Population Health and the Accelerating Leap to Outcomes-Based Reimbursement

Craig J. Wilson
Agenda / Goals

- Define Population Health Management
- Review emerging reimbursement landscape eg MACRA
- Review why PHM is critical to success in these new reimbursement models
- Offer tactics for success
Population Health Definition

- Population Health - "The health outcomes of a group of individuals, including their distribution".
- Population Health Management - "The use of a variety of interventions to help improve the morbidity patterns and health care utilization behavior of defined populations".

Ultimately it is.....

- The necessary framework to support risk-based contracting by maximizing the value provided to a population......
- Where Value = Quality / Cost
The Iron Triangle of Health Care

Cost

Access

Quality

Population Health

Experience of Care

Provider Experience

Per Capita Cost
A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

### Overall Health Care Ranking

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<thead>
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<th>Low</th>
<th>High</th>
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The Cost of a Long Life

Average Life Expectancy vs. Per Capita Spending (International Dollars)

Countries included: Japan, San Marino, Monaco, Switzerland, Australia, Sweden, Iceland, Andorra, Canada, France, Italy, Austria, Spain, Norway, Singapore, Israel, Luxembourg, New Zealand, Netherlands, Germany, Greece, Malta, Belgium, Finland, United Kingdom, Denmark, United States, Cuba, Cyprus, Ireland, Portugal.
The ground rules are changing

- CMS is accelerating away from fee for service
- MACRA is a full-on game changer
- 90% of federal payments will be tied to quality by 2018
MACRA - Medicare Access and CHIP Reauthorization Act

- Passed by Congress 4/1/15 to repeal SGR formula

- Moves all providers towards reimbursement based on outcomes, not services rendered

- Consolidates meaningful use, VBP modifier, PQRS into a single budget neutral "Quality Payment Program"

- Includes MDs, PAs, NPs, CRNAs, CNSs

- Excludes IPPS, OPPS, ASCs, anyone in 1st year of billing, groups with <$30K charges or <100 patients
Performance Year 2017

Data Submission March 31, 2018

Feedback

Payment Adjustment January 1, 2019

2015 – 2019: 0.5% annual update

2020 – 2025: Frozen payment rates

Advanced Alternative Payment Models (APM): 2026 and on 0.75% annual update

The Merit-Based Incentive System (MIPS): 2026 and on 0.25% annual update
MACRA Option 1: MIPS

- **Merit-Based Incentive Payment System**
  - Most MDs are going to fall under MIPS track
  - MDs be automatically assigned to MIPS unless in an APM or otherwise exempt
  - Will trigger progressive bonuses or penalties in 2019
  - MIPS Data will be publicly reported, with a 30day preview period for MDs
MIPS performance categories

- Quality 60% (30% by 2021)
- “Cost” Resource Use (excluding part D) (0% weight in 2017 - 30% by 2021)
- Clinical Practice Improvement Activities 15%
- Advancing Care Information 25% (replaces Meaningful use)

Reporting can be at the individual or group level.
How do performance scores translate into a payment adjustment?

1. Clinicians/groups/APM entities will be assigned a performance score of 0-100.

2. This score will be compared to the performance threshold (PT): either the mean or the median of the composite performance scores for all MIPS participants.

3. Clinicians/groups/APM entities that fall above the PT will receive bonuses, whereas clinicians that fall below the PT will face penalties.
Bonuses / Penalties under MIPS

Bonus for ultra high performers

Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool.
Impact of MIPS on CMS provider payment

1) Relative Value Unit.
2) Medicare Physician Fee Schedule.
3) Merit-Based Incentive Payment System. =NEW
MACRA Option 2: APM (Alternative Payment Model)

- 5% annual payment increase 2019-2024
- Exempted from MIPS reporting requirements
- Have to be in an advanced APM to qualify
- Criteria = 25% CMS revenue & 20% patient counts tied to a single APM or multiple APMs
- If you qualify you can't opt into MIPS instead
- You can 'partially qualify' and lose the 5% bonus but opt out of MIPS.
“Advanced" APMs Include

- MSSP ACO Tracks 2&3
- Next Generation ACOs
- CPC+ (Indiana not part of this yet)
- Medicare Advantage (starting 2021)
- Oncology / ESRD risk-based models
Top MIPS performers could out-earn APM participants for years

Source: Data compiled based on fee update and performance-based bonuses and penalties under the two incentive programs outlined in the Medicare Access and CHIP Reauthorization Act of 2015.

Note: Advanced APM line excludes contract performance and MIPS excludes the use of a conversion factor that can magnify a MIPS bonus or penalty by as much as three times to ensure budget neutrality.
APM Track requires risk

- Threshold to trigger loss must be 4% or less
- Loss sharing must be at least 30%
- Max possible loss (stop loss) must be at least 4%
- Remember....this risk may be for both Part A & Part B revenue!
What if I'm in a PCMH?

- **Medical Homes get preferential Rx under MIPS** as long as accredited by NCQA, TJC, AAAHC, or URAC

- **Automatically receive full credit in the MIPS CPIA category**
What if I'm in an ACO?

- Track 1 MSSP ACOs don't qualify as an advanced APM
- Do qualify for the "MIPS-APM Scoring Standard"
- To receive this you report to MIPS via the ACO
- All MDs in the ACO get the same score
What if I'm in an ACO?

**MIPS/APM Scoring Categories are adjusted as follows:**

- No Resource Use score
- CPIA **15%** - you automatically get 50% credit
- ACI **25%**
- Quality still **60%** and reports via ACO (GPRO)
- CPIA and ACI report MIPS data using the ACO TIN
MDs can now ease in to MACRA

Was 2 - now 4 options for participation in year 1: 2017

1. "Test" under MIPS - submit some data by 3/31/18 to avoid a negative payment

2. Start some time 1/1/17-10/2/17 to qualify for a small bump under MIPS

3. Participate for full calendar year 1/1-12/31/17 under MIPS

4. Participate in an advanced APM for 5% bump in 2019
FFS to FFV Transition Models for MD Compensation
Employed MD Compensation Modeling under MACRA

- Transition to panel size over RVUs?
- What is the appropriate blend of panel size vs RVUs?
- Incent wellness visits and coordinator engagement
- Link panel size to access metrics?
- What is the appropriate blend of productivity vs quality metrics?
Value-Based Reimbursement Is Already Here

Hospital Medicare Payment at Risk, Year by Year

- **Value-Based Purchasing**
  - Oct 2010: 1%
  - Oct 2011: 2%

- **30-Day Readmissions**
  - Oct 2012: 1%
  - Oct 2013: 2%
  - Oct 2014: 3%

- **Hospital-Acquired Conditions**
  - Oct 2015: 1%

**Total**

- Oct 2016: 2%
- Oct 2017: 3%
- Oct 2018: 5%
- Oct 2019: 6%

Source: Sg2
Don’t Forget About Bundling

Accountable Care Organizations

- Primary Care Physicians
- Specialty Care Physicians
- Outpatient Hospital Care and Ambulatory Surgery Centers
- Inpatient Hospital Acute Care
- Long-Term Acute Hospital Care
- Inpatient Rehab Hospital Care
- Skilled Nursing Facility Care
- Home Health Care

- Acute Care Bundling
- Medical Home
- Acute Care Episode with Post Acute Care Bundling
- Post Acute Care Episode Bundling

Source: American Hospital Assoc.
The Current Challenge

To prepare for the future environment of increased integration and population health while growing and prospering in the current environment of FFS payment and financial uncertainty.
Siloed Costs

- Invest in analytic system
- Convert practices to medical homes
- Redirect RN time for group visits
- Implement family education classes
- Embed care manager in the ED

Enterprise-Wide Returns

- Reduction in unnecessary hospitalizations
- Reduction in inappropriate ED utilization
Enhanced performance in risk-based / capitated models

**Siloed Costs**
- Invest in analytic system
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**Enterprise-Wide Returns**
- Reduction in unnecessary hospitalizations
- Reduction in inappropriate ED utilization
- Increase in primary care visits

*Enhanced performance in risk-based / capitated models*
So...How do I thrive under the new rules of engagement?

- Don’t be a dinosaur – embrace change / engage
- Medical practice is now officially a team sport
- Begin to appreciate the following slide....
Social determinants are stronger determinants of health outcomes than medical care provision.
'Top 10 PHM Tactics'

1. Embrace Wellness concepts

2. Engage front line Providers in Governance planning & be transparent with data

3. Maximize HCC / RAF process to accurately reflect acuity and maximize risk adjustment

4. Look at where your expenditures are

5. Look at where your opportunities are
Six. Don't waste resources on futile interventions

Seven. Attract and retain low risk patients

Eight. Monitor market leakage

Nine. Use ACO waivers to your advantage

Ten. Don't silo your PHM initiatives by payer
Ambulatory Tactics

- WELLNESS VISITS. WELLNESS VISITS. WELLNESS VISITS
- Track TCM & CCM engagement
- CCM educational video for patients
- Air Traffic Control for patient engagement
- Disease pathways
- Interface with SNFs
- Engage MDs in solutioning around quality
Top 10 reasons for Annual Wellness Visits beyond the RVUs

1. Opportunity for wrap-around referrals (SW etc)
2. Important for attribution
3. Link to ACO Quality Measures
4. Good opportunity to review diagnosis coding
5. Good opportunity to update provider list
Top 10 reasons for Annual Wellness Visits beyond the RVUs

6. Enhanced patient safety eg falls screening

7. Chance to review preventive screening schedule

8. Advance directives

9. Brown bag medication session

10. Determine ability to self-manage, refer to care coordinator as indicated.
How to make Wellness Visits work

- Screen for Wellness visit completion at each touch point
- Delegate as much as possible to MAs / RNs
- Complete screening forms in advance
- Use videos etc for CCM enrollment, Advance Directives
- Bill for all services provided - counseling, advance directives etc
Inpatient Tactics

- Many primary admissions deserve an RCA
- Concurrent coding
- Case management redesign
- Disease-specific discharge checklists
- Choosing Wisely
- Care Transition Management and Transfer reviews
SNF Expenditures – Prime Opportunities

Average Standardized Payment per Stay
- $8,000 - $9,000
- $9,000 - $10,000
- $10,000 - $11,000
- $11,000 - $11,500
- $11,500 or more
Post-acute tactics

- Preferred provider agreements
- RUG trajectory analysis
- ED utilization / readmission rates
- Narrow networks for hospice, home health care
- Patient navigators / SNFists
- Require discharge summaries for SNFs
Rising Risk Definitions

1. Typically have a set of chronic conditions – HTN, DM, CHF, Asthma / COPD
2. But...identification more closely linked to risk factors
3. Also look at ED & inpatient utilization

<table>
<thead>
<tr>
<th>Risk Factors the Underlying Force Behind Disease States, Comorbidities</th>
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</thead>
<tbody>
<tr>
<td>Common Risk Factors</td>
</tr>
<tr>
<td>✓ Obesity</td>
</tr>
<tr>
<td>✓ Depression</td>
</tr>
<tr>
<td>✓ High blood pressure</td>
</tr>
<tr>
<td>✓ High cholesterol</td>
</tr>
<tr>
<td>✓ Smoking</td>
</tr>
<tr>
<td>✓ High stress</td>
</tr>
<tr>
<td>✓ Poor eating habits</td>
</tr>
<tr>
<td>✓ Physical inactivity</td>
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Consumers’ Top 10 Primary Care Clinic Attributes

Prioritizing Convenience and Affordability

- I can walk in without an appointment, and I’m guaranteed to be seen within 30 minutes: 4.11
- If I need lab tests or x-rays, I can get them done at the clinic instead of going to another location: 3.98
- The provider is in-network for my insurer: 3.95
- The visit will be free: 3.94
- The clinic is open 24 hours a day, 7 days a week: 3.91
- I can get an appointment for later today: 3.70
- The provider explains possible causes of my illness and helps me plan ways to stay healthy in the future: 3.04
- Each time I visit the clinic, the same provider will treat me: 3.01
- If I need a prescription, I can get it filled at the clinic instead of going to another location: 3.00
- The clinic is located near my home: 3.00

Virtual Access

• Convenience
• Market retention / Brand Loyalty
• Reduce PCP follow-up time
• Create access for higher acuity patients
• Reduces average labor cost per covered life
• Synchronous or asynchronous follow-up
• >50% of Kaiser Permanente patient encounters are now virtual.
Evolving Role of Health Coordinators

**Case Management**
- Resource coordination
- Advocacy
- Targeted solutions to social barriers
- Motivational interviewing
  - **Individual level, high touch, high intensity**

**Care Management**
- High risk ID
- Wellness Visit compliance
- Adherence to disease pathways
- Link to specialty coordinator
- Care gap closure
- **Population level, high tech, medium intensity**

**Care Navigation**
- Air traffic control
- Transitions of care
- In-Network assurances
- Social media engagement oversight
Thank you –
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