Value Based Healthcare and The New Health Economy

Dan Schwebach, MHA, CPPM
Vice President, AAPC
“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
- Unit has a single admin / scheduling structure
- Multidisciplinary team
- Covers Full Cycle of Care (clinic, hospital, rehab, support svc)
#1 Organize into Integrated Practice Units (IPU)

- Imaging Center
- Outpatient Physical Therapy
- Primary Care Physician
- Outpatient Neurologist
- Outpatient Psychologist
- Inpatient Treatment And Detox Units
#1 Organize into Integrated Practice Units (IPU)

Headache Center

Care Team

Administration, Scheduling, Billing, Coordination

Neurology  MRI  PT  Counseling
#1 Organize into Integrated Practice Units (IPU)

Patient Segmentation:
- Diabetes
- Heart Disease
- Alzheimer's
- Young Healthy

Care Teams
#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: Mayo Clinic**
  - Companies: Kroger, CalPERS
  - Procedures: Orthopedic

- **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
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:

- Payment tied to overall care of patient, not just services provided.
- Align payment to what teams can control
- Motivates to improve efficiency
- Motivates to 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.

Infrastructure to support objectives 1 - 3
“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.”
Triple AIM of Healthcare

1. Build out IT infrastructure
2. Improve data and quality measuring
3. Pay for value not volume
4. Transform clinical infrastructure to improve coordination of care
5. Align incentives between payers / providers.
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

Structural Data Reforms

- Physician Quality Reporting System (PQRS)
- Inpatient Quality Reporting Program
- Meaningful Use Measures
- Value Based Payment Measures
Delivery System Reform:
Population Health Management
In our effort to fulfill this charge, our vision of future success is a high quality health care system that ensures better care, access to coverage and improved health. We are focused on measurably improving care and population health by transforming the U.S. health care system into an integrated and accountable delivery system that continuously improves care, reduces unnecessary costs, prevents illness and disease progression, and promotes health. We will find better ways to ensure that the right care is accessible and delivered to the right person at the right time, every time.
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.
360 view of patients health includes medical needs, behavioral needs and social determinants of health
Population Health Management

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.
- 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
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.

Tools to Engage – platform to help us engage patients and help them self manage.
Role of Data

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.
Population Segmentation is critical to be able to manage costs under population health management.

**Medicare Population Sample per member per year cost**

- Healthy: $2,000 / year
- Chronic Ill: $8,000 / year
- High Utilizer: $67,00 / year
Traditional Sources of Patient Information

Providers
Patient Engagement

- Pharmacy
- Claims
- Diagnosis
Providers
Patient Engagement

Remote Monitoring

Claims
Pharmacy
Diagnosis
Providers
Patient Engagement

User Supplied Data

Claims
Pharmacy
Diagnosis
Rise of new cottage industries in Healthcare

- Analytics
- Health & wellness benefits
- Model innovation
- Consumer education
- Connector
- Telehealth
- Process improvement
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>Investment (M)</th>
</tr>
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<tbody>
<tr>
<td>Analytics and big data</td>
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<tr>
<td>Healthcare consumer engagement</td>
<td>$323M</td>
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<tr>
<td>Digital medical devices</td>
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<td>Telemedicine</td>
<td>$285M</td>
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<tr>
<td>Personalized medicine</td>
<td>$268M</td>
</tr>
<tr>
<td>Population health management</td>
<td>$225M</td>
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</tbody>
</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.
Chronic Disease Management

Management for type 2 diabetes. BlueStar analyzes diabetes data entered by the patient, such as blood glucose levels. The software delivers summarized data and analytics to a patient's healthcare team and provides a self-management plan to help the patient improve their condition.
Technology Empowering Consumers and Providers

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

Increased focus on population-based health will improve health and lower costs

1. Focusing more on achieving a 360 degree view of patients health

2. Need for more sophisticated health data to include lifestyle data and social determinates of health to provide comprehensive care

3. Tools to engage consumers to help them improve their health

4. Expanding network of care providers that need to be involved.

5. Technical capability to easily track and share information across a broader spectrum of care providers
Delivery System Reform:
Integration of Care Delivery (ACOs)
Delivery System Reform

Network Integration
Using the Community too Improve Care

ACO’s
Primary Care
Specialty Care
Hospitals

Source: Patient Centered Care – UHG, MGMA 2015 Conference
Growth of ACO Market

Growth of ACOs since 2011

Source: Leavitt Partners Center for Accountable Care Intelligence
ACO Covered Lives

Covered Lives in ACOs

- 24 Million Currently
- 72 Million Predicted

Source: David Muhlestein, Growth And Dispersion Of Accountable Care Organizations In 2015
ACO Covered Lives

Covered Lives by Payer Type

- Medicaid ~ 2.8 Million
- Medicare ~ 8.9 Million
- Private Payers ~ 16 Million

- Commercial contracts tend to be larger
- Medicare open to any who qualify

Source: David Muhlestein, Growth And Dispersion Of Accountable Care Organizations In 2015
Hospitals in ACOs

Source: Leavitt Partners Center for Accountable Care Intelligence
Drivers of ACO Growth

Early Growth
- Altruism
- Experimentation
- Expansion
- Defense
- FFS Failure

Future Growth
- Success of current ACOs
- Mandated adoption
- Belief it’s inevitable
- Response to competitors
Changing Risk Profiles of Providers and Payers

Aligning Providers and Payers

Providers
- Performance Risk

Payers
- Insurance Risk

Integration

Providers
- Performance Risk
- Insurance Risk

Payers
- Performance Risk
- Insurance Risk
Some of the ACO Practical Challenges

650 Accountable Care Programs

66 Community Based Coordination Organizations

1,000 Hospitals

100,000 MDs
No Common Definition of an ACO

- Variations in structure
- Different quality metrics being tied to different contracts
- Amount and type of risk providers undertake differs by ACOs
- Provider composition varies
- Patient populations being managed varies by contract
- Contracting arrangements vary
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.
Key Considerations Moving to Value Based Health and Integration

- ACO models are picking up momentum in the markets
- Revenue Cycle Reform will take time to transition
- In order for hospitals and providers to operate in an ACO they must form a close network to serve patient populations.
- Health care system realignment & consolidation
Payment Reforms: Pay for Value
Goal #1: Tie all Provider Payments to value through alternative payment models

30% by 2016
50% by 2018

Goal #2: Tie all FFS payments to quality and value.

85% by 2016
90% by 2018

CMS Goal: Pay for Value Not Volume
# CMS Will Achieve Goal #1 through APMs

## Major APM Categories

<table>
<thead>
<tr>
<th>ACOs</th>
<th>Bundled Payments</th>
<th>Advanced Primary Care</th>
<th>Other Models</th>
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<tbody>
<tr>
<td>Medicare Shared Savings Program ACO*</td>
<td>Pioneer ACO*</td>
<td>Comprehensive ESRD Care</td>
<td>Medicare Shared Savings Program ACO*</td>
</tr>
<tr>
<td>Comprehensive ESRD Care</td>
<td>Next Generation ACO</td>
<td>Bundled Payment for Care Improvement*</td>
<td>Comprehensive Primary Care*</td>
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<tr>
<td>Comp Care for Joint Replacement</td>
<td>Oncology Care</td>
<td>Multi-payer Advanced Primary Care Practice*</td>
<td>Maryland All-Payer Hospital Payments*</td>
</tr>
<tr>
<td>ESRD Prospective Payment System*</td>
<td>Model completion or expansion</td>
<td></td>
<td></td>
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</tbody>
</table>

* Indicates model completion or expansion.
Progression of Payment Arrangements

**Population-Based**
- FFS
- Care Management
- P4P
- Shared Savings
- Shared Savings/Losses
- Partial Capitation
- Full Capitation

**Pre-ACO**

**ACO**

**Episode-Based**
- Usual & Customary
- Fee Schedule
- Prospective Payments
- Bundled Payments
Bundled Payment Programs

BUNDLED PAYMENT CONCEPT

- Manage patient care across episode
- Manage episode cost
- Achieve gainsharing bonus
Bundled Payment Programs

CMS BUNDLED PAYMENTS INITIATIVES

Bundled Payments for Care Improvement (BPCI)
- 48 bundles to choose from
- 4 different models

Comprehensive Care for Joint Replacement (CJR)
- Mandatory for hospitals in 67 MSAs

Oncology Care Model (OCM)
- For all cancer types
- 6-month episodes
- Includes all Parts A & B services
Bundled Payment Programs

48 Episodes of Care (bundles) to choose from

**BPCI Model 1:** Retrospective Acute Care Hospital Stay Bundle
- All Medicare DRGs
- Inpatient hospital services
- 0 to 2% minimum discounts up to 3 yrs.
- IPPS payment, less discount
- All hospital IQR measures

**BPCI Model 2:** Retrospective Acute Care Hospital Stay + Post-Acute Care
- Select Inpatient DRGs
- Readmissions accountability
- Minimum 3% for 30 to 89 days post discharge; Minimum 2% for 90+ days
- Retrospective bundle
- Quality measures (QM) proposed by applicant & approved by CMS

**BPCI Model 3:** Retrospective Post-Acute Care Stay
- Select inpatient DRGs
- PAC related readmissions accountability
- Proposed discounts by applicant
- Retrospective bundle
- QM proposed by applicant

**BPCI Model 4:** Acute Care Hospital Stay
- Select inpatient DRGs
- Readmissions accountability
- Minimum 3% discount
- Prospective bundle
- QM proposed by applicant

Source: Leavitt Partners Health Reform Presentation 4/11/2016
Bundled Payment Programs

BPCI Participation

- **Model 1**: Retrospective Acute Care Hospital Stay Bundle
- **Model 2**: Retrospective Acute Care Hospital Stay + Post-Acute Care
- **Model 3**: Retrospective Post-Acute Care Stay
- **Model 4**: Acute Care Hospital Stay
CJR Overview

Lower Extremity Joint Replacement Episode: MS DRG 469 or MS DRG 470
Hospital accountability for episode services & readmissions

Mandatory for 800 hospitals in 67 MSAs where 30% of US population resides
# Employer & Commercial Bundled Payment Activity

<table>
<thead>
<tr>
<th>Employers</th>
<th>Payers</th>
<th>Providers</th>
<th>Episodes</th>
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<tbody>
<tr>
<td>Walmart</td>
<td>Aetna</td>
<td>Virginia Mason</td>
<td>Cardiovascular</td>
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<tr>
<td></td>
<td>Cigna</td>
<td>Hoag</td>
<td></td>
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<tr>
<td></td>
<td>BCBS of Minnesota</td>
<td>Kaiser Permanente SSM</td>
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<tr>
<td></td>
<td>Anthem BCBS</td>
<td>Mayo Clinic</td>
<td>Spine</td>
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<td></td>
<td>Anthem BCBS Missouri</td>
<td>Scott &amp; White</td>
<td>Orthopedics</td>
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<td></td>
<td>BCBS Western NY</td>
<td>Mercy</td>
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<td>Horizon BCBS NJ</td>
<td>Northwestern</td>
<td></td>
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<td></td>
<td>Connecticutcare</td>
<td>Cleveland Clinic</td>
<td>Cancer</td>
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<td>BCBS NC</td>
<td>Geisinger</td>
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<td></td>
<td>BCBS SC</td>
<td>Johns Hopkins</td>
<td></td>
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<tr>
<td></td>
<td>Florida Blue</td>
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<tr>
<td></td>
<td>BCBS Florida</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Humana</td>
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</table>

Source: Leavitt Partners Health Reform Presentation 4/11/2016
CMS will Achieve Goal #2 through more linkage of FFS to Quality and Value

• **Hospital Value-Based Purchasing (HVBP) Program**
  - Revenue neutral
  - Evolving metrics and high volatility
  - Hospitals paying penalties tended to be larger, in urban areas with larger Medicaid Populations

• **Hospital Readmissions Reduction Program**
  - Penalties for 30-day readmissions
  - Wide variability in penalties
  - More consistent year-over-year results

• **Hospital-Acquired Conditions Reduction Program**
  - Flat penalty for lowest-performing quartile
  - Academic medical centers disproportionately penalized
CMS will Achieve Goal #2 through more linkage of FFS to Quality and Value

Hospitals, % of FFS Payment at Risk

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>2014 (payment FY16)</th>
<th>2015 (FY17)</th>
<th>2016 (FY18)</th>
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<tbody>
<tr>
<td>Readmissions Reduction Program</td>
<td>6.5</td>
<td>7</td>
<td>7</td>
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<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
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<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
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<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Leavitt Partners Health Reform Presentation 4/11/2016
MACRA PAYMENT REFORM

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

What does MACRA do?

- Consolidates all the current physician quality incentive programs
- Alters Medicare physician reimbursement to reward value, rather than volume
- Encourages physicians to participate in alternate payment models (APMs)
Payment Reform

MIPS VS APM

Annual Physician Fee Schedule Increase

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

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

MIPS

Eligible APM

Source: Leavitt Partners Health Reform Presentation 4/11/2016
Payment Reform

MIPS

- The Physician Quality Reporting System (PQRS)
- The Value-Based Modifier (VBM)
- Meaningful use of EHRs (EHR MU)

Total Performance Score =

- Quality (30%)
- Resource use (30%)
- Meaningful use of certified EHR technology (25%)
- Clinical practice improvement activities (15%)
MIPS MAXIMUM PAYMENT ADJUSTMENTS

Average of MIPS Performance Scores

2019: -4%
2020: -5%
2021: -7%
2022: -9%
2023: +9%

Payment Reform
Payment Reforms: Pricing and Data 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.
"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...."
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.”
Payment Reform: Pricing Transparency

Compare Hospital Prices

Compare charges for common procedures sourced from government.
## What Consumers Want From Hospitals and Insurers

### Hospitals — Top choices
- Receive estimates for treatment and services ahead of time
- Receive estimates for follow-up care ahead of time
- Have discussions about treatment choices and costs
- Be able to comparison shop online

### Health insurers — Top choices
- Know what care will cost ahead of time
- Be able to comparison shop online
- Receive help choosing right treatments at right price
- Have choices for care at different price points

Payment Reform: Pricing Transparency

**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>
</tbody>
</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

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**COST ESTIMATE WORKSHEET**

**PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>First Name</td>
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<tr>
<td>Last Name</td>
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<tr>
<td>Date of Birth</td>
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</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>Description of Procedure(s) or Service(s) Requested</td>
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<tr>
<td>Date</td>
<td></td>
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<tr>
<td>Health Plan</td>
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<td>Member ID Number</td>
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**PROVIDER INFORMATION (TO BE COMPLETED BY PROVIDER)**

<table>
<thead>
<tr>
<th>Servicing Provider Information</th>
<th>Procedure(s) and Diagnosis</th>
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<tr>
<td>Servicing Provider's Full Name</td>
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<td>Provider NPI Number</td>
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<td>Phone Number</td>
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<tr>
<td>Practice Contact Person</td>
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</tr>
<tr>
<td>Email</td>
<td>Date of Service (If Known)</td>
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**FACILITY INFORMATION (IF SERVICE IS BEING PERFORMED AT A FACILITY, SUCH AS A HOSPITAL OR FREESTANDING MRI OR LAB FACILITY)**

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**Date of Service (If Known)**

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<tr>
<th>Procedure Code(s)</th>
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<td>4</td>
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</table>

**Cost Estimate:** $5

**Date Estimate Received:**
# 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>
</thead>
</table>

- **Knee Replacement**
- **Hip Replacement**
- **Gallbladder Removal, Laparoscopic**
- **Lumbar Spinal Fusion, Posterior Column**
- **Lumbar Spinal Fusion, Anterior Column**
Payment Reform: Pricing Transparency
Goal of Payment Reform

- Stop paying FFS to promote volume
- Incentivize focus on Quality, by rewarding quality and good outcomes.
- Move financial risk to providers who controls the majority of spending
- Make pricing and quality information more transparent to consumers to empower them to make more informed decisions
Value Based Healthcare and Medical Coding

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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