Value Based Healthcare and The New Health Economy

Dan Schwebach, MHA, CPPM
Vice President, AAPC
The New Health Economy
Vision of Value-based Healthcare

Payment

• Services will be paid based on bundled payments, adjusted for severity
• Employer based insurance will be less predominant
• Amazon – like market place where consumers shop and compare
The New Health Economy

Vision of Value-based Healthcare
<table>
<thead>
<tr>
<th>Payment</th>
<th>• Services will be paid based on bundled payments, adjusted for severity</th>
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The New Health Economy
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Vision of Value-based Healthcare

- **Payment**
  - Services will be paid based on bundled payments, adjusted for severity
  - Almost all health plans will be high deductible
  - Amazon – like marketplace where consumers shop and compare

- **Primary Care**
  - 90% primary care services will take place via telehealth

- **Acute Care**
  - Acute care will become regionalized delivered via High Performance Centers

- **Integration**
  - All physicians are employed
  - Team based care via virtual integration
Framework of Value Based Healthcare
“We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need. We must shift the focus from the volume and profitability of services provided, to the patient outcomes achieved. And we must replace today’s fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care...”
Framework of Value-based Healthcare

“Value is the health outcomes achieved that matter to us as patients, relative to the cost of achieving those outcomes.”

Maximize Patient Value = Achieving the Best Outcome + Lowest Cost
Framework of Value-based Healthcare

Competition in Healthcare

“Competition makes things come out right. Well, what does that mean in health care? More hospitals so they compete with each other. More doctors compete with each other. More pharmaceutical companies. We set up war. Wait a minute, let’s talk about the patient. The patient doesn’t need a war.”

—Donald Berwick
Framework of Value-based Healthcare

Value Road Map

1. Organize into Integrated Clinical Units
2. Integrate Care Delivery Systems
3. Expand Geographic Reach
4. Measure Outcomes / Cost
5. Bundled Payment for Care Cycles
6. Enable IT Platforms
#1 Organize into Integrated Practice Units (IPU)

- IPU Organized around defined patient segment for primary care
- Joint Accountability for Outcomes
- Multidisciplinary team
- Unit has a single admin / scheduling structure
- Covers Full Cycle of Care (clinic, hospital, rehab, support svc)
#1 Organize into Integrated Practice Units (IPU)

- Imaging Center
- Outpatient Physical Therapy
- Outpatient Neurologist
- Inpatient Treatment And Detox Units
- Outpatient Psychologist
- Primary Care Physician
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#2 Integrate Care Delivery Systems

Attributes for system integration

- Define your scope of services. Stick with where you can achieve high value
- Concentrate volume to fewer locations
- Choose the right venue for services
- Integrate care across locations
#3 Expand Geographic Reach

- Hospital: Cleveland Clinic
  Companies: Lowe's, Boeing, Walmart
  Procedures: Cardiac

- Hospital: Mayo Clinic
  Companies: Walmart
  Procedures: Transplants and cardiac

- Hospital: Johns Hopkins Health System
  Companies: Pepsi
  Procedures: Cardiac and joint replacements

- Hospital: Bon Secours St. Francis Health System
  Companies: Michelin
  Procedures: Diabetes chronic care management

- Hospital: Hoag Orthopedic Institute
  Companies: Kroger, CalPERS
  Procedures: Orthopedic

- Hospital: Mayo Clinic
  Companies: Walmart
  Procedures: Transplants and cardiac
Tier 1 – Health Status Achieved
• % achieving full recovery

Tier 2 – Nature of Recovery
• Time to normal activity
• Pain level during recovery

Tier 3 – Sustainability of Health
• Need for replacement / revision
Payment best aligned to value is a bundled payment

- Payment tied to overall care of patient
- Allows for severity adjustments
- Align payment to what teams can control
- Motivates to improve efficiency and improve outcomes
A value-enhancing IT platform has 5 essential elements:

- Uses common data definitions
- Comprehensive data type
- Universal access
- Templates for capture of cost and outcomes details
- System architecture makes it easy to extract information
Principles of Value Based Healthcare Delivery

Payment needs to align incentives around quality and cost so competition focuses on value.

Outcomes measurement is critical to success. Requires a systematic ability to measure meaningful outcomes.

Delivery system needs re-structuring to promote efficiency. Focus around patient conditions and providing the right care for the right problem at the right location.
"This country is on an expedition around discovery of new ways to pay for health care that will be better supportive of meeting the real needs of patient communities," Berwick told Julie A. Jacob, MA.

"We [know] the current payment system isn’t working. It rewards doing more and more things whether they are of a value to patients or not, so it leads to overuse. It produces fragmentation because it doesn’t support coordinated team-based care the way we need to. It isn’t enough invested in prevention and community-based supports."

What the healthcare system needs is a complete overhaul of how it pays for quality, which Berwick calls “the match between work and need.”
Government Road Map

**Delivery Reforms**
- Patient Centered Medical Homes (PCMH)
- Community Based Care Transition Programs
- Hospital Engagement Networks
- Pioneer ACOs
- Medicare Shared Savings Program ACOs
- Next Generation ACOs

**Payment Reforms**
- Pay-4-Performance
- Hospital Value Based Purchasing
- Hospital Readmission Reduction Program
- Value Based Payment Modifier
- Bundled Payments
- Case Rate Payments

**Data / Quality Reforms**
- Physician Quality Reporting System (PQRS)
- Inpatient Quality Reporting Program
- HVBP Measures
- Value Based Payment Measures
- Meaningful Use Measures
Government Road Map

## Delivery Reforms
- Patient Centered Medical Homes (PCMH)
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Government Road Map

477 Medicare ACOs

Medicare Shared Savings Program
- 100 new participants joining
- 147 renewals (out of 199 that were up for renewal)

Pioneer Program
- 9 ACOs remain

Next Generation ACO Model
- 21 participants
  - 8 from the Pioneer
  - 8 from the MSSP
Delivery Reforms

- Patient Centered Medical Homes (PCMH)
- Community Based Care Transition Programs
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Payment Reforms

- Pay-4-Performance
- Hospital Value Based Purchasing
- Hospital Readmission Reduction Program
- Value Based Payment Modifier
- Bundled Payments
- Case Rate Payments
- Shared Savings
- Risk / Capitation

Data / Quality Reforms

- Physician Quality Reporting System (PQRS)
- Inpatient Quality Reporting Program
- HVBP Measures
- Value Based Payment Measures
- Meaningful Use Measures
HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.

HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.
Government Road Map

CMS Bundled Payments Initiatives

Source: Leavitt Partners Health Reform Presentation 4/11/2016
CMS Bundled Payments Initiatives

Bundled Payments for Care Improvement (BPCI)

- 48 bundles to choose from
- 4 different models

(400) Acute Care Hospitals
(700) Skilled Nursing Facilities
(288) Physician Group Practices
(100) Home Health
(9) Inpatient Rehab / LTC

Source: Leavitt Partners Health Reform Presentation 4/11/2016
What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan legislation signed into law on April 16, 2015.

What does MACRA do?

• Replaces the Sustainable Growth Rate (SGR) Formula
• Streamlines multiple physician quality incentive programs
• Alters Medicare physician reimbursement to reward value, rather than volume
• Encourages physicians to participate in alternate payment models (APMs)
MIPS vs APM

Annual Physician Fee Schedule Increase

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS</td>
<td>0.5%</td>
<td>0%</td>
<td>0.25%</td>
</tr>
<tr>
<td>APM</td>
<td>0.5%</td>
<td>0%</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

PQRS, EHR Meaningful Use, and Value-based Modifier Incentive Programs

Source: Leavitt Partners Health Reform Presentation 4/11/2016
Government Road Map

MIPS

Total Performance Score

Quality (30%) + Resource use (30%) + Meaningful use of certified EHR technology (25%) + Clinical practice improvement activities (15%)

Source: Leavitt Partners Health Reform Presentation 4/11/2016
Government Road Map

Degree of Care Provider Integration and Accountability

Performance-based Incentives

PCP Incentives

Performance-based contracts

Bundles & Episodes Service Line Programs

Condition Programs

Managing specific condition or service line

Managing Entire Health Populations

Shared Risk

Shared Savings

Capitation

Accountable Care Programs

Achievement Specific Metrics

Level of Financial Risk

FFS

Source: United Health Group MGMA Presentation
Key Take Aways

- Increased focus on population-based health
- Increased physician migration toward APMs
- Health care system realignment & consolidation
- Continued focus on development of improved outcome measures
- Payment models are moving toward value
- Providers will increasingly bear financial risk for defined populations
Payers
Commercial Payers
Their Role in the Healthcare Ecosystem

Develop
• Provider networks
• Contracting and pricing

Partner
• Sales and marketing
• Data sharing to support quality outcomes
• Facilitate claims payment

Connect
• Aggregate lives
• Provide members w/ information
Commercial Payers
Value – Based Payment Progression

Level of Financial Risk

Managing specific condition or service line

Managing Entire Health Populations

Capitation

Shared Risk

Shared Savings

Accountable Care Programs

Degree of Care Provider Integration and Accountability

Source: United Health Group MGMA Presentation
The Payers’ success depends on changing the behavior of both the Provider and the Patient.
Evolution of Deliver Systems

Managed Care HMOs
- Need to Focus on Outcomes

Medical Homes
- Look for solutions outside of clinics

Accountable Care Organizations
- Serve needs of patients with more intensive care coordination

Care Coordination Organizations
- Health is more than Healthcare

Community Health
- Full Integration

Populations
- Moms and Babies
- People with Disabilities
- People with LTC Needs
- People with Special Healthcare Needs
- People with significant Behavioral Health Needs
Population Health Management (PHM) seeks to improve the health outcomes of a group by monitoring and identifying individual patients within that group and using data to provide a comprehensive picture of a patient whereby we can improve health outcomes and lower costs.
Providers
Shift to Population Health

360 view of patients health includes medical needs, behavioral needs and social determinants of health
Network Integration
Using the Community too Improve Care

- Patient Centered – Care for whole person
- Expands scope of medical care to include integration of medical, behavioral and social care factors.
- Ability to place people into care models best suited to their needs (population segmentation and risk stratification)
- Utilizes Multi-disciplinary Teams to coordinate resources across the community of providers.
- Real-time data sharing across the continuum of care to support better outcomes and decision making.

Source: Patient Centered Care – UHG, MGMA 2015 Conference
Care Transition Data
• Information needed to help transition patients from one setting to the next setting.

Identify and Closing Gaps in Care
• Equipping providers with the ability to identify real time Gaps in care so teams can respond and close Gaps as they occur.

Risk Stratification
• Tools to help a practice with thousands of members identify individuals with high health risks so they can proactively manage patients and avoid hospitalizations or acute episodes.

Patient Profiling
• Ability to see all of the patient’s interactions in the health community (e.g. labs, visits, hospitalizations, specialty visits).
• Utilizing population registries to obtain both clinical and lifestyle data so you start to develop a complete 360 view of patients.
Network Integration
Using the Community too Improve Care

Payers: Move to Community Health

ACOs
CCOs
For high utilizers
Payers: Progression to ACOs

650 Accountable Care Programs

- 66 Community Based Coordination Organizations
- 1,000 Hospitals
- 100,000 MDs
Key Considerations Moving to Value Based Health and Integration

1. Critical to align providers with health plans goals.
2. Information has to become more centralized.
3. Network needs to expand beyond the health plans provider directory and include community of providers and resources.
Providers
Growth of ACOs since 2011

Source: Leavitt Partners Center for Accountable Care Intelligence
Providers

Covered Lives in ACOs

- 24 Million Currently
- 72 Million Predicted

Source: David Muhlestein, Growth And Dispersion Of Accountable Care Organizations In 2015
Providers perspective on challenges of integration

- Engaging patients in their care management is difficult
- Managing change is difficult
- Physician buy-in is difficult to come by and critically important for success
- No common definition of an ACO
- Payers not providing timely feedback
- Infrastructure is costly

Source  http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2015/rwjf417961
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Providers
Shift to Population Health

Patient Engagement is a key attribute of managing the health and wellness of populations.

Data - Data about the patients that can provide a better picture of our patients, help us understand their preferences, behavior and types of incentives they will respond to can help us.

Tools to Engage – platform to help us engage them and help them self manage.
Traditional Sources of Patient Information

Providers
Patient Engagement

Pharmacy | Claims | Diagnosis
Providers
Patient Engagement

Non-Health Consumer Data
“Life Style data”
Rise of new cottage industries in Healthcare

- Analytics
- Health & wellness benefits
- Model innovation
- Consumer education
- Connector
- Telehealth
- Process improvement
Technology Empowering Consumers and Providers

In 2014 there were 258 new start up Digital Health Companies that raised over $4.1B in investor funding. Top 6 categories of investing are in healthcare

<table>
<thead>
<tr>
<th>Category</th>
<th>Funding</th>
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<tbody>
<tr>
<td>Analytics and big data</td>
<td>$393M</td>
</tr>
<tr>
<td>Data aggregation and analysis to support a wide range of healthcare use cases</td>
<td></td>
</tr>
<tr>
<td>Healthcare consumer engagement</td>
<td>$323M</td>
</tr>
<tr>
<td>Consumer tools for the purchasing of healthcare services or health insurance</td>
<td></td>
</tr>
<tr>
<td>Digital medical devices</td>
<td>$312M</td>
</tr>
<tr>
<td>Software/hardware designed to treat a specific disease or condition</td>
<td></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>$285M</td>
</tr>
<tr>
<td>Delivery of healthcare services through virtual channels (e.g., phone, video, text)</td>
<td></td>
</tr>
<tr>
<td>Personalized medicine</td>
<td>$268M</td>
</tr>
<tr>
<td>Software to support the practice of medicine customized to an individual's genetics</td>
<td></td>
</tr>
<tr>
<td>Population health management</td>
<td>$225M</td>
</tr>
<tr>
<td>Platforms for managing population health under the shift to risk-based payment models</td>
<td></td>
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</table>
Patient outreach / engagement

Providers can dictate instructions into the app, such as medication information, check lists for things like post-discharge activities or pre-admit activities. Alerts to patients to perform tasks, allows providers to monitor compliance. Patients can also ask follow-up questions about their care.
Consumer Trends
Technology Evolution

Number of healthcare Apps

- 37% Exercise / fitness / weight
- 31% Diet / food / calories
- 10% Connect to sensors for monitoring
- 5% Health indicators like blood pressure
- 4% health information / sync provider
- 2% Medication Management
- 2% Diabetes Management

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Payment Model Progression

Pay for Structure
- EMR Implementation / Meaningful Use

Incentive Payments

FFS Plus Payments
- Medical Homes

Case Rates

Pay for Care Collaboration
- Shared Savings Programs

Bundled Payments

Pay for Quality
- PQRS

Value Based Modifiers
63% of physicians use at least one type of risk-based payment model today, up from 23% two years ago. Two years from now, 83% expect to use at least one risk-based payment model.
Shift to pricing transparency

Can anyone imagine going into a restaurant and ordering a meal that had no price listed, or signing a contract to buy a car and then being told the price? It would never happen. But in health care, we not only tolerate such behavior, we are often reticent to even ask about prices.

The US health care industry is, by and large, completely opaque...market opacity prevents consumer-patients from comparison-shopping.
Providers
Commoditization of Healthcare

Shift to pricing transparency

“Access to cost and quality information before medical treatment lowers costs and improves outcomes. When people have the information they need, they become smart consumers....”

Source: healthcare Incentives Improvement Institute
Medicare released an announcement that they are “taking a major step forward in providing unprecedented access to information about the number and type of services individual providers deliver and the amount Medicare paid for those services. Providing consumers with this information will make healthcare more transparent and accountable, allowing consumers to make more informed choices about the care they receive.”
### Consumer Preferences

#### Commoditization of Healthcare

**What Consumers Want From Hospitals and Insurers**

<table>
<thead>
<tr>
<th><strong>Hospitals</strong> — Top choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶️ ▶️ ▶️ Receive estimates for treatment and services ahead of time</td>
</tr>
<tr>
<td>▶️ ▶️ ▶️ Receive estimates for follow-up care ahead of time</td>
</tr>
<tr>
<td>▶️ ▶️ ▶️ Have discussions about treatment choices and costs</td>
</tr>
<tr>
<td>▶️ ▶️ ▶️ Be able to comparison shop online</td>
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</thead>
<tbody>
<tr>
<td>▶️ ▶️ ▶️ Know what care will cost ahead of time</td>
</tr>
<tr>
<td>▶️ ▶️ ▶️ Be able to comparison shop online</td>
</tr>
<tr>
<td>▶️ ▶️ ▶️ Receive help choosing right treatments at right price</td>
</tr>
<tr>
<td>▶️ ▶️ ▶️ Have choices for care at different price points</td>
</tr>
</tbody>
</table>

Compare Hospital Prices

Compare charges for commonly sourced from government.
Providers
Commoditization of Healthcare

ESTIMATED OUT-OF-POCKET COSTS

<table>
<thead>
<tr>
<th>Code</th>
<th>Consumer Description</th>
<th>Est. Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>45330 A</td>
<td>Diagnostic examination of descending portion of large bowel using an endoscope</td>
<td>$393.00</td>
</tr>
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</table>

Since you are not covered by insurance, this rate represents 100% of what you may be expected to pay, unless you and your provider agree to a different amount.

Estimated Out-of-Pocket Cost $393.00

NOTE: Facility (e.g. hospital or ambulatory surgery center) charges are billed separately and are NOT included in the estimate above.

GEOZIP: 840xx
This GEOZIP includes zip codes with the following prefixes: 840
Estimated Charge is set at FAIR Health's 80th percentile

Adjusting Estimated Charges

Adjust Percentile

50  60  70  80  90
Providers
Commoditization of Healthcare

Surgeon Scorecard

MCKAY DEE HOSPITAL CENTER

4401 HARRISON BOULEVARD, OGDEN, UTAH, 84403, PHONE: 801-387-2800

How Surgeons at This Hospital Perform, by Procedure

<table>
<thead>
<tr>
<th>Low</th>
<th>Medium</th>
<th>High Adjusted Rate of Complications</th>
</tr>
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<tbody>
<tr>
<td><img src="image.png" alt="Image of Surgeon Scorecard" /></td>
<td><img src="image.png" alt="Image of Surgeon Scorecard" /></td>
<td><img src="image.png" alt="Image of Surgeon Scorecard" /></td>
</tr>
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</table>

- Knee Replacement
- Hip Replacement
- Gallbladder Removal, Laparoscopic
- Lumbar Spinal Fusion, Posterior Column
- Lumbar Spinal Fusion, Anterior Column
Providers
Commoditization of Healthcare

Dr. Richard Jones
Board Certified
Scenic Hospital

Dr. Skip Thomas
Board Certified
Mary Beth Medical Center

Dr. Sally Supwater
Board Certified
James Town Medical Center
Providers

Key Considerations Moving to Value Based Health and Integration

1. Changing reimbursement models from FFS to bundled, shared savings and capitated arrangements.

2. Care models are moving towards addressing population health management and patient engagement.

3. Data is becoming the new currency.

4. Performance will be under constant scrutiny.
As value based healthcare matures, how will it affect medical coding?

- HCC and Episodic models are based on diagnosis codes
- Capitated models or shared savings arrangements base payment on overall costs of care for the population over time.
- Effective population management requires ability to track utilization for activity based accounting
- FFS will not disappear
- Clinical information will remain vital to track outcomes and quality
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