

Thomas Jefferson University College of Population Health  
The Sixteenth Population Health Colloquium

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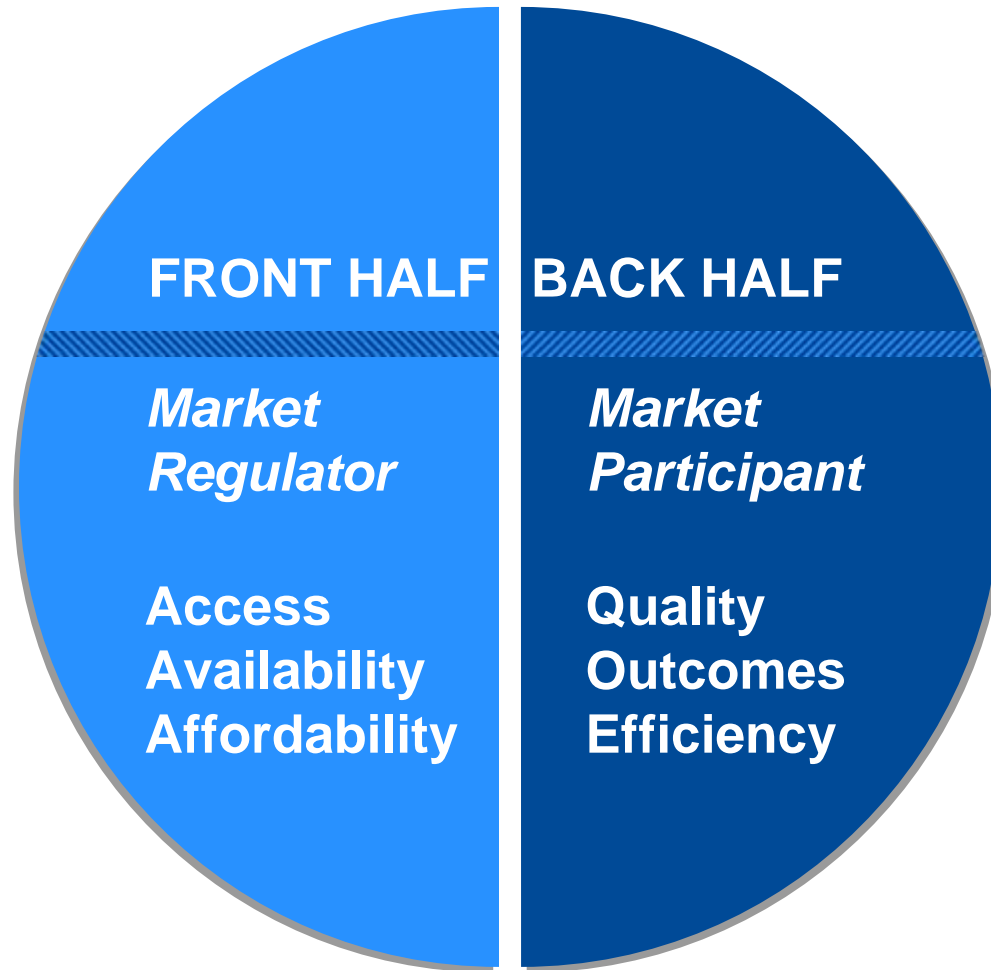
# Value Transformation:

Paying for Sick Care vs. Funding Population Health

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March 7, 2016





# The Time Is Now



## *Medicare Transition to Value-Adjusted FFS Payments and Alternative Payment Models (APMs)*

2016



**85%** of Medicare fee-for-service payments tied to scores on quality and efficiency measures.

2018



**90%** of Medicare fee-for-service payments tied to scores on quality and efficiency measures.



**30%** of traditional Medicare payments through ***alternative payment models***, e.g. ACOs, bundled payments.



**50%** of traditional Medicare payments through ***alternative payment models***, e.g. ACOs, bundled payment.

# 75% of Business in Value-Based Payment Arrangements by 2020



Launched in February 2016 by 20 major companies

- American Express, Verizon, Coca-Cola, and HCA
- Spend \$14 billion/year to provide healthcare for 4 million employees and dependents

Transform corporate healthcare benefit marketplace

- Greater marketplace efficiencies
- Learning from data
- Educating employees regarding healthcare choices
- Breaking bad habits (passing along costs)

# Fee-for-Service Reimbursement



## INCENTIVES

- Maximize patients
- Maximize services



## MEASURES

- DRGs and APCs
- CPTs



## REGULATORS

- Fraud and Abuse Laws
- Reimbursement Rules



## PROVIDERS

- Silos
- Competitors



## PATIENTS

- Unmanaged chronic conditions
- Uninvolved in care



## RISK

- Resides with payer
- Increasing costs

# Value-Based Reimbursement



## INCENTIVES

- Manage patient population
- Coordinate continuum of care



## MEASURES

- Quality
- Efficiency



## REGULATORS

- Network Participation



## PROVIDERS

- Continuum of care
- Collaborators



## PATIENTS

- Educated
- Engaged



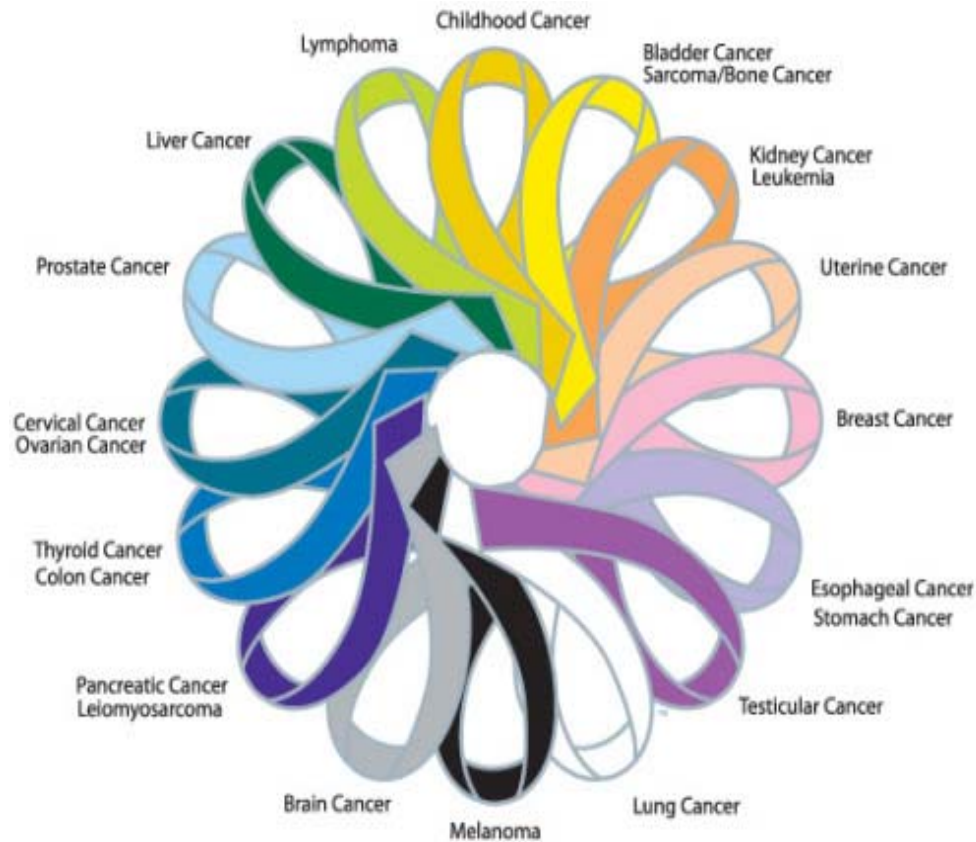
## RISK





- Moves to providers





# Re-Thinking ROI



FEE-FOR-SERVICE (FFS) PAYMENTS	VALUE-ADJUSTED FFS PAYMENTS	APMs INCORPORATING FFS PAYMENTS	POPULATION-BASED APMs
			
<b>A</b> Traditional FFS <b>B</b> Infrastructure Incentives <b>C</b> Care Management Payments	<b>A</b> Pay For Reporting <b>B</b> Pay For Performance <b>C</b> Pay/Penalty For Performance	<b>A</b> Total Cost of Care Shared Savings <b>B</b> Total Cost of Care Shared Risk <b>C</b> Retrospective Bundled Payment <b>D</b> Prospective Bundled Payment	<b>A</b> Condition-Specific Population-Based Payments <b>B</b> Primary Care Population-Based Payments <b>C</b> Comprehensive Population-Based Payments



**Medicare Access and CHIP Reauthorization Act of 2015**  
*("MACRA")*



**FFS payment adjustments based on individual composite performance score**

*Quality*

*Efficiency*

*Meaningful use*

*Clinical practice improvement activities*



**Exception for qualifying APM participants**

# Core Quality Measures Collaborative

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February 16, 2016

- Multi-payer alignment, for the first time, on core measures primarily for *physician quality programs*
- Seven measure sets
  1. ACOs, PCMH, and Primary Care
  2. Cardiology
  3. Gastroenterology
  4. HIV and Hepatitis C
  5. Medical Oncology
  6. Obstetrics and Gynecology
  7. Orthopedics

# Oncology Measures



<i>Hospice / End of Life</i>			
0210	Proportion receiving chemotherapy in the last 14 days of life	ASCO	Clinician
0211	Proportion with more than one emergency room visit in the last 30 days of life	ASCO	Clinician
0213	Proportion admitted to the ICU in the last 30 days of life	ASCO	Clinician
0215	Proportion not admitted to hospice	ASCO	Clinician
0216	Proportion admitted to hospice for less than 3 days	ASCO	Clinician
0384	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology	AMA-PCPI	Clinician

# ACO Growth



MAR.  
2012

**157**  
ACOs

**7** million  
covered lives

DEC.  
2015

**782**  
ACOs

**32** million  
covered lives

2020

*CONSERVATIVE:*

**41** million  
covered lives

*BASELINE:*

**105** million  
covered lives

*AGGRESSIVE:*

**171** million  
covered lives

# Five Stepping Stones To Population Health Management

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- 1 **Educate Internally**
- 2 **Understand Risk**
- 3 **Manage Total Cost of Care**
- 4 **Improve Operational Efficiency**
- 5 **Make New Friends**

# Step 1: Educate Internally





## Step 2: Understand Risk

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### Quantify risk in attributed population

- Establish PCP relationships
- Improve provider documentation and coding (HCCs)
- Secure additional data sources (rest of the story)

### Risk stratify attributed population

- Establish criteria
- Perform analysis

### Define interventions

- High risk
- Rising risk
- Low risk

## Step 3: Manage Total Cost of Care

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### **Harvest low-hanging fruit**

- Ambulatory care management for high risk patients
- Advance care planning

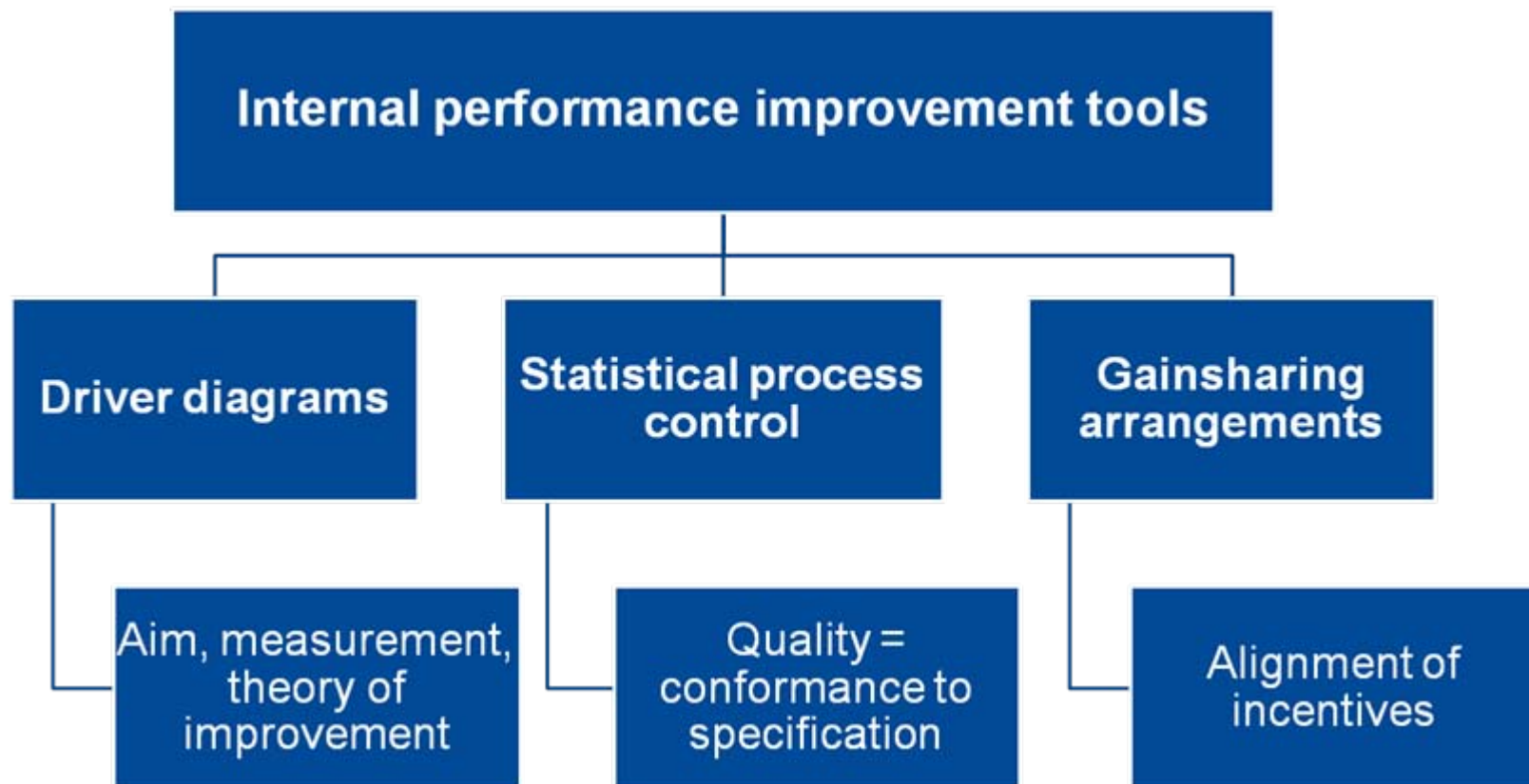
### **Secure actual or approximated claims data**

- Government programs vs. commercial payers

### **Pursue targeted initiatives**

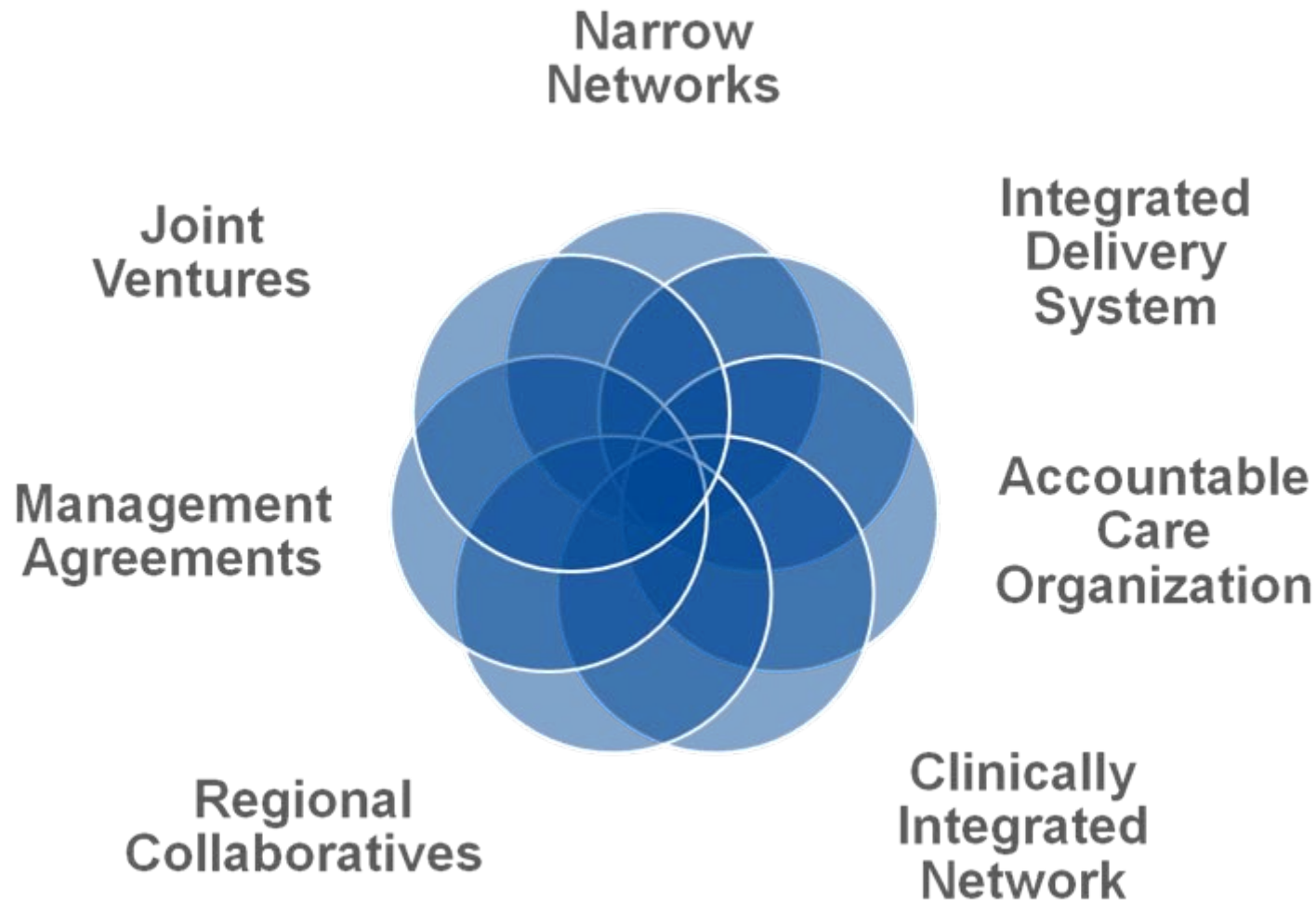
- Specific diagnoses
- Well-defined metrics
- Regular reporting

## Step 4: Improve Operational Efficiency



# Step 5: Make New Friends

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“It is not necessary to change.  
Survival is not mandatory.”

*W. Edwards Deming*



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