



# Value-Based Payment 101: A Primer

The Eleventh National Value-Based Payment and Pay for Performance Summit  
San Francisco, California  
February 17, 2016

# What you can expect from today's session



The range of value-based payments and the approaches required to succeed



Take-away tools, approaches, and strategies to succeed within value-based payment



What others have learned in their journey within population health management



An interactive session – sharing questions, answers, and observations



# What's on the agenda



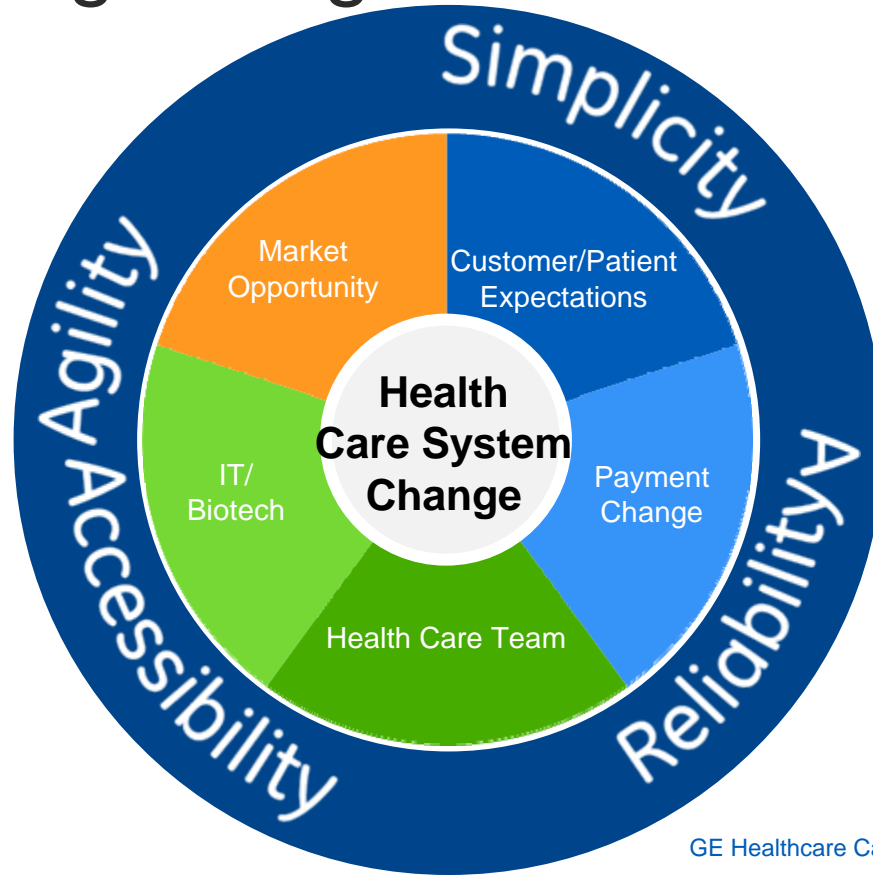
- Overview – Value-based Payment
- Follow the Money: Population Risk Models
- Break
- Care Model Execution and Clinical Cultural Transformation
- Other Considerations for Success
- General Q&A



# Overview – value-based payment



# Trends driving change



# Over-used, but under-done

Outcomes

Value-based

Patient-centered

Transformational

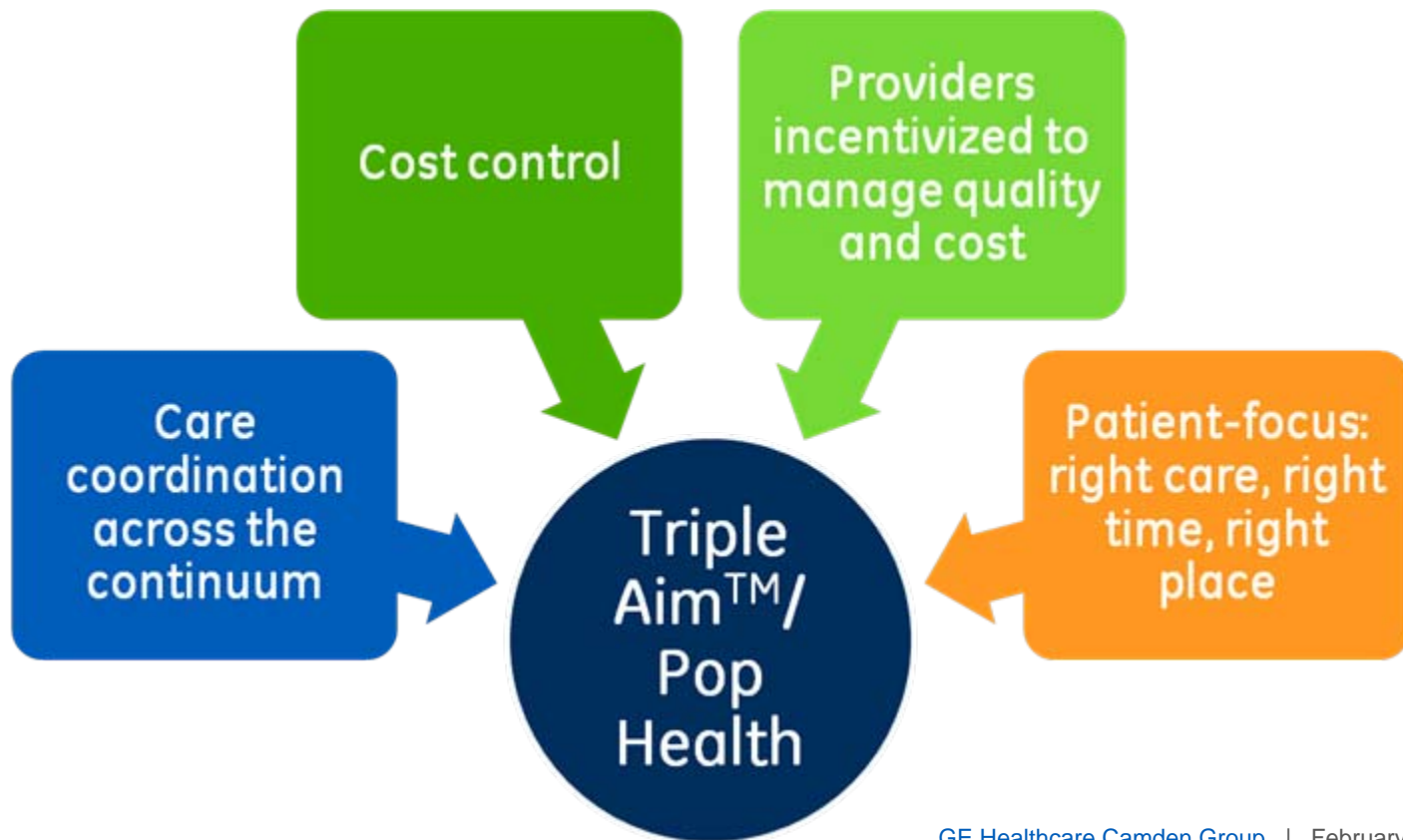
Change management

Population health management

Care model redesign



# What does the marketplace want?



# A few facts about the market

31 percent of Medicare enrollees are in Medicare Advantage (“MA”) Plans; total enrollment grew by 7 percent between 2014-2015

- 54 percent of new MA plans in the last 4 years were sponsored by a provider organization

There are 744 ACOs nationwide; 434 Medicare ACOs

- 23.5 million covered ACO lives (7.7 million Medicare)
- 132 different payers have entered into at least one ACO contract (up from 51 in 2012)

HHS wants 50 percent of fee-for-service (“FFS”) plans in Alternative Payment Models by 2018

Sources: Kaiser Family Foundation, Avalere Health LLC, Leavitt Partners





# MACRA

## Merit-Based Incentive Payment System (“MIPS”)

### FFS system

- Consolidates: Meaningful use (“MU”), the Physician Quality Reporting System (“PQRS”), and the Value-Based Payment Modifier (“VBPM”)
- Assesses individual physician performance in:
  - Quality
  - Resource use
  - MU of certified EHR technology
  - Clinical practice improvement activities
- Assessed as a group

## Alternative Payment Model (“APM”)

### Innovative payment model\*

- Medicare Shared Savings Program ACO
- Medicare Health Care Quality Demonstration Program, Medicare Acute Care Episode Demonstration Program, or another demonstration program

\*Expanded under the Center for Medicare & Medicaid Innovation (CMMI), including Comprehensive Primary Care (CPC) initiative participants



# MACRA timeline and payment impact

Measurement/ Report Period is typically 2 years earlier

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Fee	0.5	0.5	0.5	0.5	0.5	0	0	0	0	0	0	0.75*0.25**
MIPS	PQRS, VM, EHR Incentives/Penalties (up to 9%)				4%	5%	7%	9%	9%	9%	9%	9%
APMs	Medicare Payment Threshold				5%	5%	5%	5%	5%	5%		
	Excluded from MIPS											

\*Qualifying APM conversion factor, \*\*Non-qualifying APM conversion factor

Source: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF>



# It's not just two canoes anymore...



# “Risk” models come in many flavors

“Riskometer”



High

Low

## Fee-for-Service

## Episode of Care

## Population Risk

### BREADTH OF RISK

Pay-for-Performance + Cost Management Incentive

Pay-for-Performance

Pay-for-Reporting

Discounted Fee Schedule

Percent of Charges

Full Charges

Prospective Payment

Bundled Payment  
90 Days

Bundled Payment  
30/60 Days

Retrospective Payment

“Shared Savings”  
Per Episode (e.g., Oncology)

Case Rate or DRG

Full/Global Risk

ACO or Shared Savings –  
Upside and Downside

Professional OR Institutional  
Capitation

ACO or Shared Savings– Up-  
side Only

Case Management Fee Plus  
Incentive (e.g., PCMH)

## Critical Success Factors

- Cost Per Unit
- Market Price Sensitivity
- Volume
- Billing/Coding
- Patient Satisfaction

- Per Episode and Per Unit Cost
- Case Volume
- Care Coordination Across Continuum
- Physician Engagement
- Adherence to Protocols
- Quality/Experience Outcomes

- Covered Population Size
- Patient Attribution
- Total Cost of Care and Risk Adjusters
- Care Redesign Across Continuum
- Patient and Physician Engagement
- Quality/Experience Outcomes
- Multi-year Agreements + Reserves



# Value-based critical success factors



Strong Care  
Management  
Capabilities



Enabling  
Information  
Technology



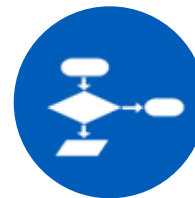
Effective Care  
Teams



Larger Patient  
Population



Efficient Clinical  
Operations



Contracting Models  
Support Population  
Health



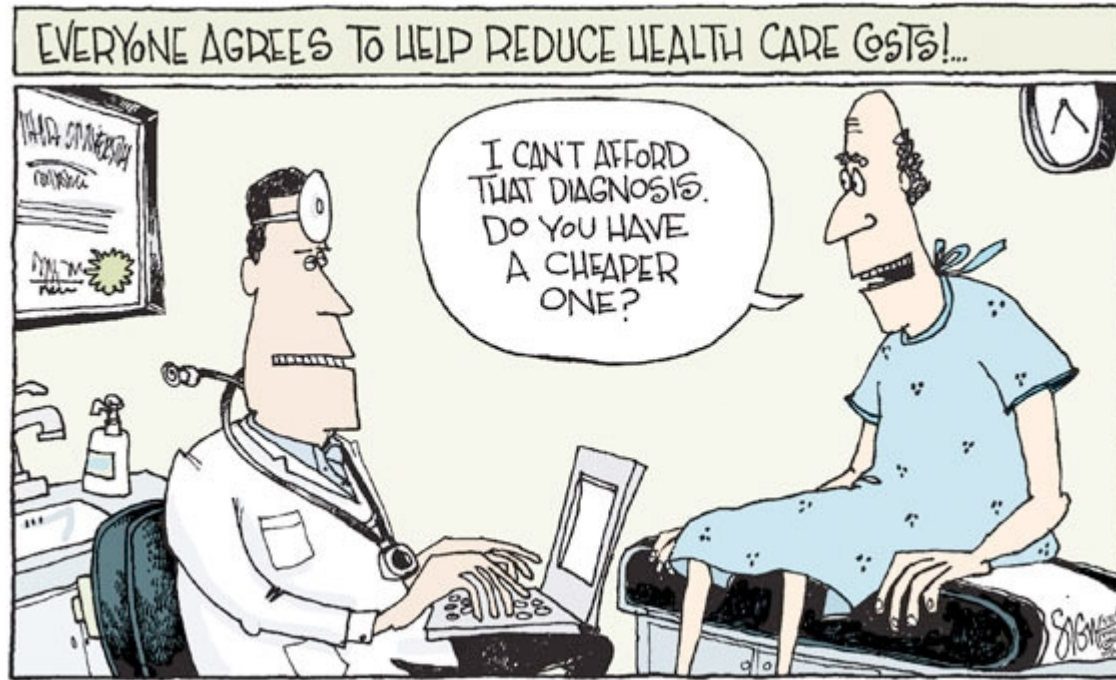
Physician Compensation  
Model that Aligns  
Incentives



# Follow the money – population risk models



# Managing healthcare costs



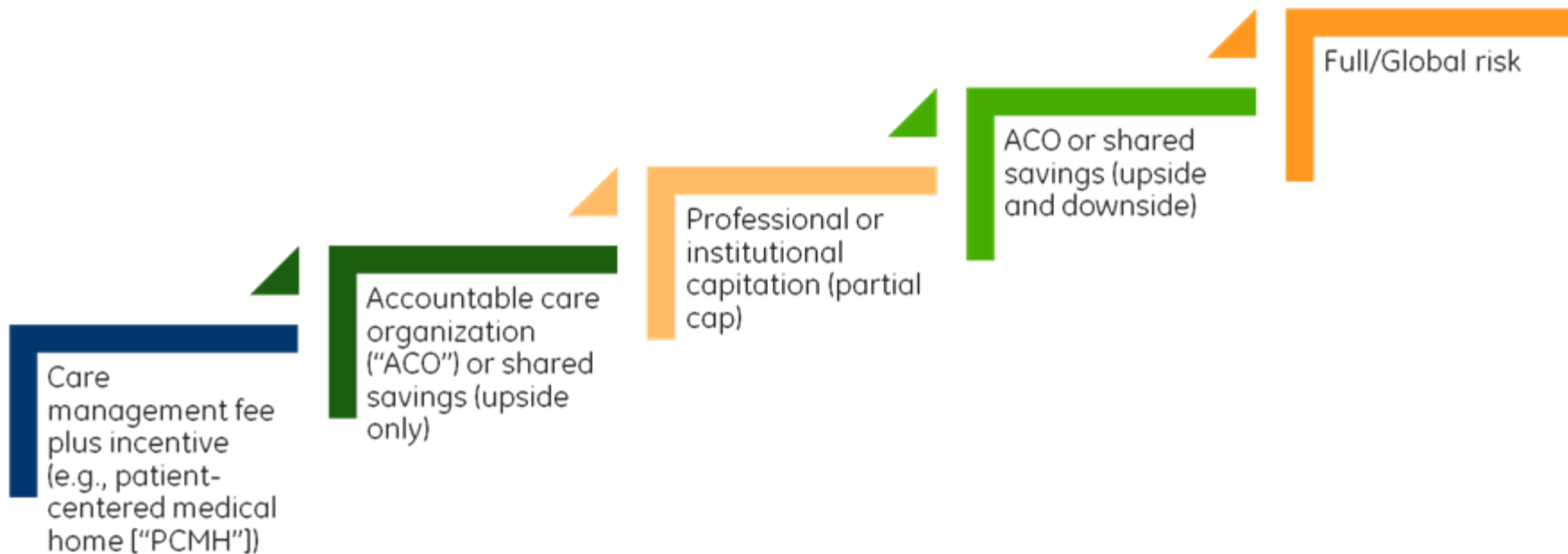
Source: The Center for American Progress, 2009-

<https://www.americanprogress.org/cartoon/2009/05/12/12835/everyone-agrees-to-reduce-health-care-costs/>

GE Healthcare Camden Group | February 17, 2016 | 15

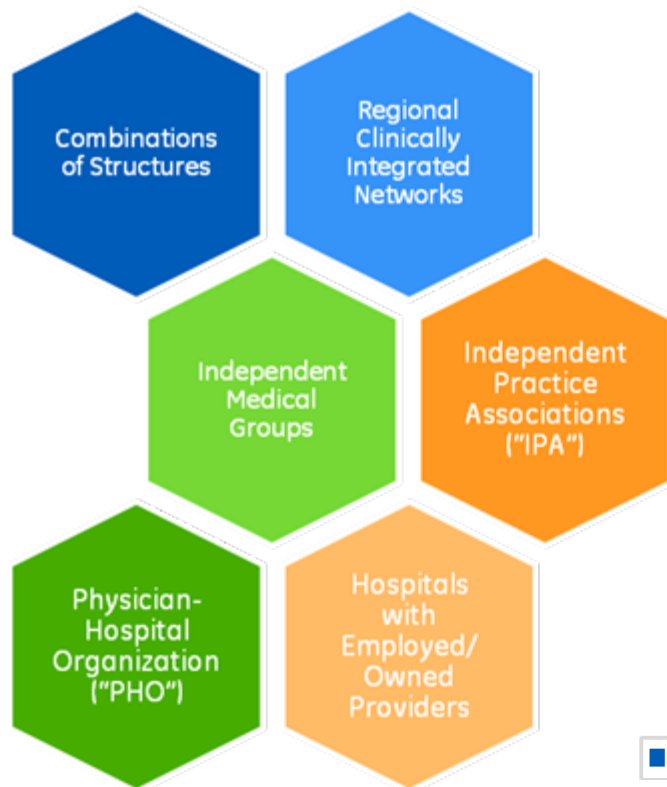
# Population risk

## Today's focus is on the “higher risk models”

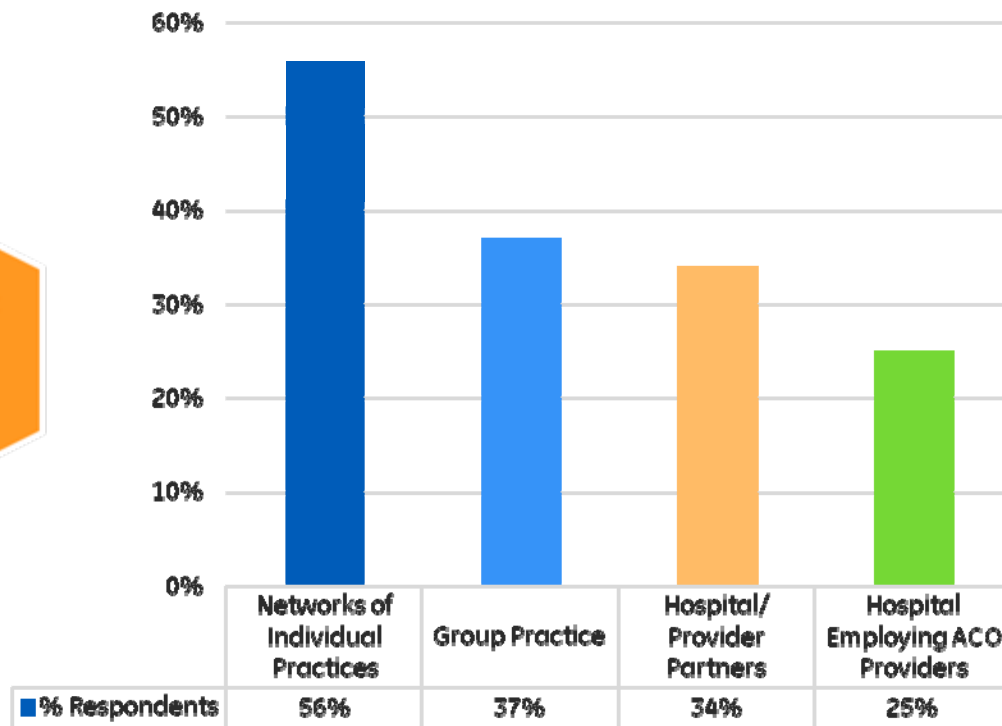




# Types of organizations taking risk



**ACO Participants by Type1**

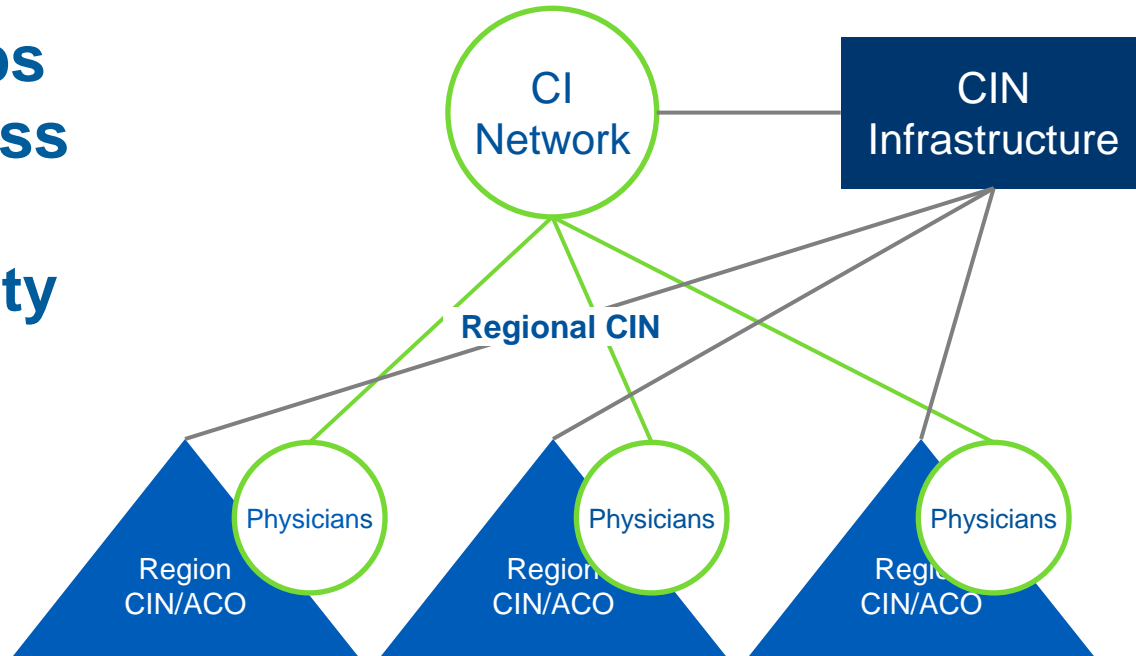


Source: CMS, 2015. Note: ACOs could select more than one option.

1 Not reflective of all risk bearing organizations, representative of MSSP participants only

# Types of organizations taking risk CINs of hospitals and physicians

**Partnerships  
Drive Success  
and  
Sustainability**



# The evolution of CI and management of risk

<b>Phase 1</b> <b>Develop the Structure</b>	<b>Phase 2</b> <b>Establish Partnerships</b>	<b>Phase 3</b> <b>Management of Risk</b>
<ul style="list-style-type: none"><li>• Build the organizational infrastructure</li><li>• Establish quality programs, incentive models, and outcome tracking</li><li>• Develop care management infrastructure</li><li>• Enter into limited risk-based contracts</li></ul>	<ul style="list-style-type: none"><li>• Leverage infrastructure with providers in new markets</li><li>• Develop products</li><li>• Partner with payer(s) (carrier as the middle-man)<ul style="list-style-type: none"><li>– Larger provider network</li><li>– Access to membership</li><li>– Direct to employer contracts</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Full-service provider of population health services</li><li>• Offer insurance products direct to the market or partner with major payers to manage professional or global risk</li><li>• Commoditize products and services direct full-risk contracting with employers</li><li>• Advanced benefits designs</li></ul>



# Care management fees

Fees paid by the health plan to physicians for the provision of care management services.

- Typically risk-adjusted and paid on a per-member-per-month (“PMPM”) basis.

Requires critical mass of patients to be effective.

Should be done in conjunction with a shared savings program.

Part of medical expenses or administrative expenses?

**Commercial**

**\$3 PMPM**

It really depends on what is included in  
the care management fee

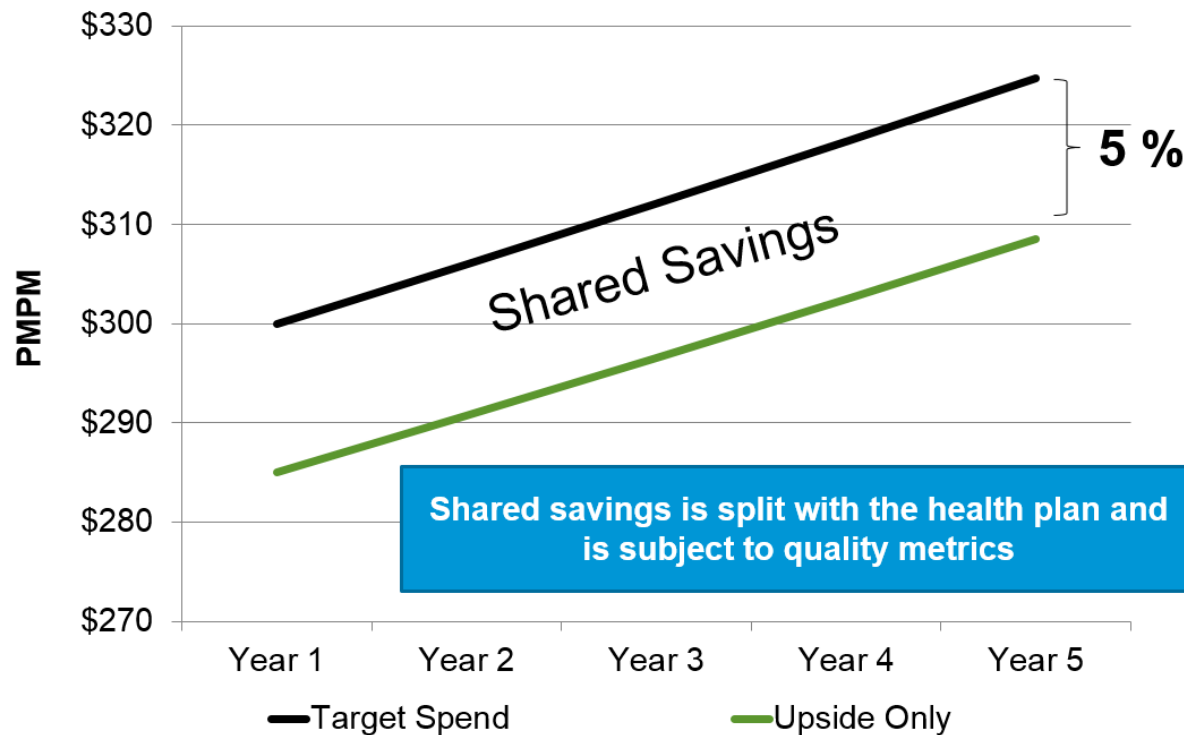
**Typical Care Management Fee Range**

**Medicare  
Advantage (“MA”)**

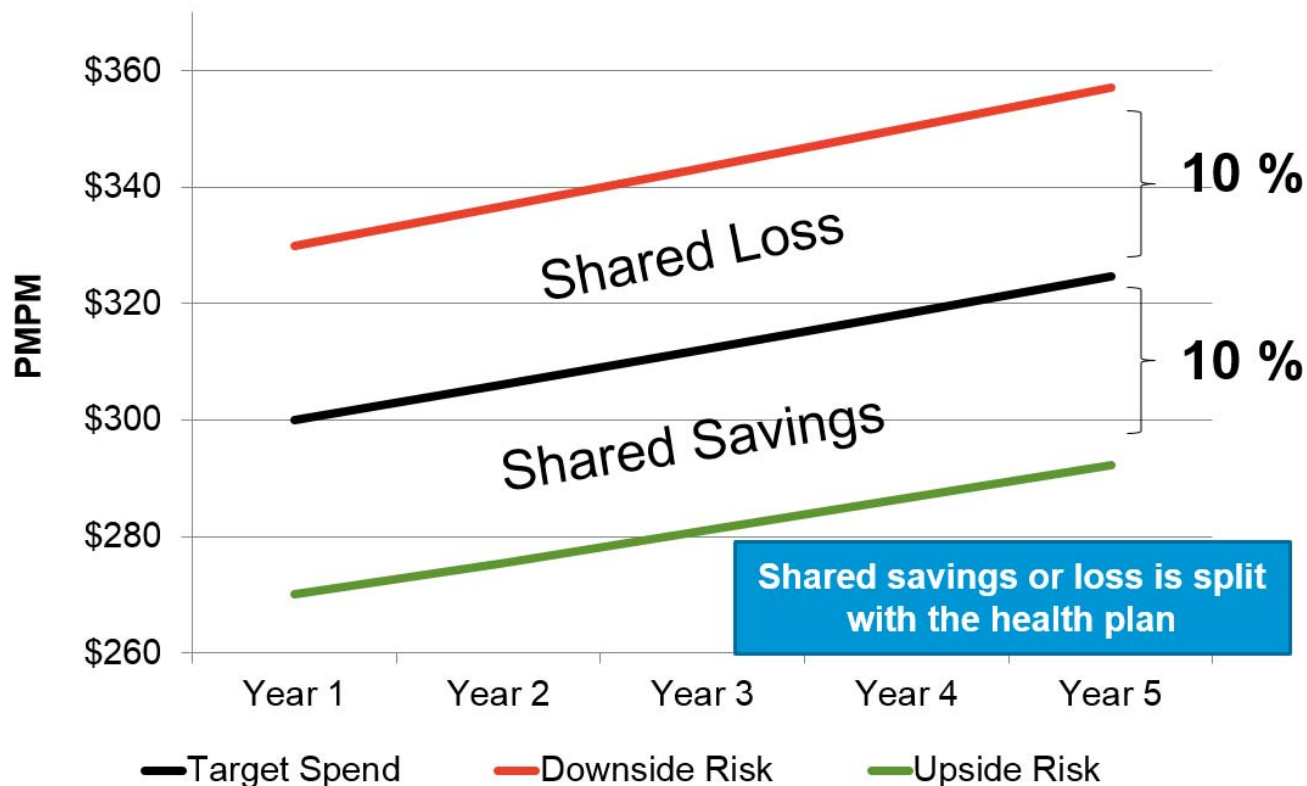
**\$20 PMPM**



# Shared savings: upside only



# Shared savings: upside and downside



# Professional risk

\$Amount

**Payer**

FFS  
\$W

**Hospitals**

Cap  
\$X

**Organized  
Physician Group**



FFS, Cap,  
Alternatives \$\$

**Physician  
Network**

FFS  
\$Y

**Pharmacy**

FFS  
\$Z

**Post-Acute**



Note: Only top 4 categories of health spending displayed.

# Full and global risk contracts

## Full Risk

- Capitation for institutional and professional services.
- Medical group and hospital often share surplus and deficit in risk pool.

## Global Risk

- Single entity receives all funding and pays all claims.





# Regulatory issues

## States regulate risk bearing entities.

Know your state requirements - they vary widely.

- Knox-Keene Health Care Service Plan Act of 1975 (California).
- New York required the Department of Health to establish a program governing the approval of ACOs.
- Massachusetts requires all Risk Bearing Provider Organizations (“RBPO”) to register with state agencies.
  - Provider organizations that take on significant risk must fall under the DOI oversight even under alternative payment models.



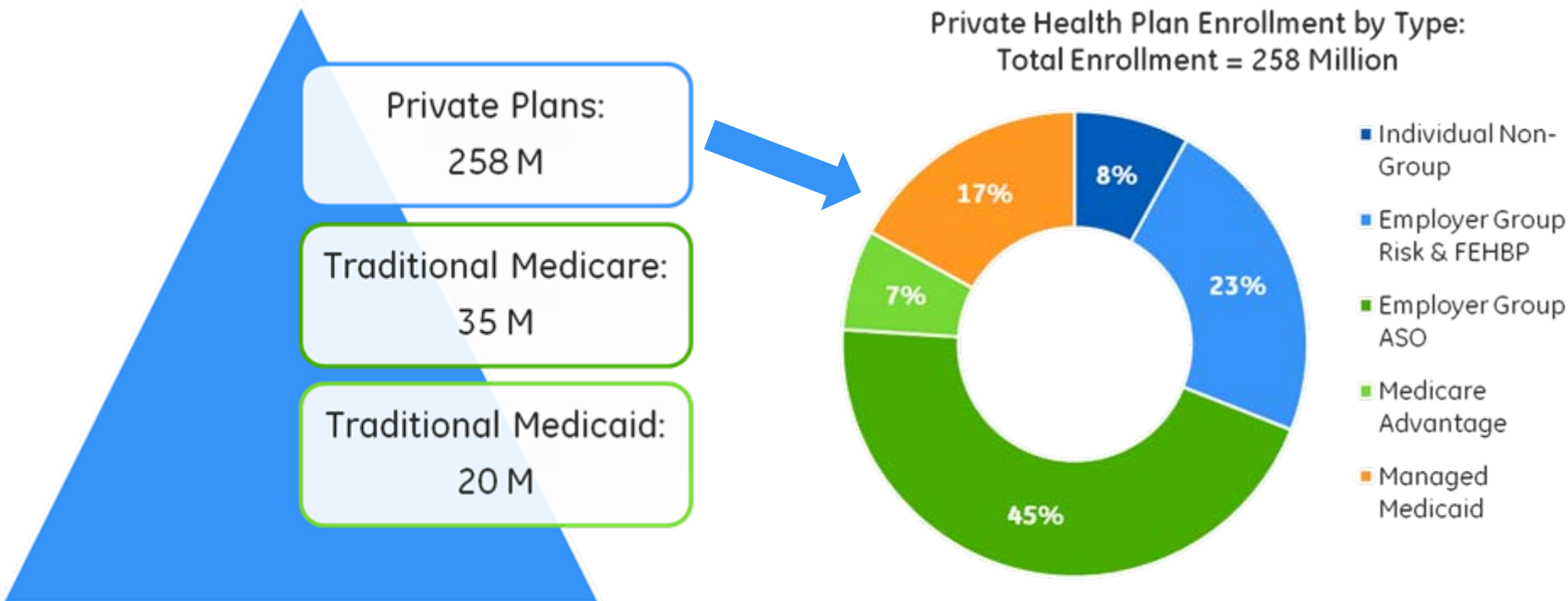
# Models vary by product lines

Medicare, MA, Medicaid, Managed Medicaid, and Commercial products have unique characteristics, varying payment models and per capita healthcare resource consumption rates, and distinct approaches to population management.

- Within each of these lines of business, there are diverse subpopulations.
- Providers must understand the different nuances and program types when considering risk bearing within and across different product lines and subpopulations.



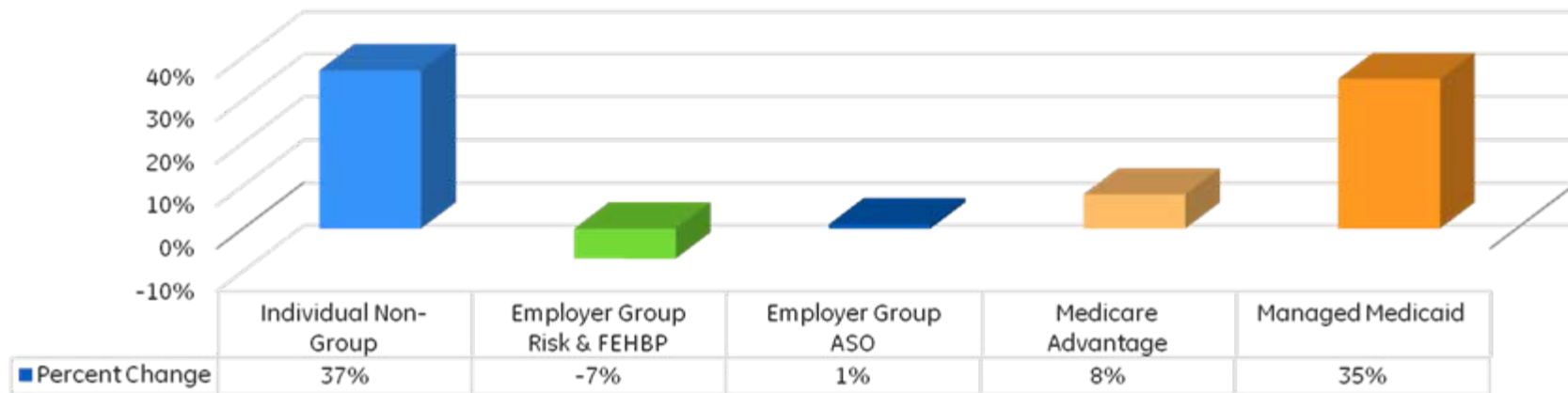
# Health insurance coverage by type



# Enrollment changes 2014 to 2015

## How has your organization's payer mix changed?

1Q 2014-1Q 2015 Percent Change in Enrollment by Private Plan Type



# Product differentiation when assuming risk

Understanding an organization's payer mix is integral to the foundational strategy of moving into risk models.

- Does the organization have prior experience in risk?
- Does the organization have a self-funded employee health plan?
- Does the organization have a predominance of a certain payer or product type, e.g., Medicare, Medicaid, etc.

While it may add administrative complexity to the risk-taking arrangement, separate agreements or parameters for separate products and types (even with the same carrier) help to mitigate risk.

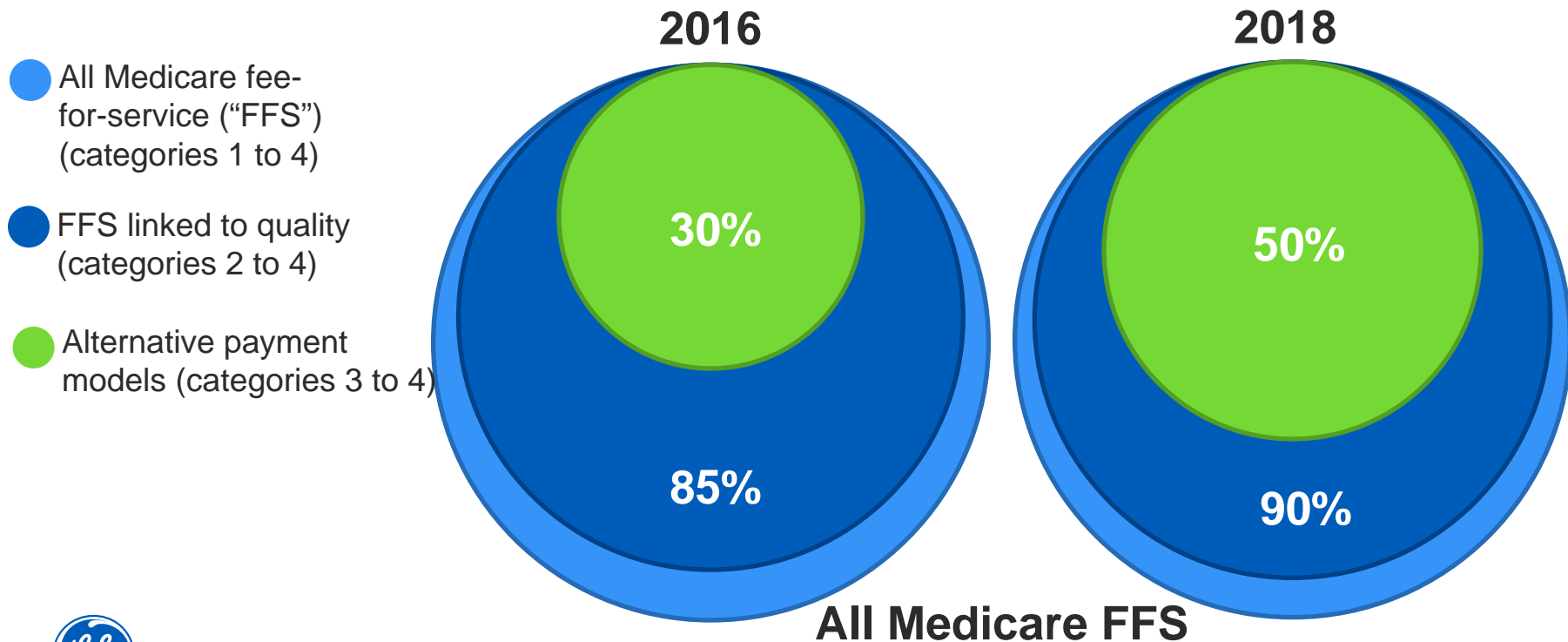


# Medicare



# Why is value more important now?

## Medicare's move to payment for value accelerates



# Medicare payment taxonomy framework

## Category 1

- Traditional FFS, volume driven, no link to quality or efficiency

## Category 2

- FFS linked to quality
- At least a portion of payments vary based on quality or efficiency, e.g., hospital value-based purchasing, physician value-based payment modifier

## Category 3

- Alternative payment models built on FFS architecture
- Some payment is linked to effective management of a population or an episode of care. Opportunities for shared savings or two-sided risk, e.g., Medicare Shared Savings Program ("MSSP"), ACOs, bundled payments.

## Category 4

- Population-based payments
- Payment is not directly triggered by service delivery, so volume is not linked to payment, e.g., eligible Pioneer organizations in years 3 to 5





# Medicare ACO models

## Pioneer

- Offers the option of 5 payment arrangements, which share savings and losses of 50 to 75 percent (1 option that has 1 year of 1-sided, all other 2-sided risk)
- Savings and losses are subject to MLR/MSR of option chosen
- Population-based payment starting in year 3 for qualifying organizations

## MSSP

- Upside Risk only in Track 1
- Upside and downside risk in Tracks 2 and 3
- 50 to 75 percent shared savings/losses (as applicable) above MLR/MSR
- Eligible organizations may elect the Advance Payment Model or ACO Investment Model (for rural and underserved areas)

## Next Generation

- Track one has 80 percent sharing rate for performance years 1 to 3 and 85 percent for performance years 4-5
- Track 2 has 100 percent risk for Part A and Part B expenditures in each year
- Has a PMPM option



# MSSP

## Track 1

Upside Risk Only

Shared Savings of 50 Percent

MLR/MSR of 2 to 3.9 percent based on number of beneficiaries

10 Percent Savings Cap

Minimum Attribution: 5,000

## Track 2

Upside and Downside Risk

Shared Savings/Loss Rate of 60 Percent

(i) no MSR/MLR; (ii) symmetrical in 0.5% increments between 0.5% - 2.0%;(iii) symmetrical and varied based upon number of assigned beneficiaries

15 Percent Savings Cap/  
5 to 10 Percent Loss Cap

Minimum Attribution: 5,000

## Track 3

Upside and Downside Risk

Shared Savings/Loss Rate of 75 Percent

(i) no MSR/MLR; (ii) symmetrical in 0.5 percent increments between 0.5 to 2.0 percent ;(iii) symmetrical and varied based upon number of assigned beneficiaries

20 Percent Savings Cap/  
15 Percent Loss Cap

Minimum Attribution: 5,000



# Next generation ACO

## Track 1

Upside and Downside Risk

Shared Savings of 80  
Percent for Years 1-3; 85  
Percent for Years 4 to 5

No MLR/MSR

15 Percent Savings/Loss  
Cap in All Years

Minimum Attribution: 10,000

## Track 2

Upside and Downside Risk

100 Percent Risk for Part A  
and Part B Expenditures

No MLR/MSR

15 Percent Savings/Loss  
Cap

Minimum Attribution: 10,000



# Centers for Medicare & Medicaid Services ACO

**Models** Benchmark in MSSP is based on historical 3 years of spending data, risk adjusted using Medicare hierarchical condition categories (“HCC”).

- Next Generation employs a similar methodology, although with regional adjustment and plans to transition away from emphasizing historical expenditures.
- Clearly delineated methodology, with several options available based on provider’s degree of risk acceptance/aversion.
- Unlike commercial carriers, programs are very structured, not negotiable - has its benefits, e.g., you know how the benchmarking methodology is set; and drawbacks, e.g., inflexible/can’t be changed based on provider needs.



# Risk adjustment

- The Centers for Medicare & Medicaid Services (“CMS”) -HCC prospective risk adjustment models are used to calculate the ACO’s assigned beneficiary population’s risk scores for the benchmark years, which are used in calculating the historical benchmark.
- Changes in the ACO’s risk score between benchmark years 1 and 3 are used to trend forward benchmark year 1 expenditures.
- Similarly, changes in the ACO’s risk score between benchmark years 2 and 3 are used to trend forward benchmark year 2 expenditures.



# Risk adjustment

HCC becomes increasingly important with degree of

risk  
Hypothetical example of individual risk score

- Beneficiary is male, age 77, with the chronic conditions: congestive heart failure (“CHF”), diabetes with complications, and chronic obstructive pulmonary disease (“COPD”)



# Risk adjustment

HCC becomes increasingly important with degree of risk (cont'd)

- Risk adjustment model coefficients:
  - Male age 77 = \$5,100
  - CHF = \$3,900
  - Diabetes w/comp = \$3,300
  - COPD = \$3,700
  - Beneficiary's predicted expenditures are \$16,000
  - Average expenditures for all beneficiaries are \$10,000
  - Beneficiary's risk score =  $\$16,000 / \$10,000 = 1.6$



# Risk adjustment

As degree of risk increases, risk adjustment becomes increasingly important. In Medicare shared savings, it impacts the provider's benchmark; and in advanced risk (capitation) for MA, it impacts the payment to the plan and subsequent capitation to the provider organization.





# Attribution: Medicare ACOs

Patients that have received at least one primary care service from a primary care physician (“PCP”) in the ACO

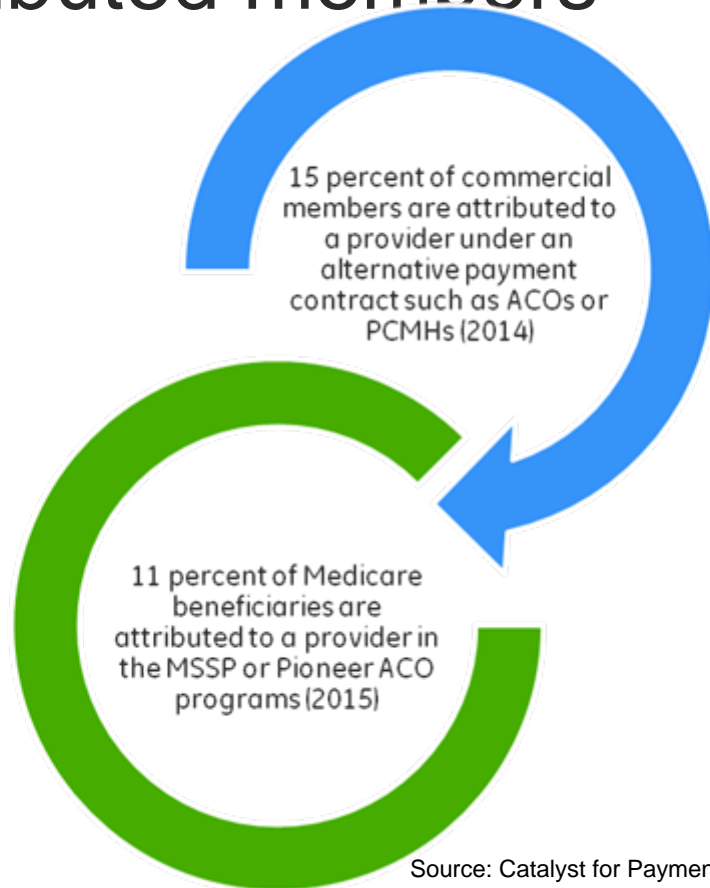
- Attribute to the ACO if the PCPs in the ACO provide the plurality of primary care services for the beneficiary
- PCP includes general practice, family medicine, internal medicine, geriatric medicine, FQHC, or RHC

Patients that have not received a primary care service from any PCP

- A beneficiary is assigned to an ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners
- Non-physician practitioners include nurse practitioners, clinical nurse specialists, and physician assistants



# Attributed members

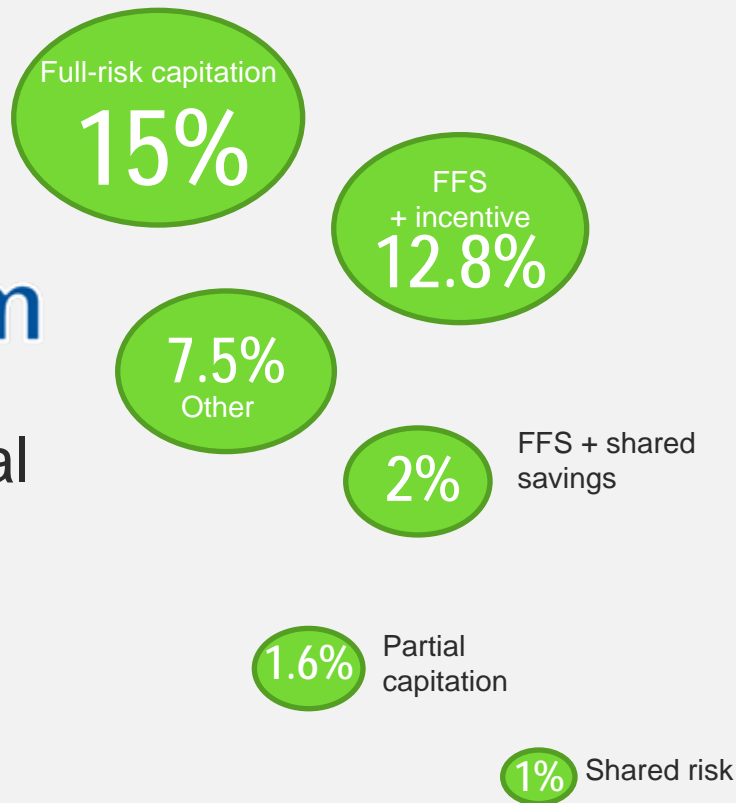


Commercial products  
and/or private plans with  
government products



# National Scorecard on Payment Reform

**40%** of all commercial  
payments to hospitals and  
doctors are “value-based.”  
Here’s how it breaks down:



# Why is value more important now?

## The healthcare transformation task force

Industry consortium that brings together **patients, payers, providers, and purchasers.**

Committed to having 75 percent of their respective businesses operating under value-based payment arrangements by 2020.



Catholic Health Initiatives

*Imagine better health.™*

**aetna**



**PBGH**  
PACIFIC BUSINESS  
GROUP ON HEALTH

**national partnership  
for women & families**



**CAESARS**  
ENTERTAINMENT.

**ASCENSION**



**Advocate Health Care**



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS



**Trinity Health**  
Liveries, PA



**Blue Cross  
Blue Shield**  
of Michigan

**MASSACHUSETTS**



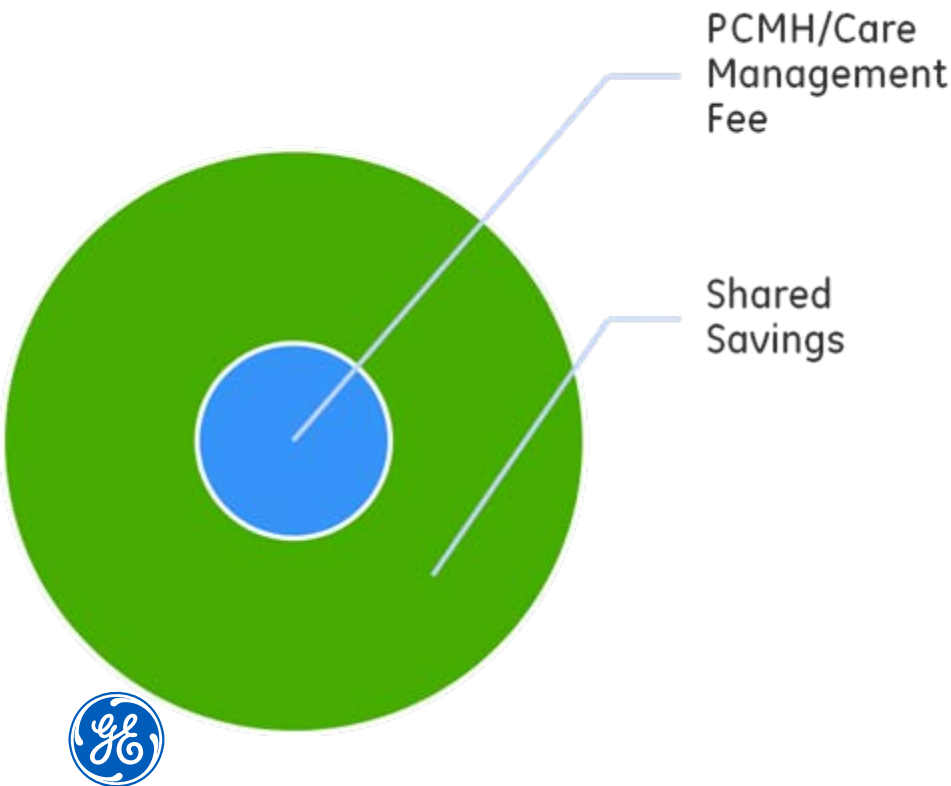
# Risk-based value oriented payments: commercial

Of the 40 percent of value-based payments, the majority are “at-risk.”



# Commercial carrier programs

## Often a combination of methodologies



- Some level of formal PCMH accreditation may be required.
- Care management fees paid on a PMPM basis are negotiable and often deducted from any savings (also negotiable).
- Number of attributed lives requirement may be lower (e.g., 1,500)
- Quality metric performance and STAR rating (MA) are important components.

# Product differentiation in commercial when assuming risk

The mix of members within the population may vary from what the carrier assumed, subjecting providers to substantial mix risks.

The profiles in the individual population will range from:

- Those not previously seeking insurance (young invincibles)
- Medically underwritten
- Previously uninsured

The composition and size of the small group population for a carrier could vary significantly depending on the size of the groups enrolled and the prevalence of small group self-insured products.





# Commercial risk

## Full or Partial Risk

Provider's Own Self-Funded Group

Direct to Employer Contracting

Professional Capitation

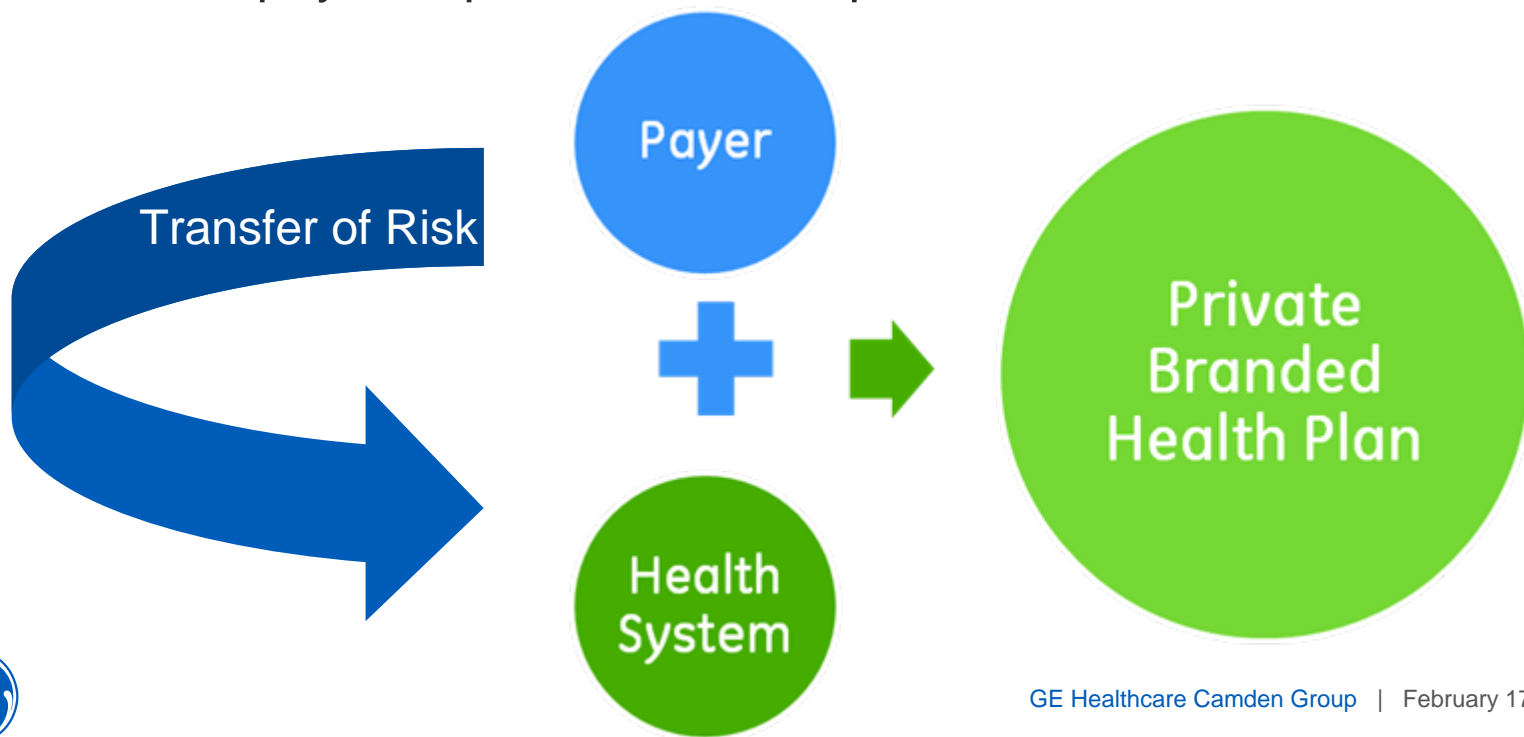
Full Risk or Global Risk



# MA

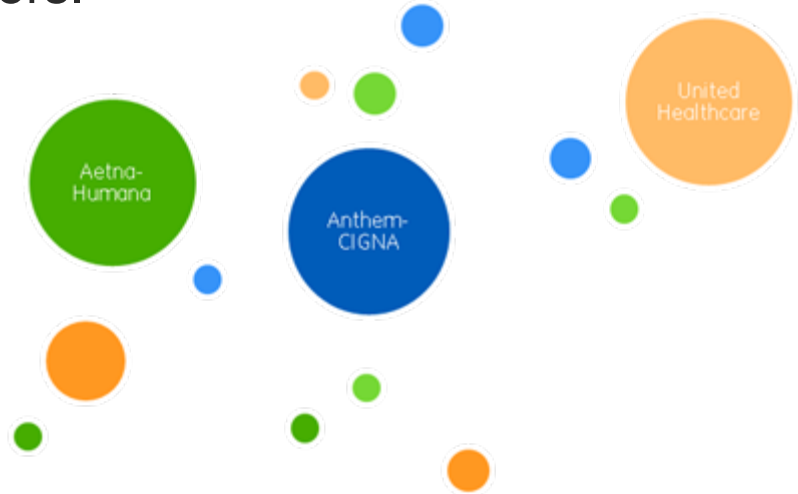
Enrollment growth, attractive option for health systems to:

- Partner with payers - private branded plan



# MA

- Many health systems starting their own plan, predominantly in the MA space.
- Significant capital and infrastructure requirements.
- Compete with the large, national carriers.
- Provides greatest risk/reward.
- Requires culture change
- What is your strategy?



# Managed Medicaid

- Managed Medicaid plans often willing to share risk and/or capitate providers.
- Shared savings/ACO, partial and full capitation alternatives.
- Need to understand the differences in populations and sub-populations, e.g., pediatric population, low-income adults, disabled individuals, dual eligibles, etc.
- Many organizations taking risk for Medicaid often have a high volume of Medicaid enrollees and experience caring for this population.



# Commercial/Private contracting considerations

Which products are included? Individual, exchange, SHOP, employer group risk, self-funded, etc.

Is this a private plan with a MA or Managed Medicaid product?

3 R's

- Risk adjustment
- Re-insurance
- Risk corridors

If pursuing partial capitation, what are carveouts (e.g., pharmacy, mental health, transplants, etc.)

If shared savings, how are benchmarks established?

What is attribution process?



# Attribution

## Non-HMO attribution can be handled in several ways

### Prospective

Organizations are provided with a list of attributed members at the beginning of a performance year; attribution is based on data from the patients' use of services in the previous year.

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### Performance Year

Patients are attributed to organizations at the end of the year based on patients' use of care during the actual performance year.

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### Hybrid

Preliminary prospective assignment methodology with final retrospective reconciliation where there is prospective attribution initially; followed by retrospective reconciliation.

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# Implementing capitation-based contracts

Provider orientation - when to refer

How is the eligibility and benefit information delivered?

Knowing your experience and cost:

- Whose data do you use and how accurate is it (e.g., actual vs. actuarial data)?
- Fixed capitation (e.g., age/sex) vs. percent of premium?
- Covered vs. not-covered? Experimental procedures, carve-outs, and out of area
- How to pay for non-covered services?
- How is the capitation distributed?



# Implementing capitation-based contracts

- Tracking and gathering encounter data and sharing with providers to change behavior.
- Termination clause to deal with: continuing care obligations, communication to members, medical record transfer, not to compete.
- Bonus pools for quality of care, patient satisfaction, and administrative compliance.
- Policies for use of other specialists and ancillary providers.



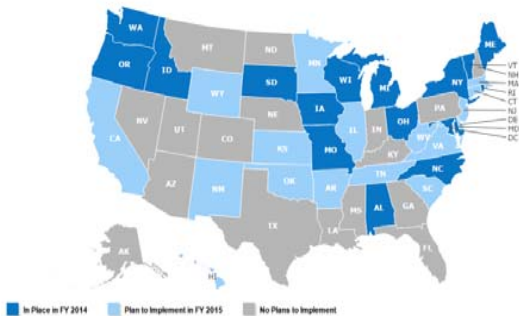


# Medicaid

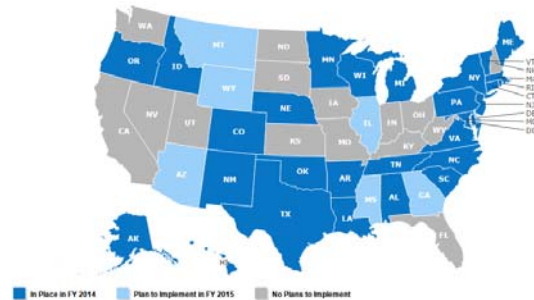


## State Medicaid programs with alternative payment models

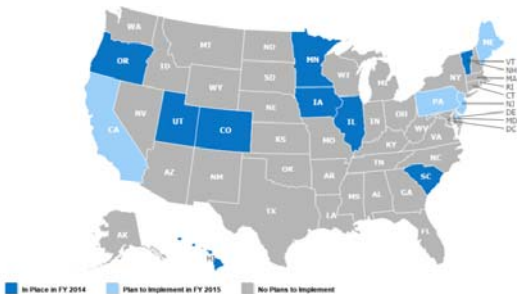
# Health Home Models



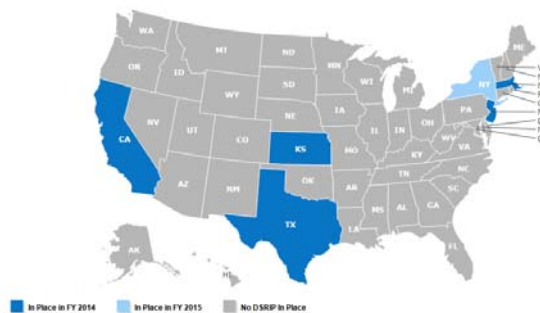
## PCMH Models



# ACO Models



## DSRIP Models



Source: Kaiser Family Foundation, 2015

# Care model execution and clinical cultural transformation



# Burning platform for care model change

Balance between purchasers and providers

Baby Boomers- getting older and demanding the most (not necessarily the best)

Obesity up 60 percent in 10 years

Increased incidence of chronic disorders such as heart disease, diabetes, asthma, and mental health conditions

Continued rising costs

De-linking of healthcare coverage from employment



# Current trends



# Reality check

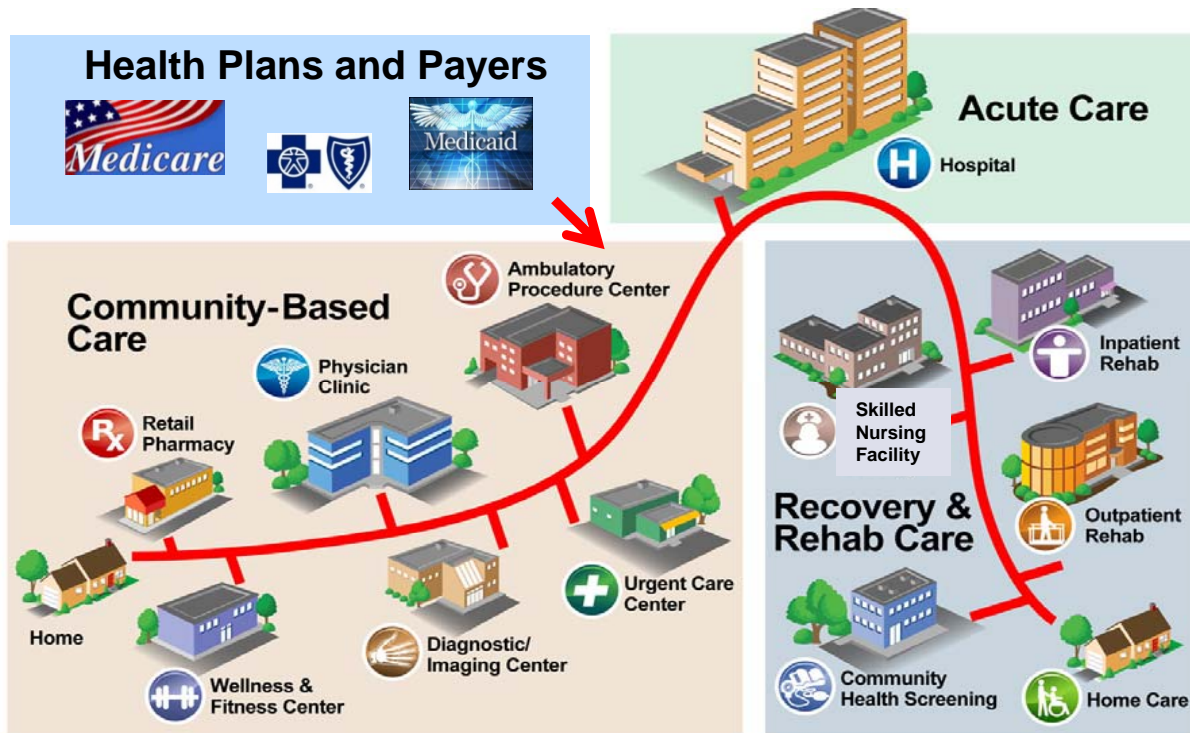
If all you do is rearrange the deck chairs...the ship still hits the iceberg

Must change how care is delivered to have a positive change in outcomes and produce value



# Care management is the common thread

## Linking the patient through every setting



# Pathway to value

## Care management

“A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.”

- The Case Management Society of America





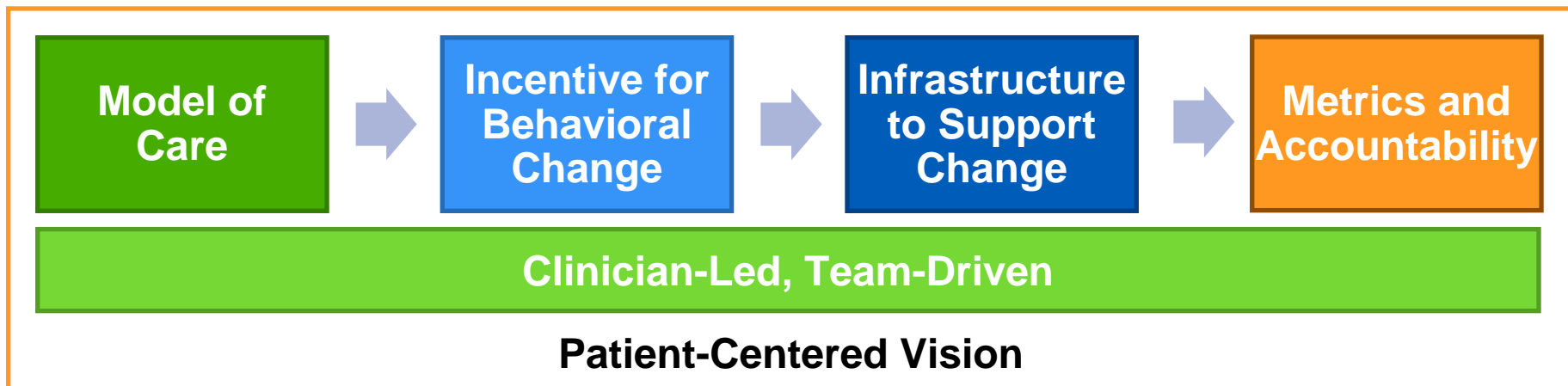
# Across the continuum Care management

...a patient-centered, assessment-based, interdisciplinary approach to integrating healthcare with the goals of improving patients' health status while reducing the cost of care

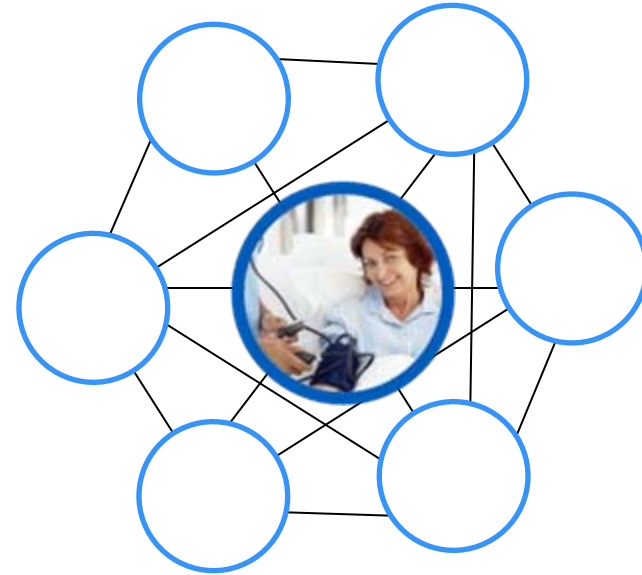
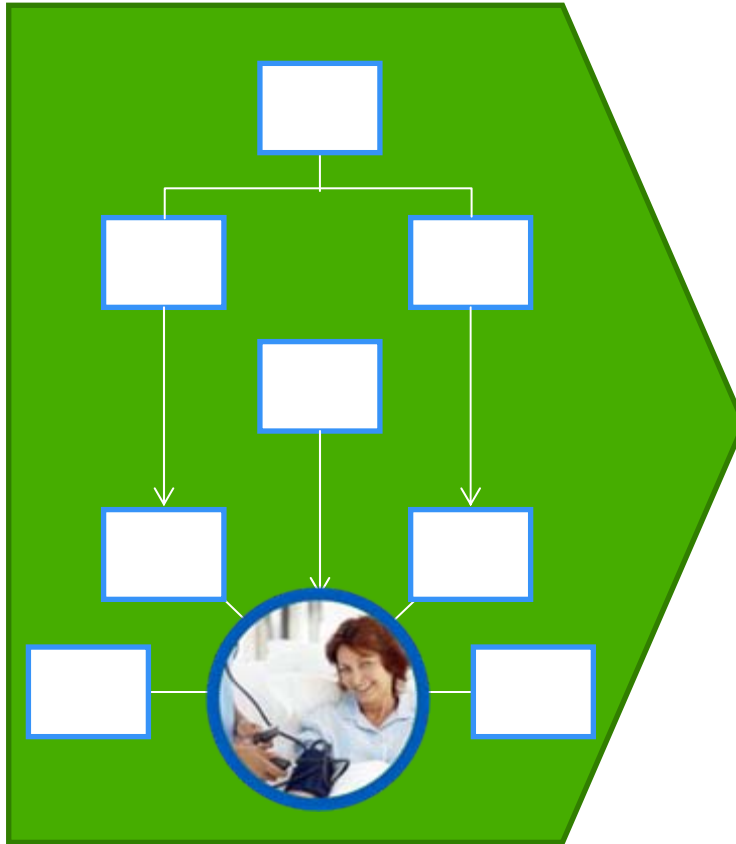
- Patient and caregiver engagement/education
- Care plan development
- Medication management
- Advance care planning
- Care coordination and information transfer
- Biopsychosocial consideration



# Care management Across the continuum



# Rethinking our organizational orientation



# Focus areas: Where are the opportunities?

Preventive health, gaps in care

Diabetes

Heart failure

Asthma – adult and pediatric

Readmission prevention

Behavioral health

Care transitions between settings

Utilization management (reducing unnecessary ED utilization)

Care coordination/navigation

- Transportation
- Referrals
- Community resources
- Health education



# Focus areas: Where are patients managed?

Comprehensive care coordination across the continuum

- PCP
- Ambulatory care management (“CM”) (embedded and non-embedded)
- Inpatient case management including hospitalists
- ED case management
- Sub-acute facilities’ resources
- Behavioral health
- Home health
- Community linkages
- Long-term acute care hospital/skilled nursing facility (“SNF”)
- Urgent care centers
- Emergency medical services triage
- Outpatient clinics (patient-centered medical home, clinics)



# Care management functions

Education/Self-management

Care coordination across networks

Support to patient and caregivers

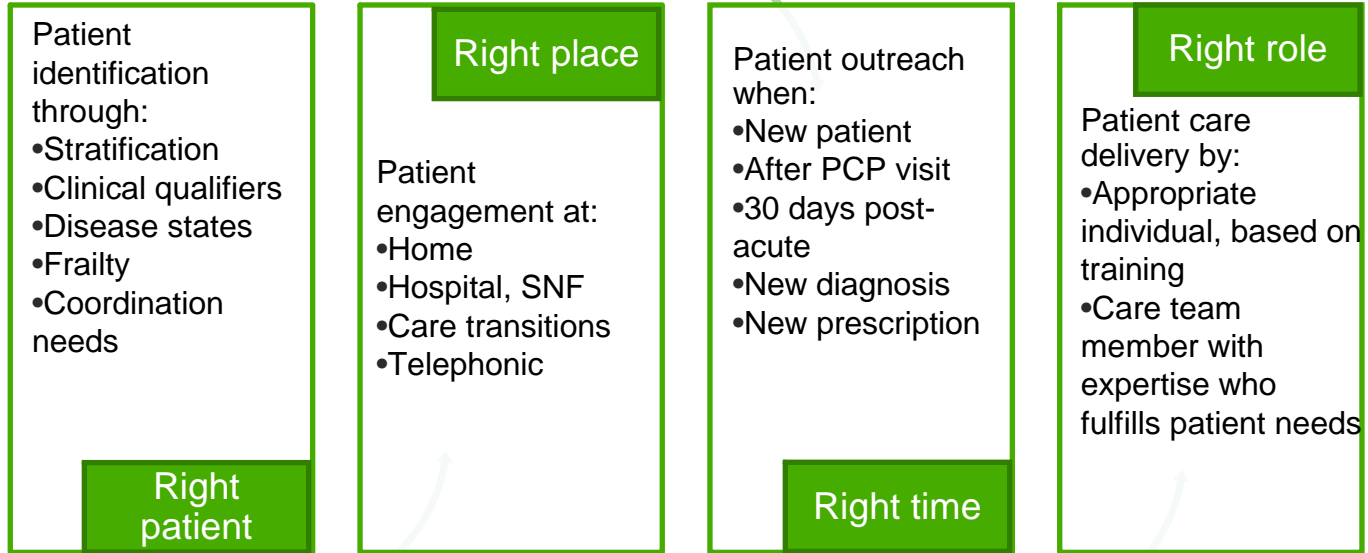
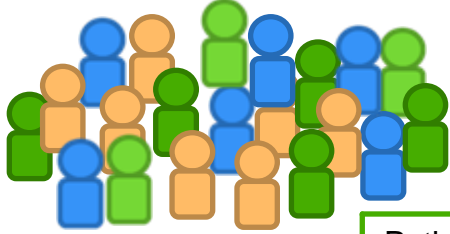
Referral to community-based resources

End-of-life support

- Hospice referrals
- Advanced directives



# Who, where, and when?



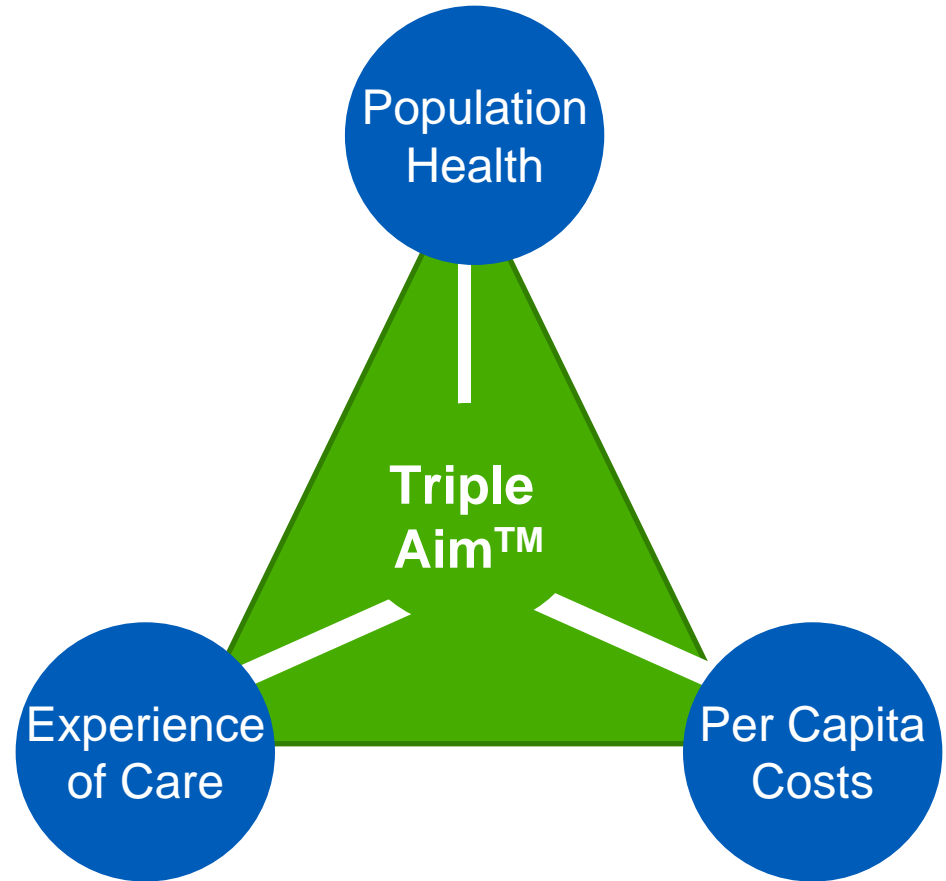
# Risk stratification methods





# The Triple Aim™

Risk Stratification tools can help achieve the Triple Aim™ by identifying “at risk” populations and enabling providers to match them up with the appropriate level of intervention to improve clinical outcomes and maintain and even reduce healthcare costs.



# Why is it important?

Organizations assuming risk for populations based on overall performance

Majority of healthcare dollars are spent by a small percentage of population

- 80/20 rule

Risk stratification helps care managers organize their workflow and task activities

Focus high intensity services on high-risk populations

Rapid increase in the need to risk stratify

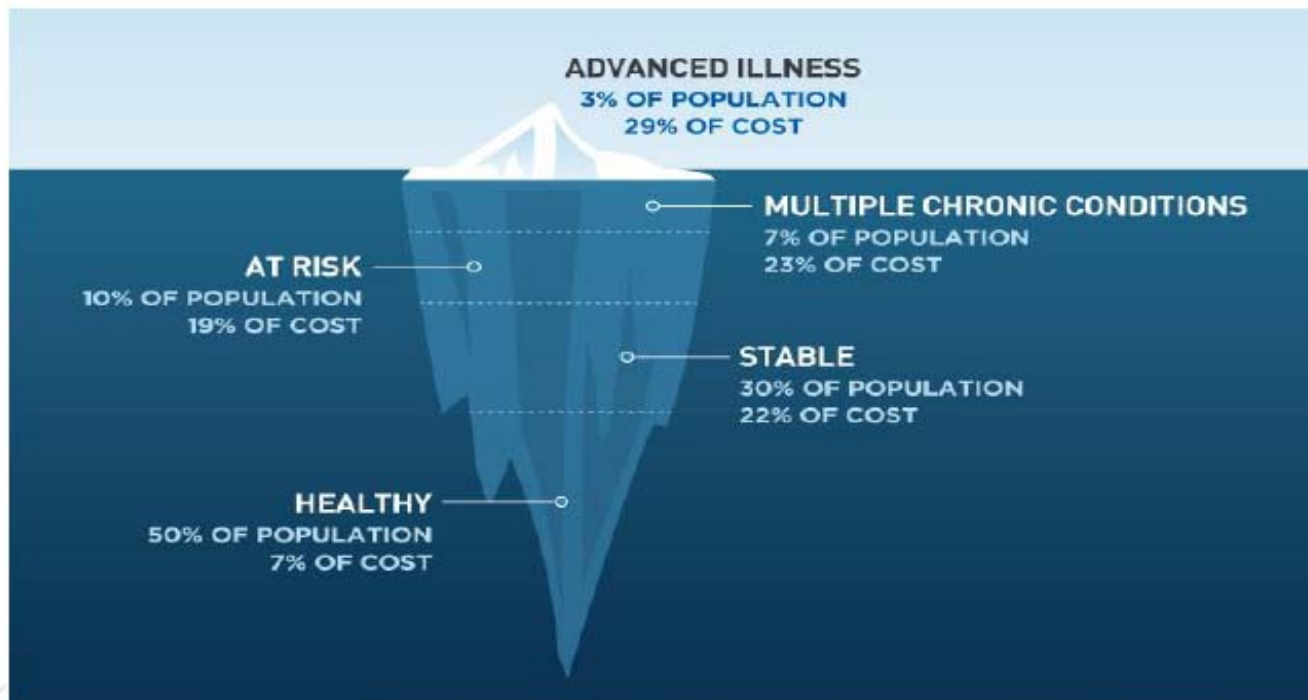
- Healthcare reform

-  Rising costs

- Prevalence of chronic diseases

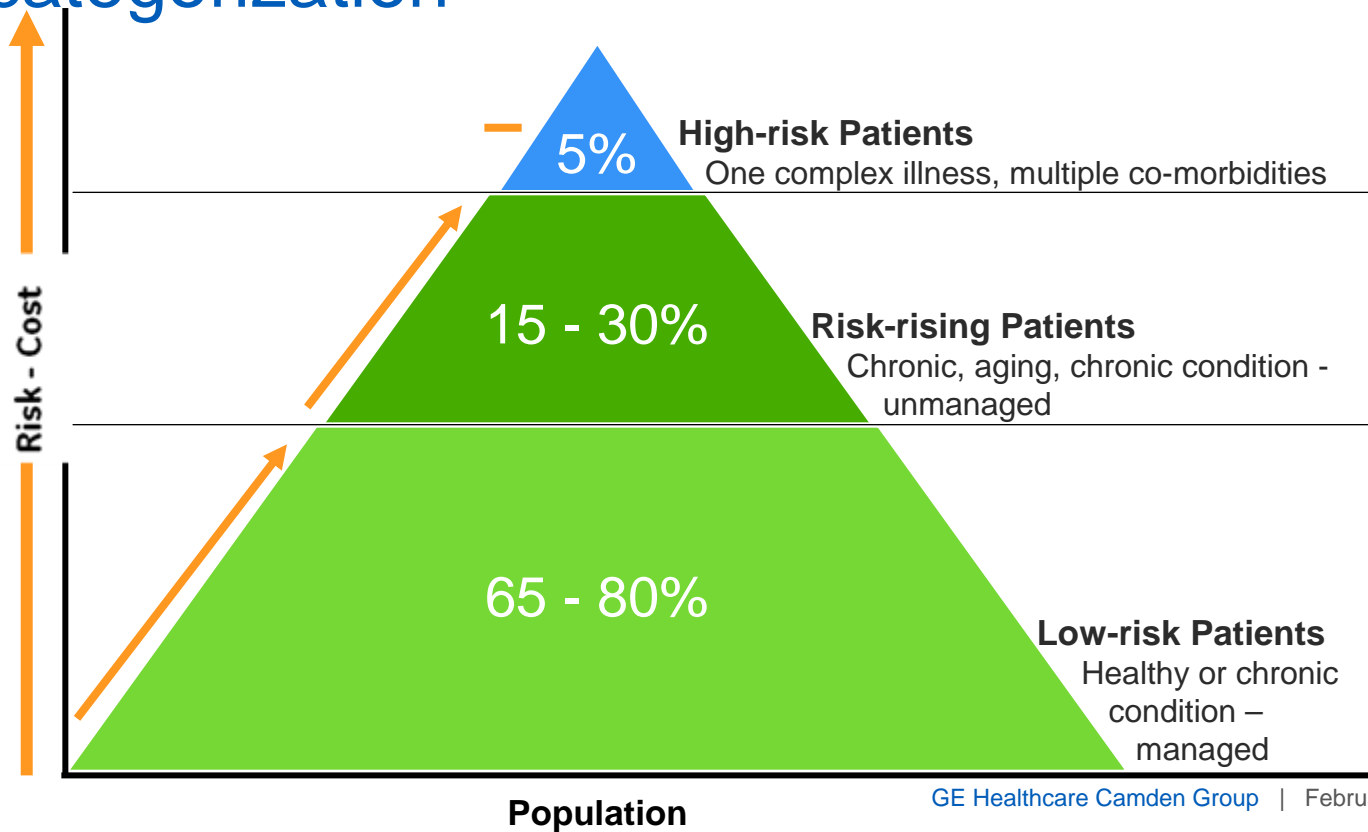
# Why is it important?

## Looking at patients with emerging risk



# Population care management

## Risk categorization



# Triggers or patient criteria

## Inpatient

- Patients with extended LOS (> 5 days)
- Patients with more than 1 unplanned admission within the past 90 days
- Patients with high intensity of service: ventilators, dialysis
- Age > 75 years
- Admission to a long-term care facility
- Certain high-risk diagnoses (both primary and secondary) including: heart failure, COPD, renal failure, stroke, complex cancers, dementia, or severe mental health issues
- High risk units (ICU, step down, transplant)
- Any admission or ED visit for a patient on CM



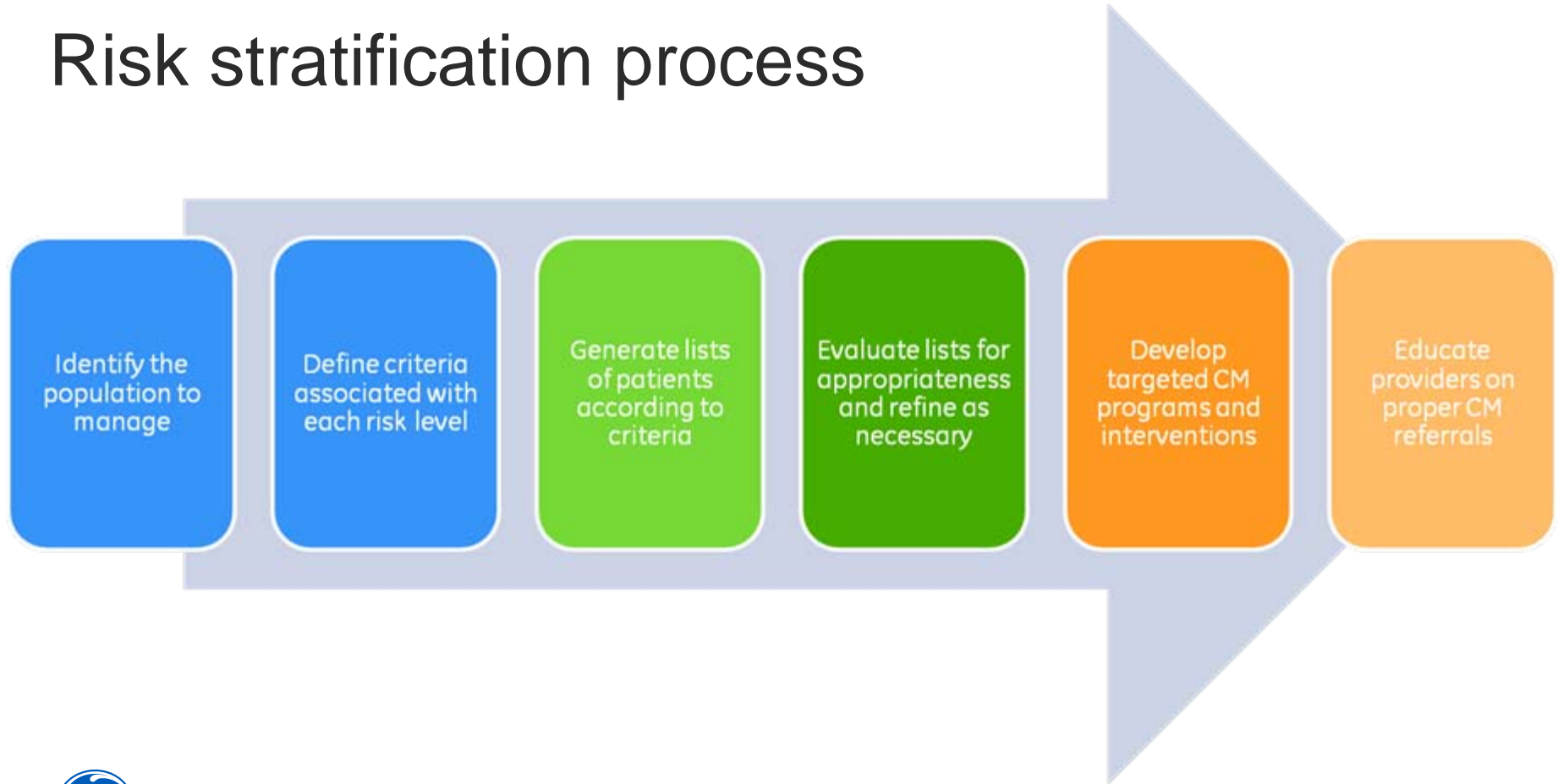
# Triggers or patient criteria

## Outpatient

- Chronic diseases with potential down the road complications: diabetes, asthma, hypertension, coronary heart disease
- Triggers to indicate poor self-maintenance such as HbA1c > 10
- Patients with more than 3 chronic conditions
- Patients with more than 7 medications
- Patients with history of frequent ED visits and admissions
- Mild to moderate mental health issues



# Risk stratification process



# The “new model” for risk stratification

Evaluate data coming from claims files or the EMR, including lab results and medications. Below are commonly used indicators or metrics in risk stratification. They are usually weighted and then a calculated score is assigned to the patient indicating risk level:

- Age
- Gender
- Costs
- Diagnosis codes or DRG
- Frequency of utilization (e.g., hospitalizations, ED visits, PCP visits)
- Number of medications
- Variability in providers (e.g., number of unique PCPs)





# The “new model” for risk stratification

In addition to claims data, the following can determine risk:

## Clinical judgment

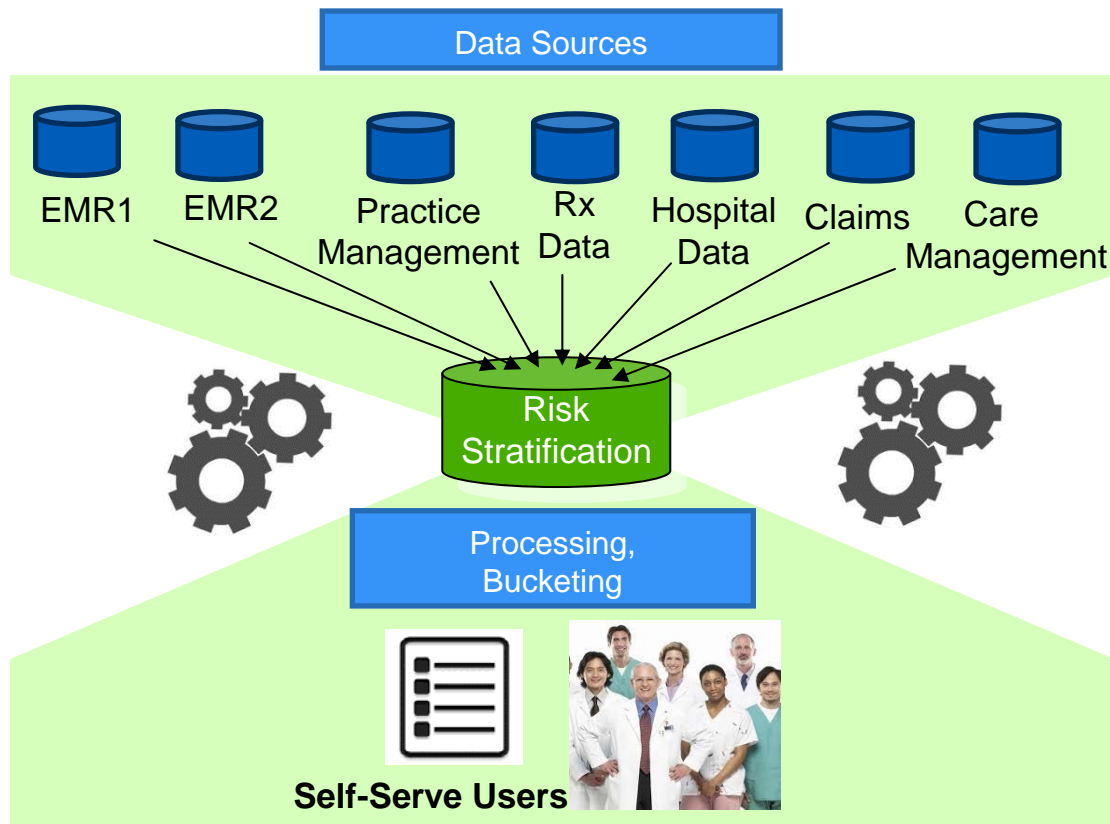
- Ask team members to refer appropriate patients to CM
  - Define the CM referral process
- Supply a list of “Referral Criteria” or “Risk Criteria” as a guide

## Survey or assessment data

- Beneficial to have psychosocial or qualitative data as part of the risk stratification formula
- Health Risk Assessment (“HRA”) or something similar to collect data



# Data infrastructure



# Output of risk stratification tools

These robust systems usually provide patient profiles with metrics such as these:

- Risk score
  - Percentage format (e.g., patient has a 98 percent chance of high utilization in the next 12 months)
  - Numerical format (e.g., patient is ranked with a score of 4.5 out 5.0)
  - Tiers (e.g., high risk, moderate risk, or mild risk)
- Total costs
  - Total inpatient costs (by condition, by specific time periods)
  - Total outpatient costs (by condition, by specific time periods)
  - Total pharmacy costs (by condition, by specific time periods)



# Output of risk stratification tools

## Utilization

- Total hospital admissions within a time period (with average length-of-stay)
- Total ED visits within a time period
- Total number of ambulatory visits within a time period

## Disease-based registries

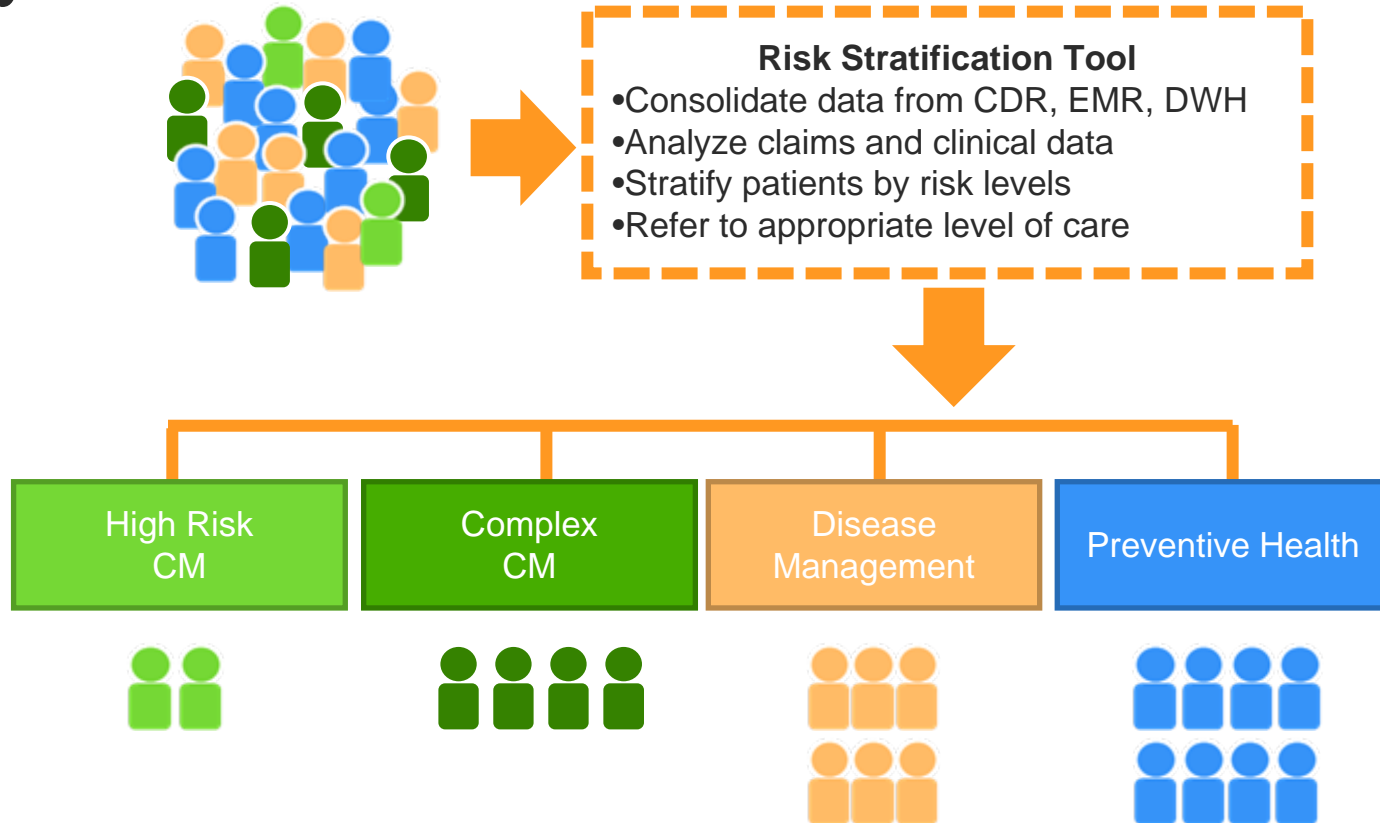
Total number of comorbid conditions

Total number of filled medications

Total number of providers (by provider type)



# Apply risk stratification to the care model



# Sample interventions for different risk levels

## High Risk CM

- Care Manager calls 3 times per week
- In-person, in-clinic visit with patient
- Work in partnership with practices and providers
- Early intervention for urgent symptoms – refer to urgent care or hospitalists

## Complex CM

- Care Manager calls 2 times per week
- Early identification of patients requiring medical intervention
- Symptom and disease education

## Disease Management

- Interactive Voice Response (“IVR”) outreach
- Care Manager calls when triggered by IVR
- Care coordinator calls 1 time a month, can refer to Care Manager

## Preventive Health

- Automated clinical workflow
- Letter generation
- Patient education materials



# Design and align workflows



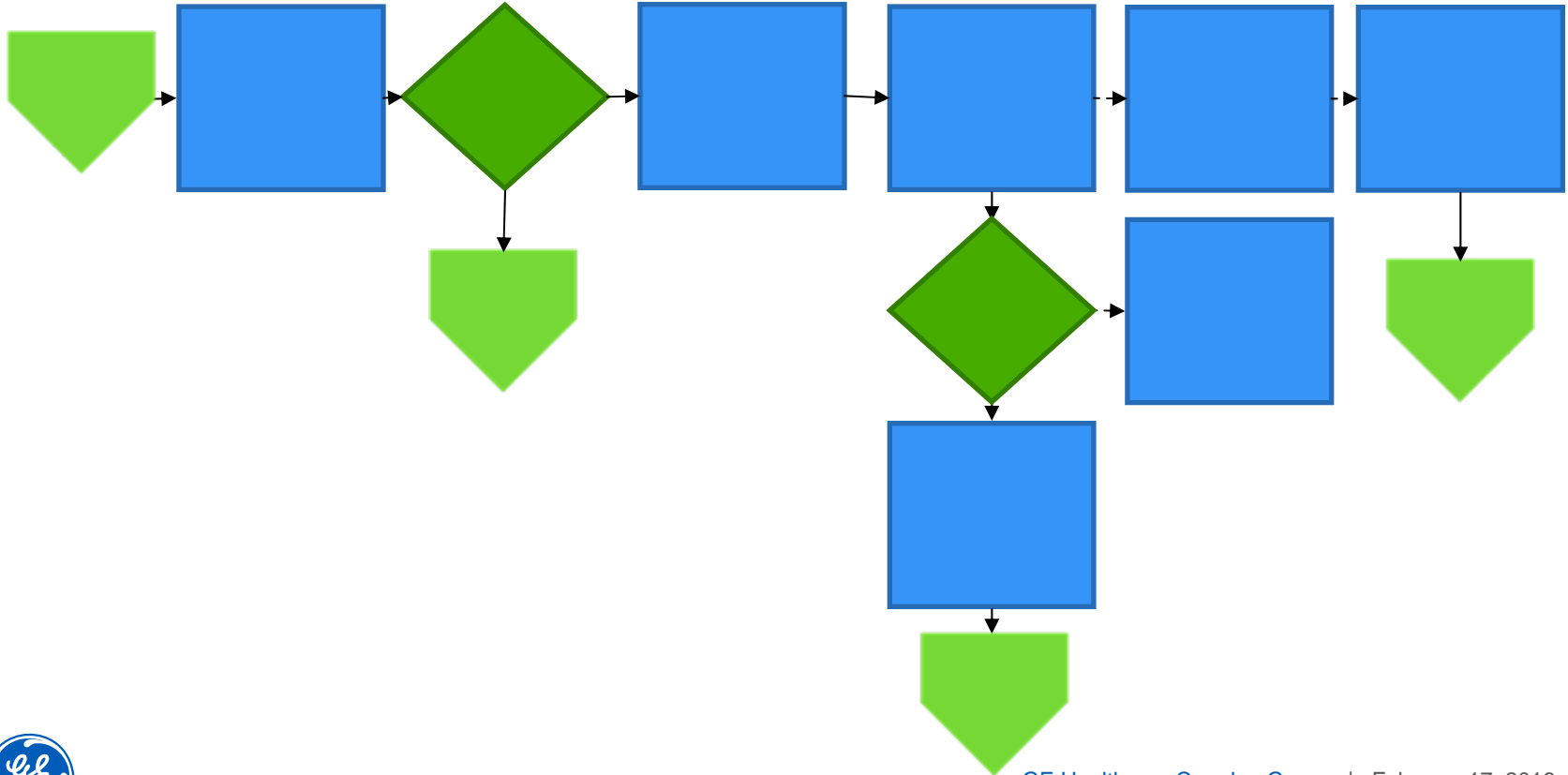
# Design and align workflows

- Compose a workflow team with representation from every care team member.
- Draw workflows outlining how a patient moves through the system.  
Processes might include:
  - Referral and enrollment
  - Escalation paths
  - Discharge and transition
- Address and outline:
  - Roles and responsibilities
  - Interventions and procedures
- Coordinate processes with all providers and care team members.
- Share clinical information and communicate with entire care team.
- Use technology systems to support workflows.





# Design and align workflows



# Staffing/Personnel

Common job titles for “Care Managers” include:

- Care/Case Manager
- Care Coordinator
- Health Navigator
- Patient Coach

Care Managers have clinical backgrounds and are typically:

- Registered Nurses (“RN”)
- Licensed Vocational Nurses (“LVN”) or Licensed Practical Nurses (“LPN”)
- Social Workers (“SW”)

Support team members

- Medical Assistants (“MA”)
- Non-clinical staff



# Rethinking the care team



# Staffing ratios

Variables to consider include:

- Patient population
- Encounter frequency
- Interventions
- Length-of-stay in program
- Location of services
- Geography
- Team composition
- Technology support
- Other resources



Benchmarks	
Ratios	Population
Tier 3 Patients	2 - 5%
Tier 2 Patients	5 – 8%
Tier 1 Patients	~90%
Staffing	Panel Sizes
<b>Hospitalist</b>	<b>18-22</b>
Primary Care Physician	1,500-2,500
Inpatient Care Manager	25-50
In-home Care Manager	25-100
Telephonic Care Manager	100-250
Care Coordinator	250-500
Social Worker	50-150
Clinical Pharmacist	150-500

# Planning for population health management

## Patient engagement



“Actions individuals must take to obtain the greatest benefit from health care services available to them.”

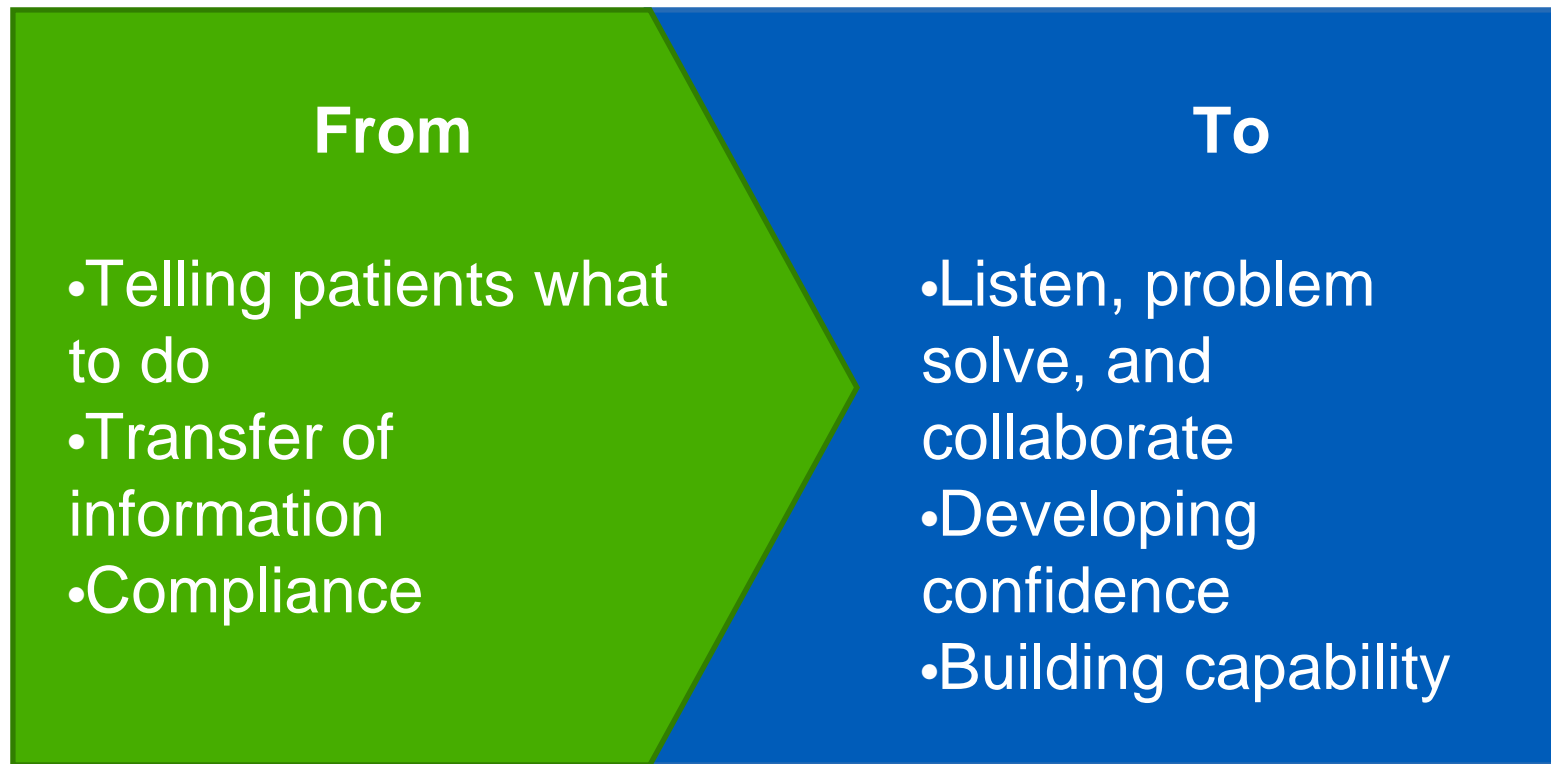
-The Center for Advancing Health

Focus on behaviors of individuals relative to their healthcare that are critical to health outcomes

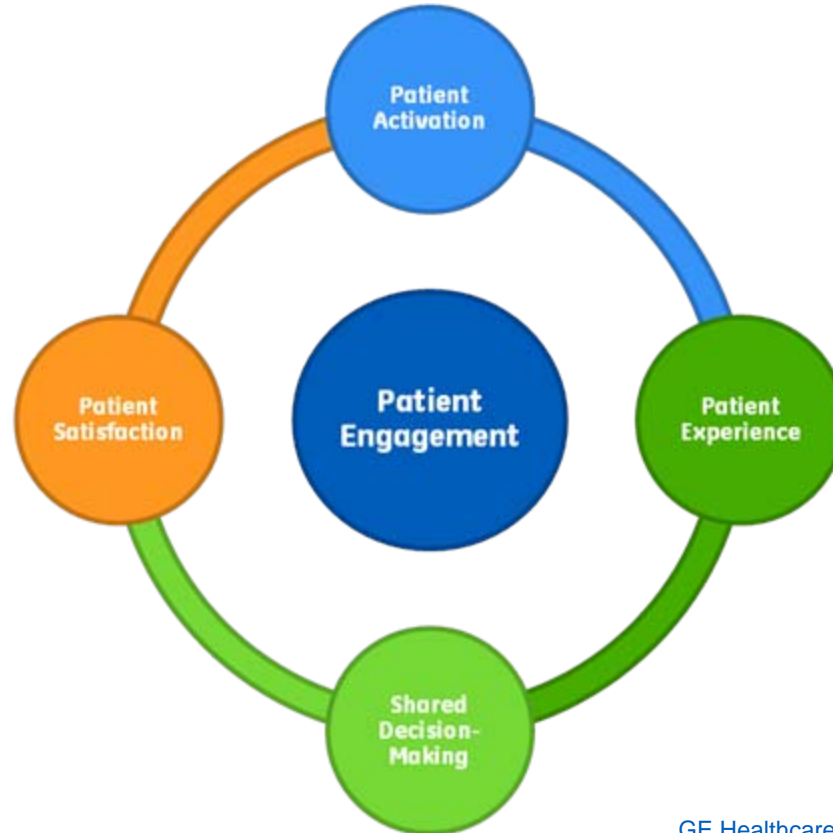
Individual synchronizes information and professional advice with their own needs, preferences, and abilities



# Patient engagement paradigm shift



# Components of patient engagement



# Pathway to patient engagement

A paradigm shift is required to develop collaborative and meaningful patient and provider relationships serving as the foundation for patient engagement.

Patient engagement is integral to achieve better outcomes, increased patient satisfaction, and improved efficiencies in service delivery.

CMs may face resistance in engaging the patient and the first step to success should include meeting patients where they are.

There are several well honed tools to used to engage patients: PAM<sup>®</sup>, Health Confidence Measure<sup>®</sup>, and the Trans Theoretical Model.

Coaching takes time and skill but is successful in changing health behaviors and nurturing patient engagement.





# Building a plan of care



# Pathways to population health management

## Care management

Which of the following is not essential to the CM process?

- A. Assessment
- B. Planning
- C. Facilitation and advocacy
- D. EMR
- E. Collaboration



# One patient care plan



# Clinical protocols

Acute Myocardial Infarction

Substance Abuse

Asthma

Cancer Screening

Community Acquired Pneumonia

Congestive Heart Failure

COPD

Depression

Diabetes

End Stage Renal Disease

Hypertension

Lipid Management

Low Back Pain

Osteoporosis

Pain Management

Tobacco Treatment



# Patient care plan: Goals

Capture patient preferences, patient goals, and action items (a standardized template should be used)

Develop in collaboration with the patient, family, caregiver(s), patient's provider(s), and care managers

Update frequently based on changes in the patient's health status and goals

Share with members of the patient's interdisciplinary care team

Share with the patient, family, and caregiver(s) to align expectations and goals and available in the appropriate language and literacy level

- Attach patient educational materials, as appropriate



# Basic elements of a patient care plan

## Patient goals

- Align essential health goals with patient and family/caregiver preferences and personal goals
- Goals need to be measurable – tie them with an outcome

## Problems/Issues

- These do not need to be (and often are not) ICD diagnosis codes
- May include chronic conditions like diabetes or COPD, but also issues like nutrition or falls

## Interventions/Action Items

- To-dos” or next steps that need to be taken in order to meet the goal(s)

## Delegation /Timeline

- Interventions and action items can be assigned to any member of the care team and/or the patient/family along with a target completion date; progress should be tracked

## Barriers

- Any actual or potential obstacles or challenges that arise that could impede the completion of an intervention or fulfillment of a goal; all barriers need to be overcome with an action



# Action plan

## Problems

- What diagnoses, conditions, and issues are the patients facing today? These do not need to be ICD-10 codes but rather real concerns the patient has
  - Example: At risk for falls

## Goals

- List achievable goals, something you can check off as complete
  - Example: Change home setting to reduce risk of falls

## Barriers to goals

- What is in the way of the patient achieving this goal?
  - Example: Patient is not physically able to move furniture



# Action plan

## Interventions and action items

- List the tangible action item(s) that need to be completed to meet and achieve the goal(s), including who is accountable and when
  - Examples:
    - Ask cleaning lady to remove all throw rugs on next Wednesday
    - Ask son-in-law to purchase and replace all dead light bulbs in the hallways and rooms by end of the month





# Sample care plan

## Goal

- “I want to be able to get back to my gardening.”
- General strengthening, improve and stabilize quad strength and ambulation.

## Problems

- Currently walker-dependent s/p right knee replacement.
- Pain management: Currently on PCA pump.

## Actions

- Exercises to progress knee strength and range of motion to 80° flexion by D/C. Practice walker stability, stairs.
- Progress from PCA to oral meds within next 24 hours with pain controlled at 3.

## Delegation

- PT, OT
- M.D., nursing

## Barriers

- 3 steps leading to home: PT and OT working on walker safety on steps.



# 4 types of care plans

Simple: Episode-based

Routine: Focused on annual wellness exam

Complex: For patients suffering from chronic conditions

Advanced: End-of-Life issues



# Effective care plans

Care plans will need to be revisited several times as new needs, goals, and challenges occur

Care plans should extend and support the patient during the full course of their illness

Care plans should be developed with the patient and family/caregiver, and a copy given to them whenever possible

- Keep language in a patient-family/caregiver version easily understandable, around 6<sup>th</sup> grade level
- Use pictures and visuals whenever possible



# Aligning incentives



# Effective design of incentives is integral to change



# Provider value equation

$$\begin{array}{c} \text{V} \\ \text{(Value)} \end{array} = \frac{\begin{array}{c} \text{Q} \\ \text{(Quality)} \end{array} + \begin{array}{c} \text{S} \\ \text{(Service)} \end{array}}{\begin{array}{c} \$ \\ \text{(Cost)} \end{array}}$$



# Which factors are important to success?

Revenue: HCC/RAF

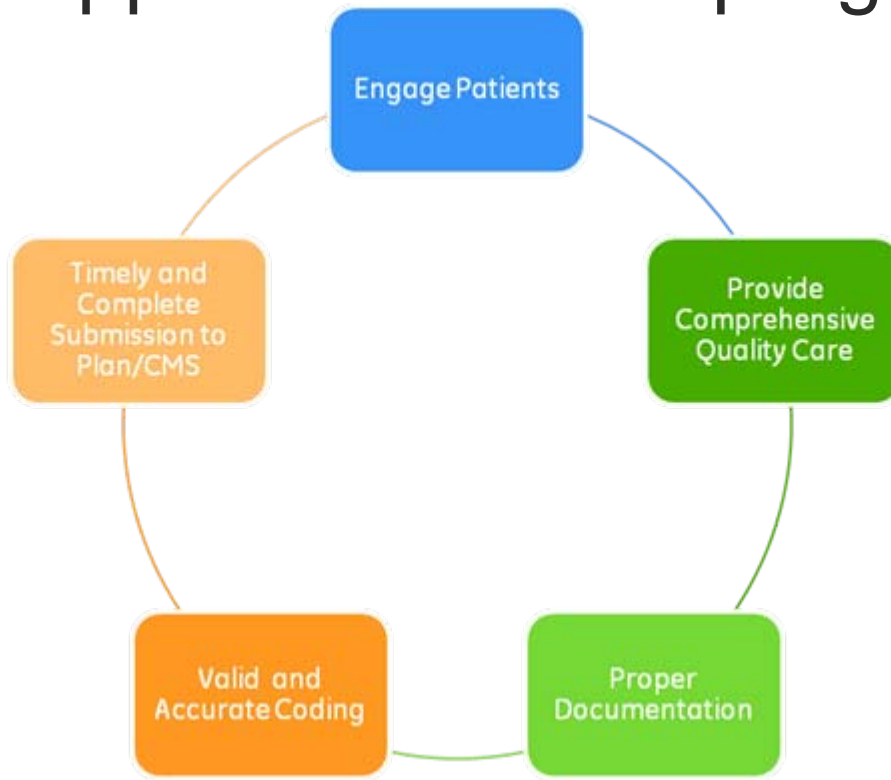
Expense: Manage utilization and appropriate sites of care; implement care model redesign

Quality: Clinical metrics and outcomes

Service: Patient experience



# Holistic approach to HCC programs

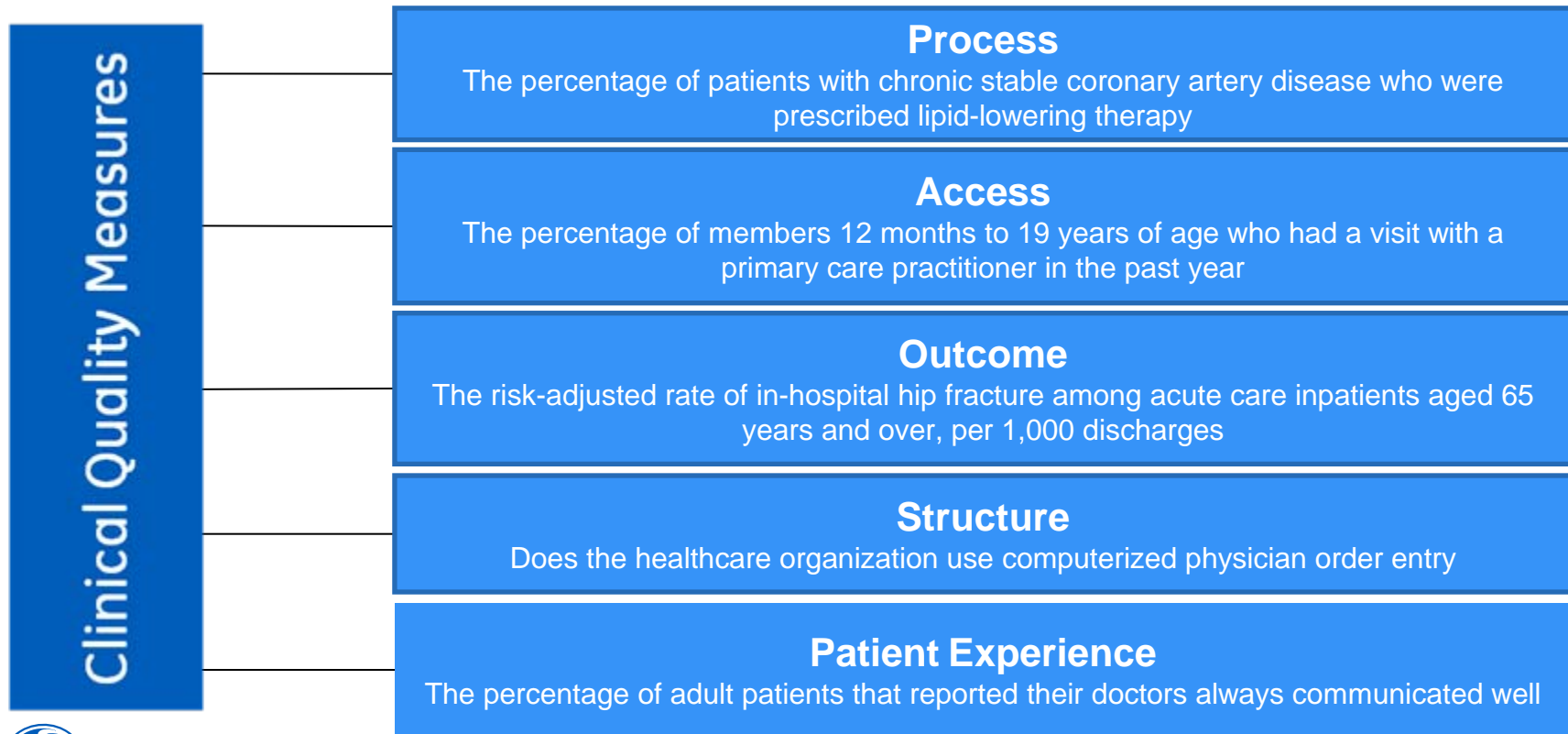


Properly incentivize and educate provider network to fully capture diagnoses to reflect accurate risk scores





# Domains of quality and service



# Why is it so difficult?

Lack of consistent manner to measure quality.

Physicians asked to comply with different measures depending on the payer.

## United Healthcare PCP Incentive Program

Medication Safety Monitoring: ACE or ARB Therapy, Digoxin, Diuretics

Breast Cancer Screening: Mammogram (42 to 69 years)

Cervical Cancer Screening: Pap Test (24 to 64 years)

Diabetic Care: HbA1c Test (18 to 75 years)

Diabetic Care: LDL-C Screening (18 to 75 years)

Diabetic Care: Nephropathy Screening (18 to 75 years)

Pharyngitis: Abx and Group A Strep Test (2 to 18 years)

URI and No Abx Prescription (3 months to 18 years)



## Anthem Blue Cross Blue Shield Quality In-Sights PCP Program

Dilated Retinal Exam — Members with diabetes, age 18 to 75, who had an eye exam with an eye care professional during the measurement year or the year prior to the measurement year.

HbA1c Test — Members with diabetes age 18 to 75, who received 2 HbA1c tests, at least 3 months apart, during the measurement year.

LDL-C Test — Members with diabetes, age 18 to 75, who received an LDL-C test during the measurement year.

Appropriate Medication Use - Members with persistent asthma, age 2 to 56, who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year.

Well Child Visits — Members, age 3 to 5, who received a well care visit during the measurement year.

Adolescent Well Care Visits — Members, age 11 to 18, who received a well care visit during the measurement year.

Members, age 2 to 18, who were diagnosed with pharyngitis or tonsillitis, prescribed an antibiotic, and received a group A streptococcus test for an episode in the measurement year.

# Patient satisfaction

## Everyone is rating physicians



# Patient satisfaction

- It is both important to manage your reputation with the multitude of ratings and to measure patient satisfaction internally.
- Some organizations rely on health plan or CMS satisfaction surveys.
- CG-CAHPS or other tested, reliable, and comparable tool is recommended.
- Integrate patient satisfaction into physician compensation.
- Be cautious about interrelationship between clinical quality metrics and patient satisfaction.

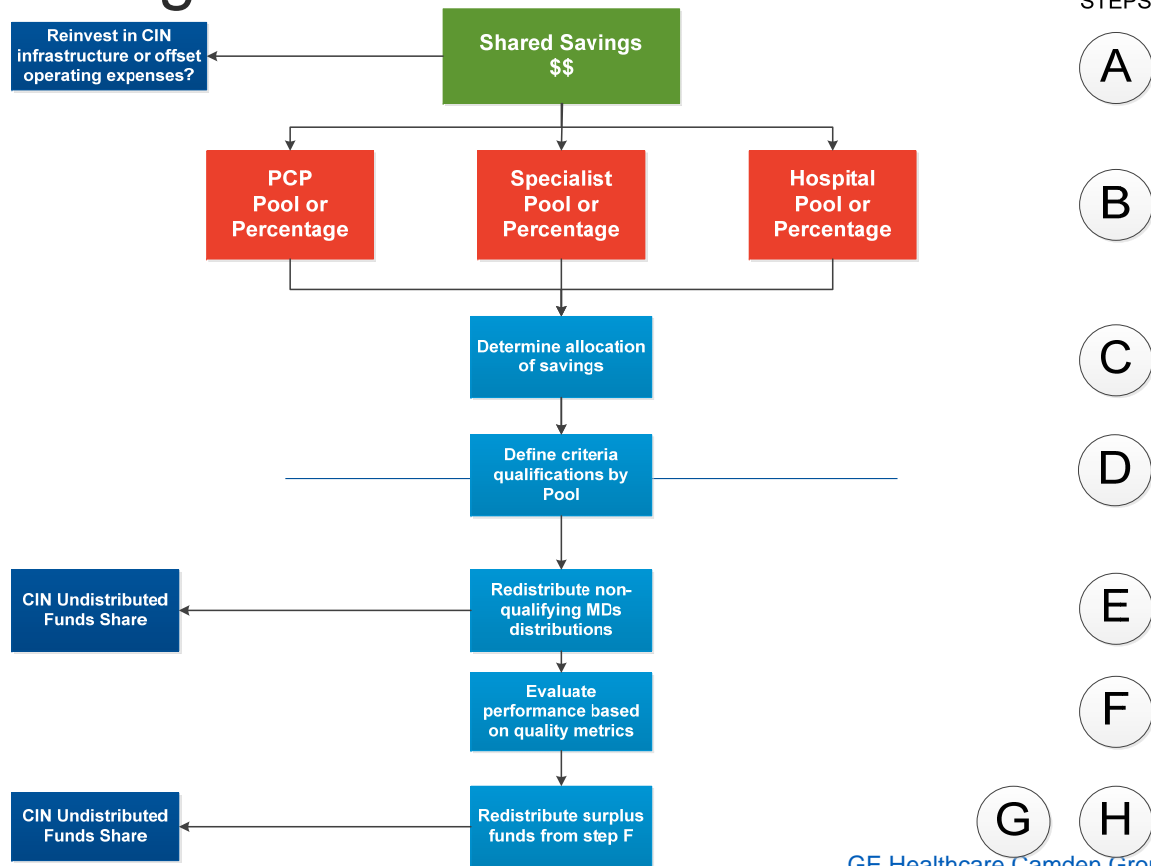


# Funds flow

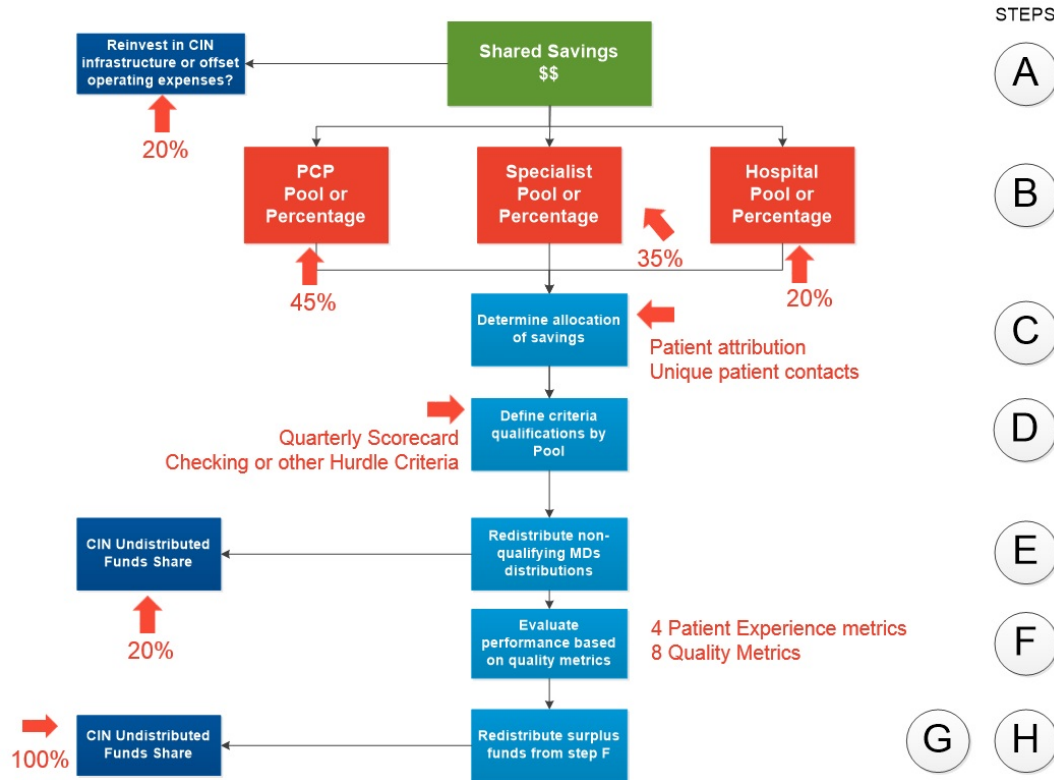
- Once you have achieved savings or “profit”, how are the funds distributed back to the providers of care that are working to improve the delivery system?
- Depending on the structure, your organization may not have the authority to distribute back to individual providers, diluting the impact of the incentive.
- Funds flow decisions should be made **BEFORE** there is savings to be shared and criteria for distribution clearly delineated and communicated in advance.



# Shared savings: funds flow model decision points



# Shared savings: funds flow model decision points example



# If taking full or partial risk (capitation) Physician reimbursement

Structure of organization will impact how this is handled.

For PCPs:

- Continue FFS with optional withhold
- Capitation - flat fee by product line; or age/sex differentiated by product line
- Percent of premium

For specialists:

- FFS
- Sub-capitation





# Tie in to physician compensation

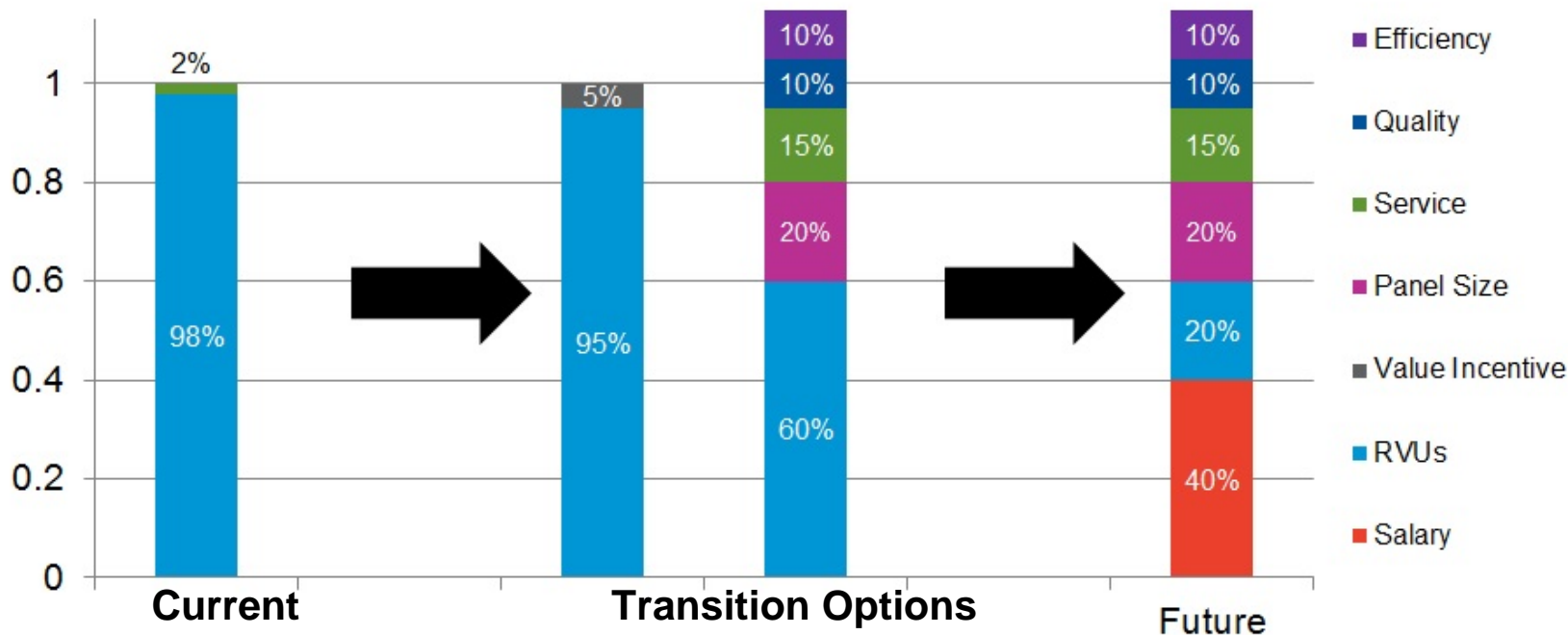
## Are distributions and reimbursement aligned with physician compensation?

- Make sure incentives that are driving reimbursement and distribution are reflected in individual physician compensation and/or bonus structure.
- Can be extremely challenging with multiple organizations, payers, risk arrangements, and quality/clinical metrics involved.



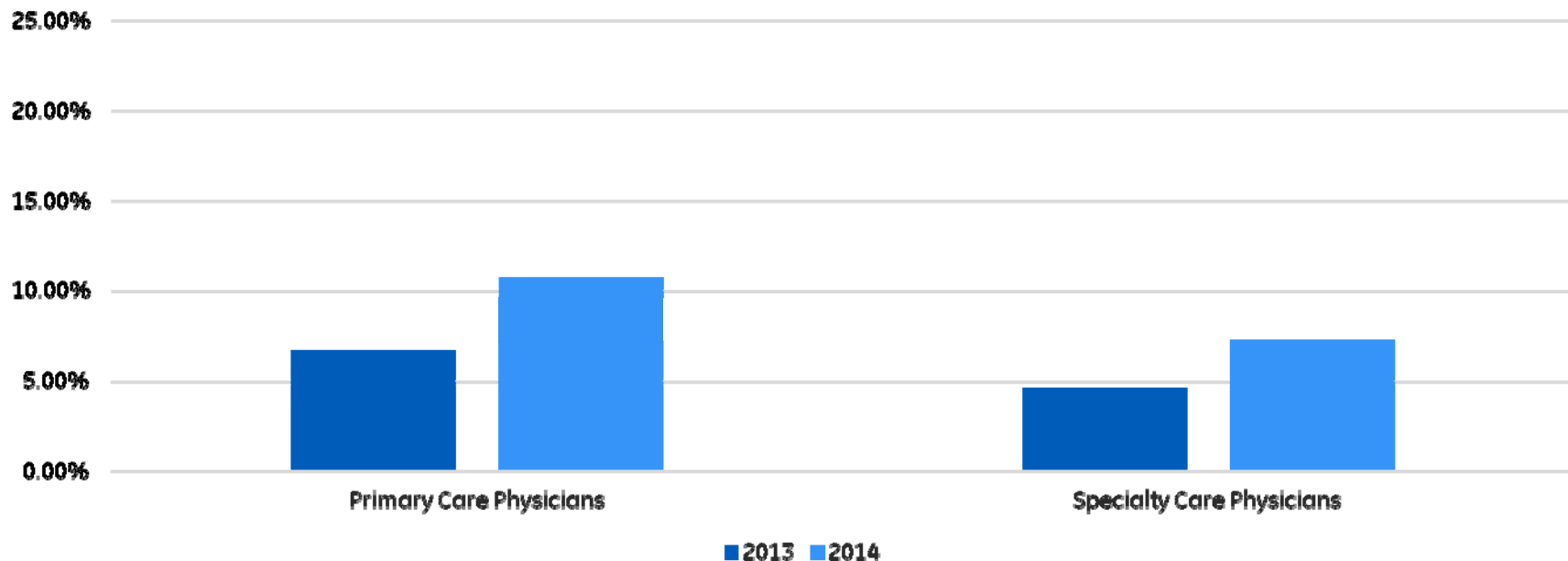
# Aligned incentives: physician compensation

## Sample Medical Group Compensation Model Transition

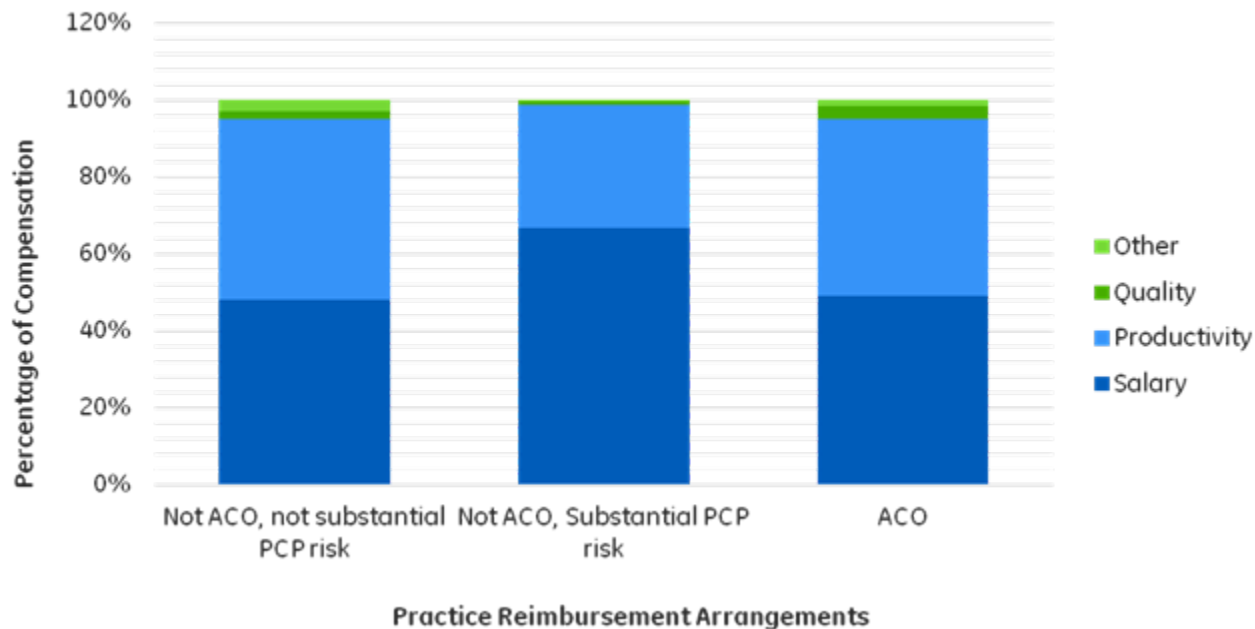


# Physician compensation

## Percentage of Total Compensation Tied to Quality (Excluding Patient Satisfaction), 2013-2014



# Physician compensation under different practice arrangements



# Aligned incentives: physician compensation

Align compensation with organizational vision and goals as well as contractual reimbursement structures.

If “bonuses” or shared savings are paid down from a CIN or risk bearing entity to the tax identification number (“TIN”) level, the purpose of the incentive may be defeated if performance isn’t integrated into compensation at the TIN level.

- Consider issues associated with fair-market-value of compensation, inability to distribute additional “bonus”.

Effectively aligning incentives is integral to successful behavioral change.



# General requirements for managing risk

Integrated information systems.

Comprehensive utilization management system.

Selected risk sharing partners.

Provider performance review process.

- Quality and outcome measurements, access and availability, patient satisfaction, compliance with policies and procedures, evaluation of specialists by PCPs.

Adequacy and geographic coverage of network, including hospitals.

Creation and dissemination of physician profiles.

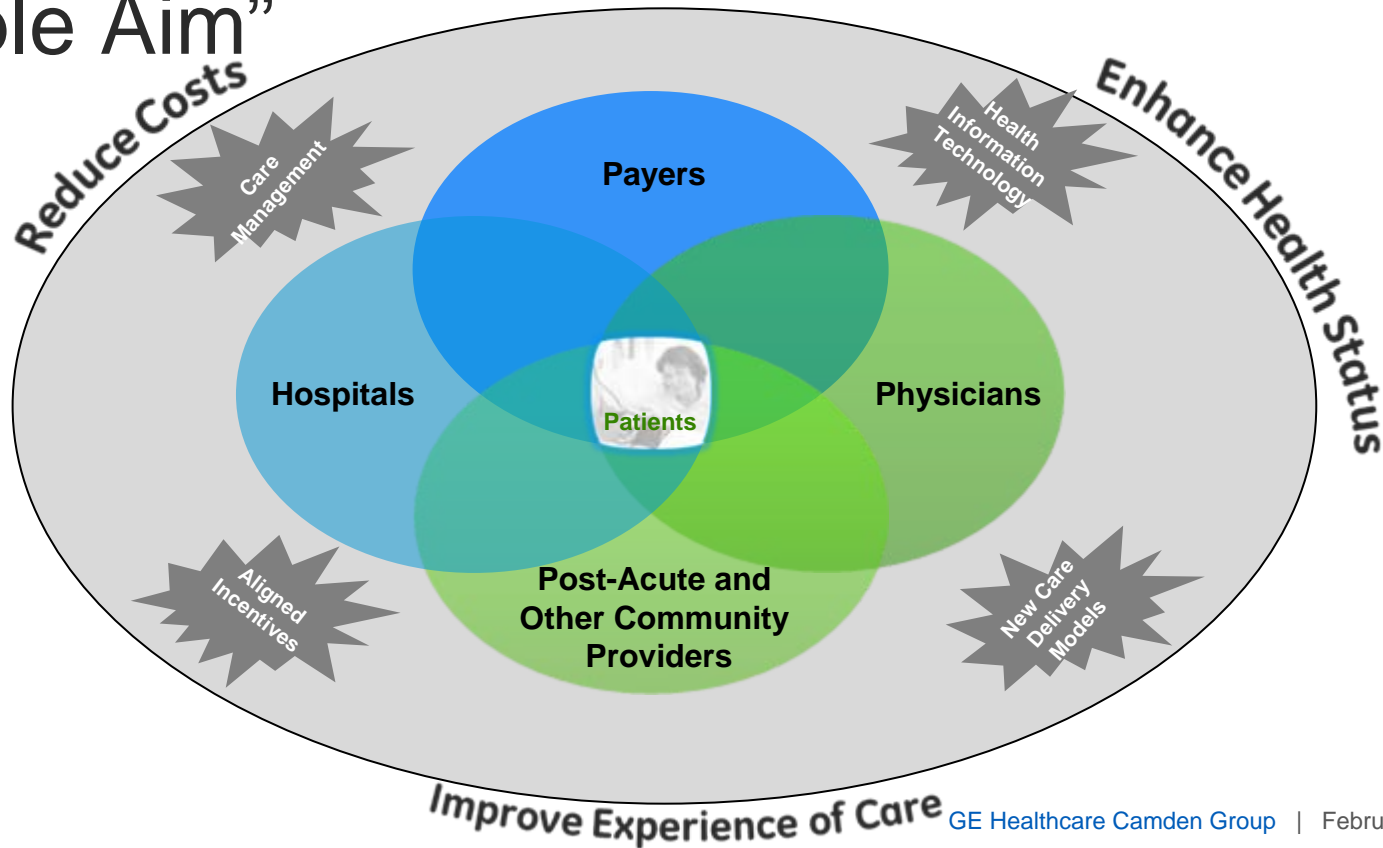
- Referrals to specialists, utilization of ancillary services, inpatient admissions and length-of-stay, use of outpatient facilities, pharmacy cost, patient complaints and requests for second opinions, patient panel



# Other considerations for success

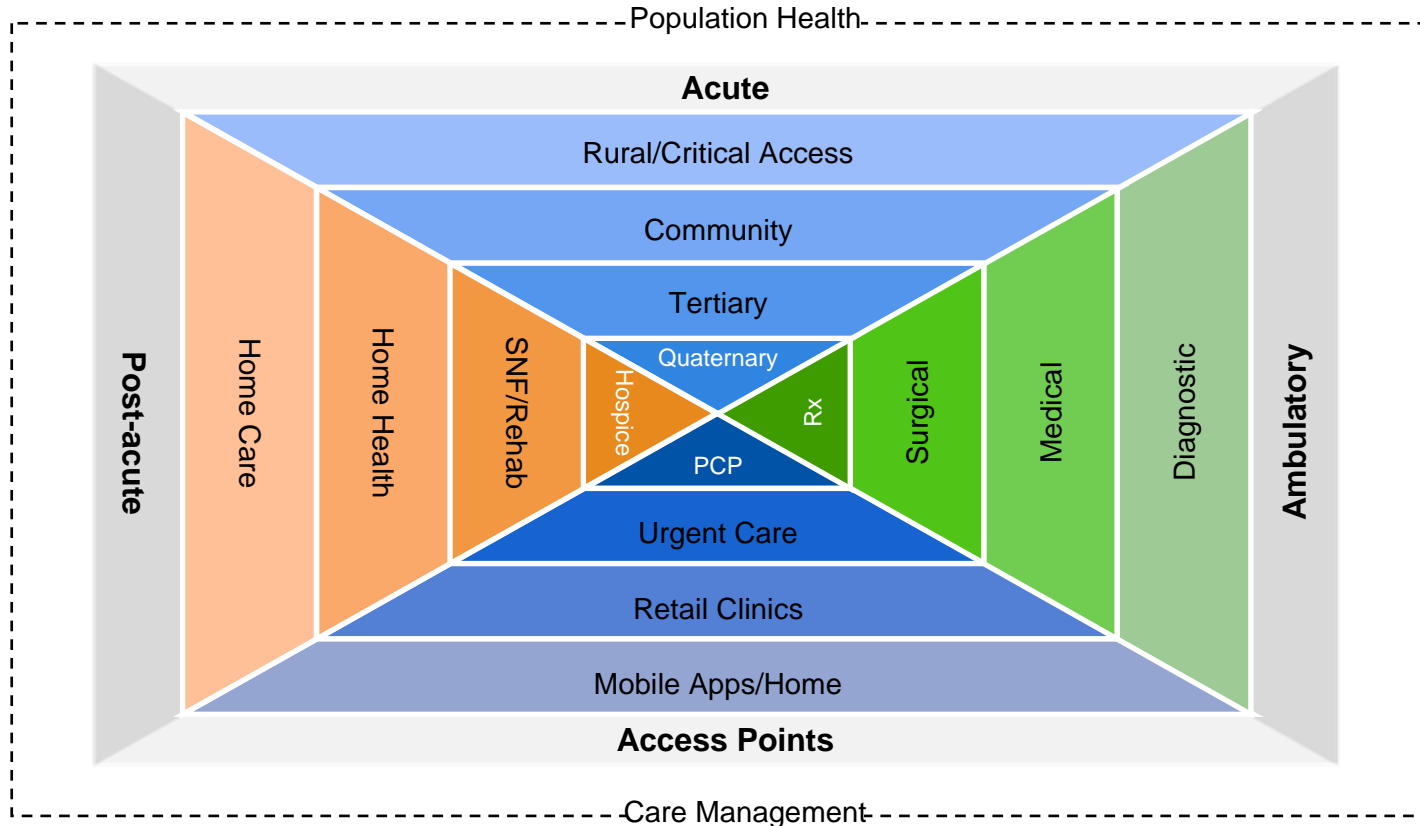


# Clinical Integration – Aligning to Achieve the “Triple Aim”

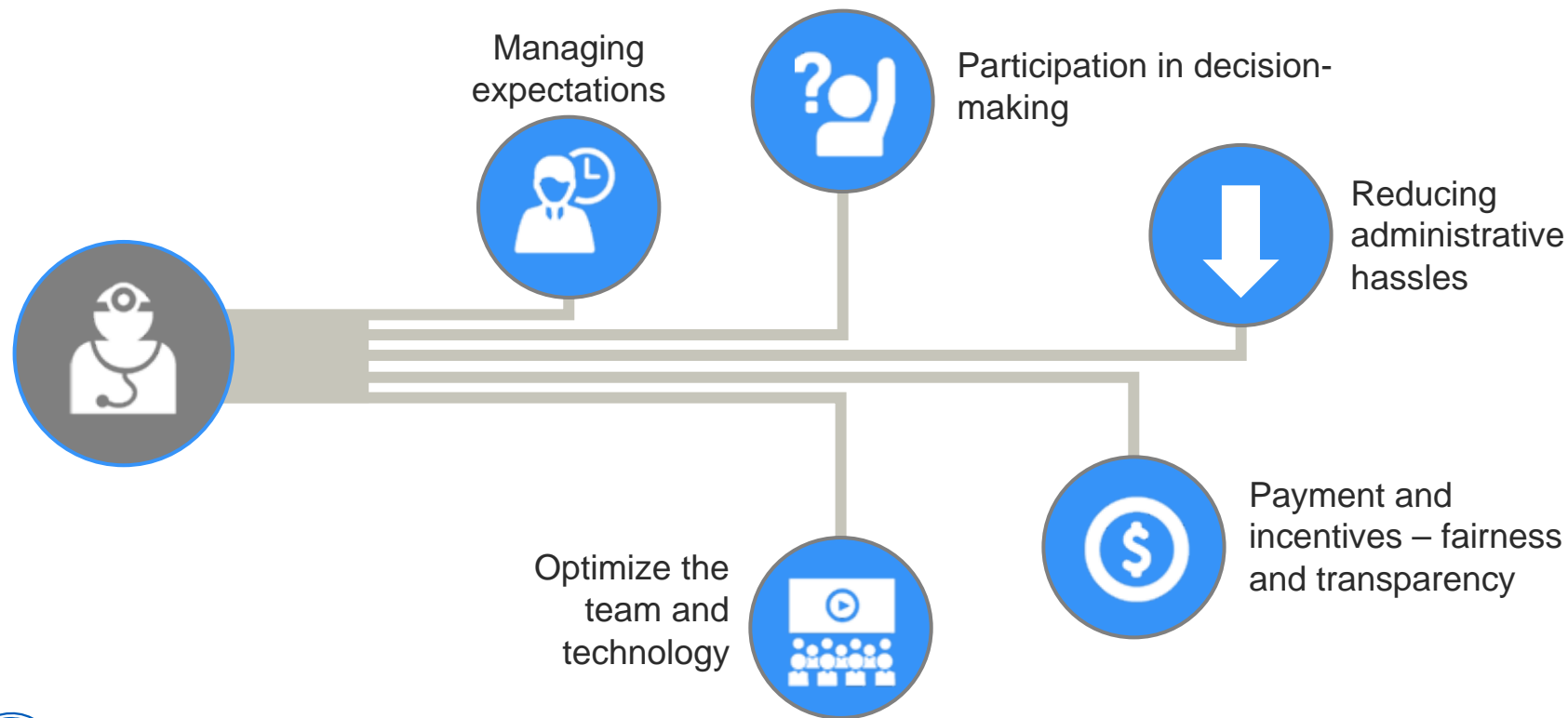




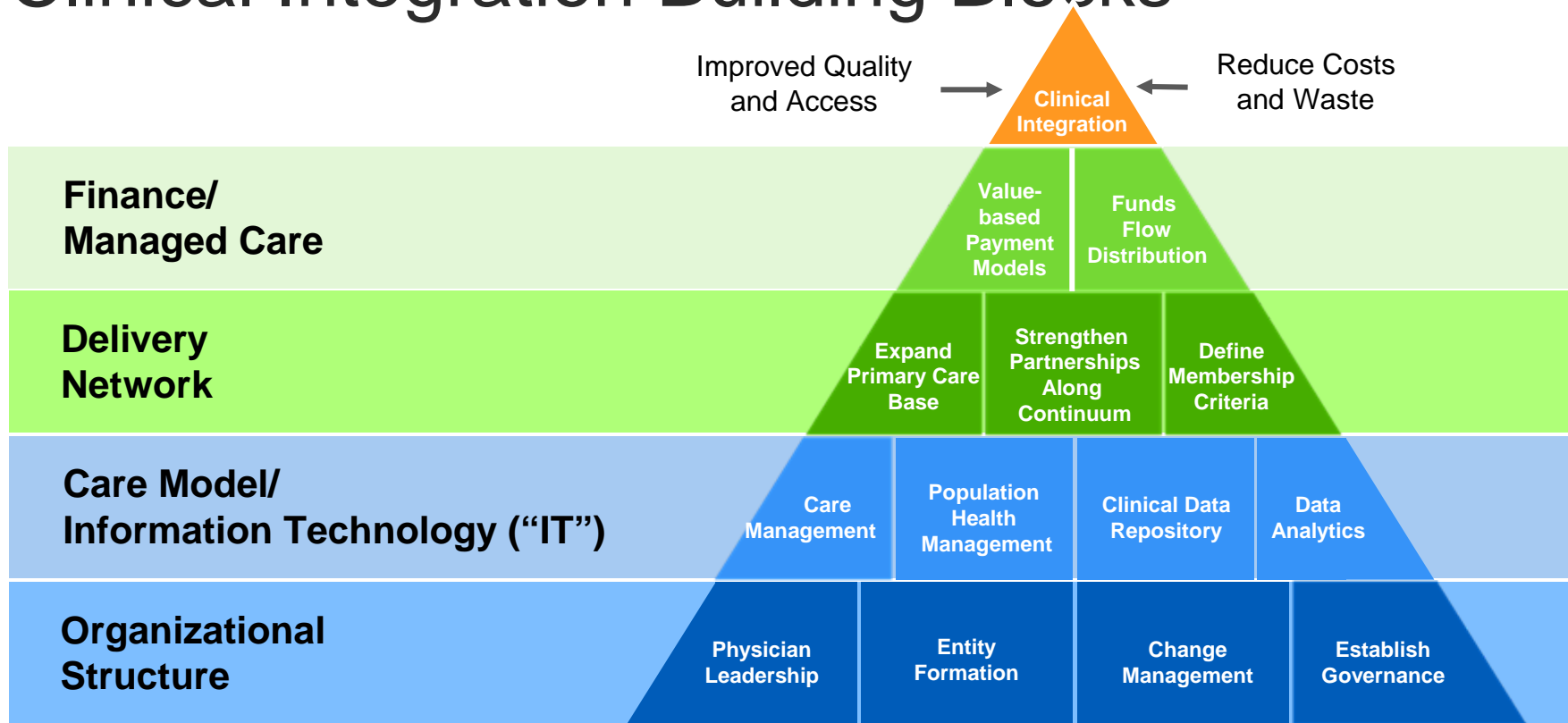
# Pyramid of success



# Physician engagement – what does it take?



# Clinical Integration Building Blocks



# Evolving Leadership Requirements

**Fee-For Service**

**Transition**

**Fee-for-Value**



Hospitalist and  
Case Management

Throughput

Patient Safety

Reduce  
Re-admissions

Clinical  
Co-management

Physician  
Enterprise  
Restructure

Medical  
Home

ACO

Care  
Management

Clinical  
Integration



**Key Leadership  
Requirements**

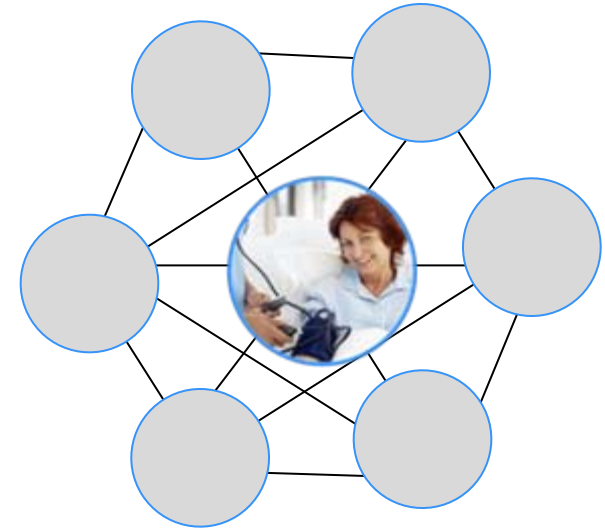
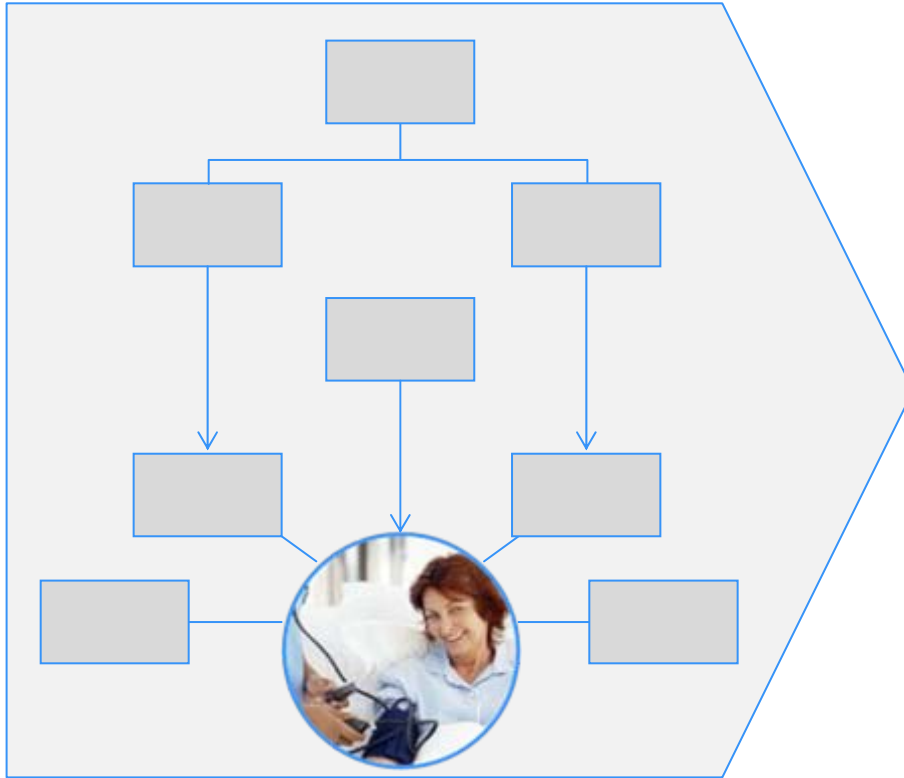
**“Lean” Management  
Vision  
Seek Growth**

**Change Management  
Communication**

**Collaboration  
Transparency**



# Rethinking Our Organizational Orientation



# Creating an “Integrated” Culture



# Critical Success Factors

Integrated **clinical management** infrastructure (e.g., care management capability and acute case management with hospitalists)

**Commit the resources** required for timely and successful execution (capital, IT infrastructure, physicians, network development, human capital/time)

Create and adhere to a **prioritized operational action plan** for implementation, with clear timeframes, measures, and accountabilities

**Disseminate actionable and meaningful data** quickly and transparently to drive decision-making and accountability

Develop a **unified culture that breaks down silos** and achieves buy-in through collaborative decision-making



# Questions and Discussion





