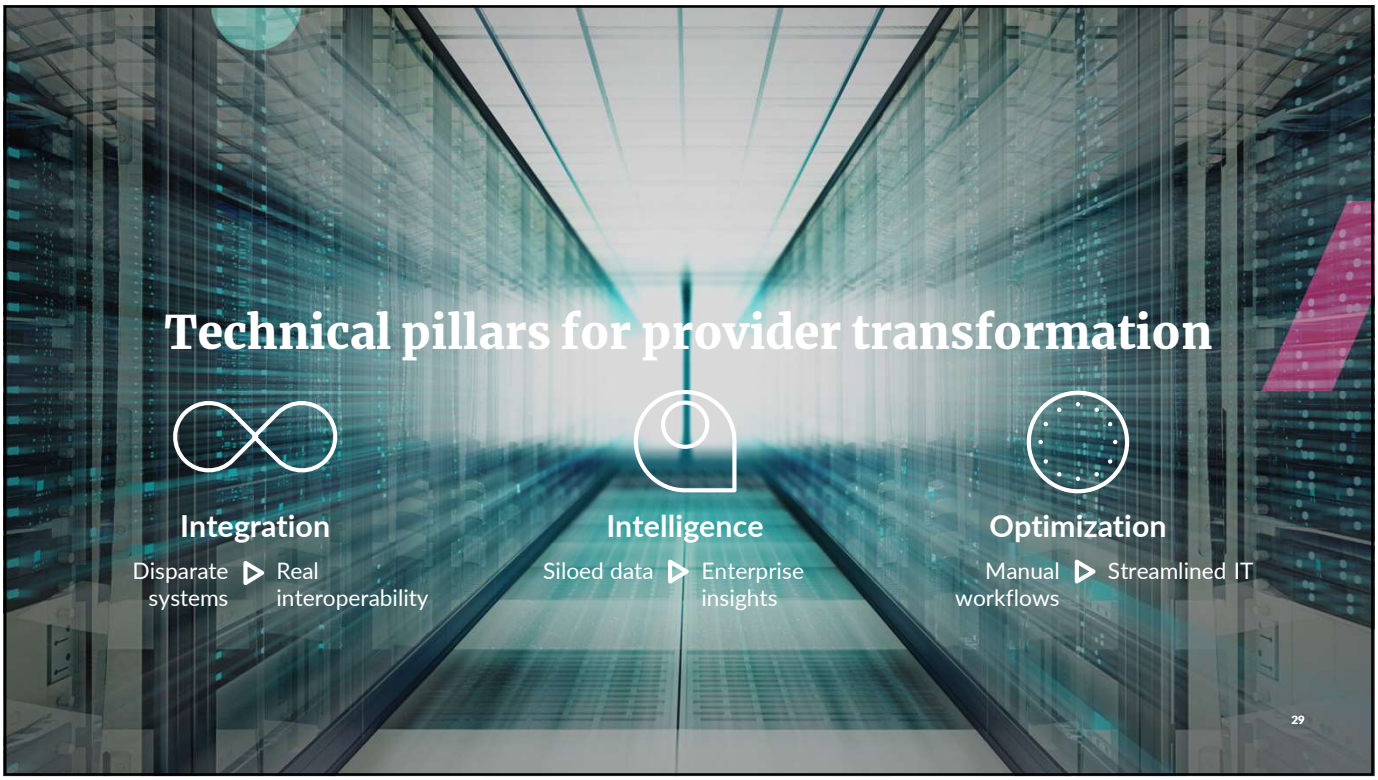

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Strategies for transitioning to value-based care can also support fee for service

Focused on better supporting physicians

Doing a better job of managing beneficiaries with costly or complex care needs

Managing relationships with skilled nursing facilities and home health by creating lists of preferred providers and doing warm handoffs into and out of post-acute care

Using technology to improve care coordination and overcome interoperability issues.

Improved patient relationships, including increasing the number of annual wellness visits

Managing hospitalizations, working to reduce avoidable hospitalizations, and finding alternatives to the emergency department

Working to address behavioral health needs and the social determinants of health

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THANK YOU

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