Welcome and Introductions

Today's Objectives

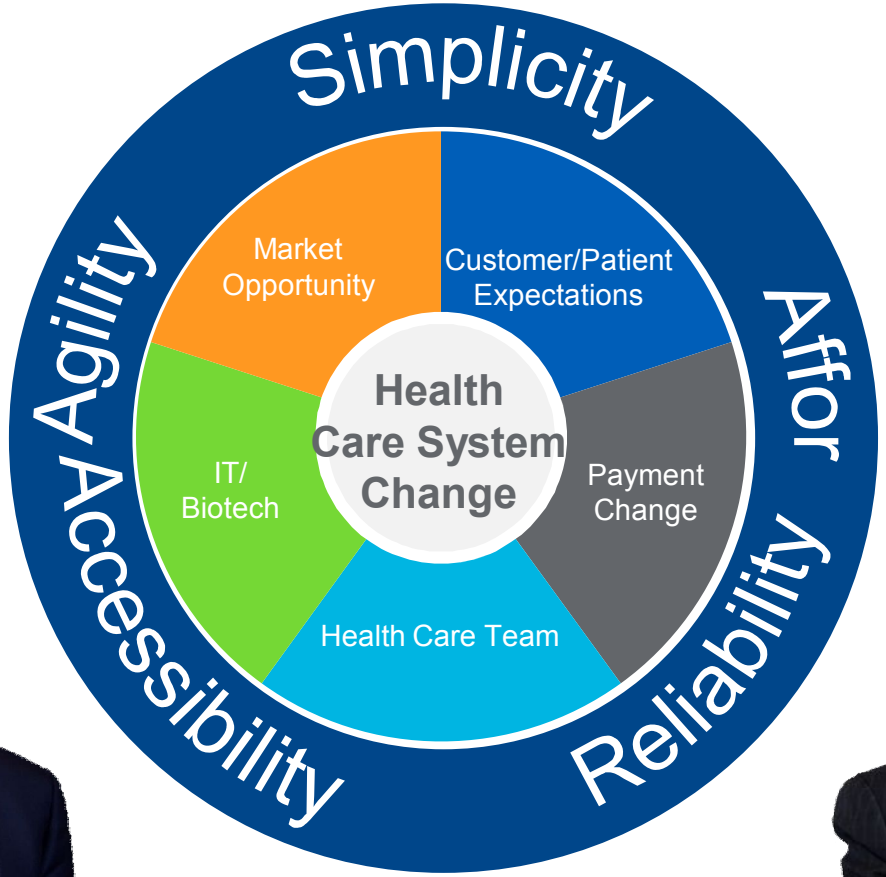
- Discuss economic and regulatory trends affecting the healthcare industry in the US
- Explore practical approaches, strategies and tools to succeed within value-based payment
- Understand the range of value-based and risk-based payment methodologies and the approaches required to succeed
- Understand MACRA: MIPS and APMs
- What others have learned in their journey: an interactive session – sharing questions, answers, and observations

Today's Agenda

- The Winds of Change: Economic and Regulatory Trends and the Shift from FFS to FFV
- Follow the Money: Value-Based and Risk-Based Payment Models
- **Break**
- MACRA and Maximizing Performance
- Tactical Approaches to Achieve Clinical and Cultural Transformation
- Developing and Activating a Care Plan
- Aligning Incentives
- Leadership and Governance: Clinical Engagement
- Patient Engagement
- General Q&A

The Winds of Change: Economic and Regulatory Trends and the Shift from FFS to FFV

Trends Driving Change



Over-used, but Under-done

Value-based

Outcomes

Patient-centered

Transformational

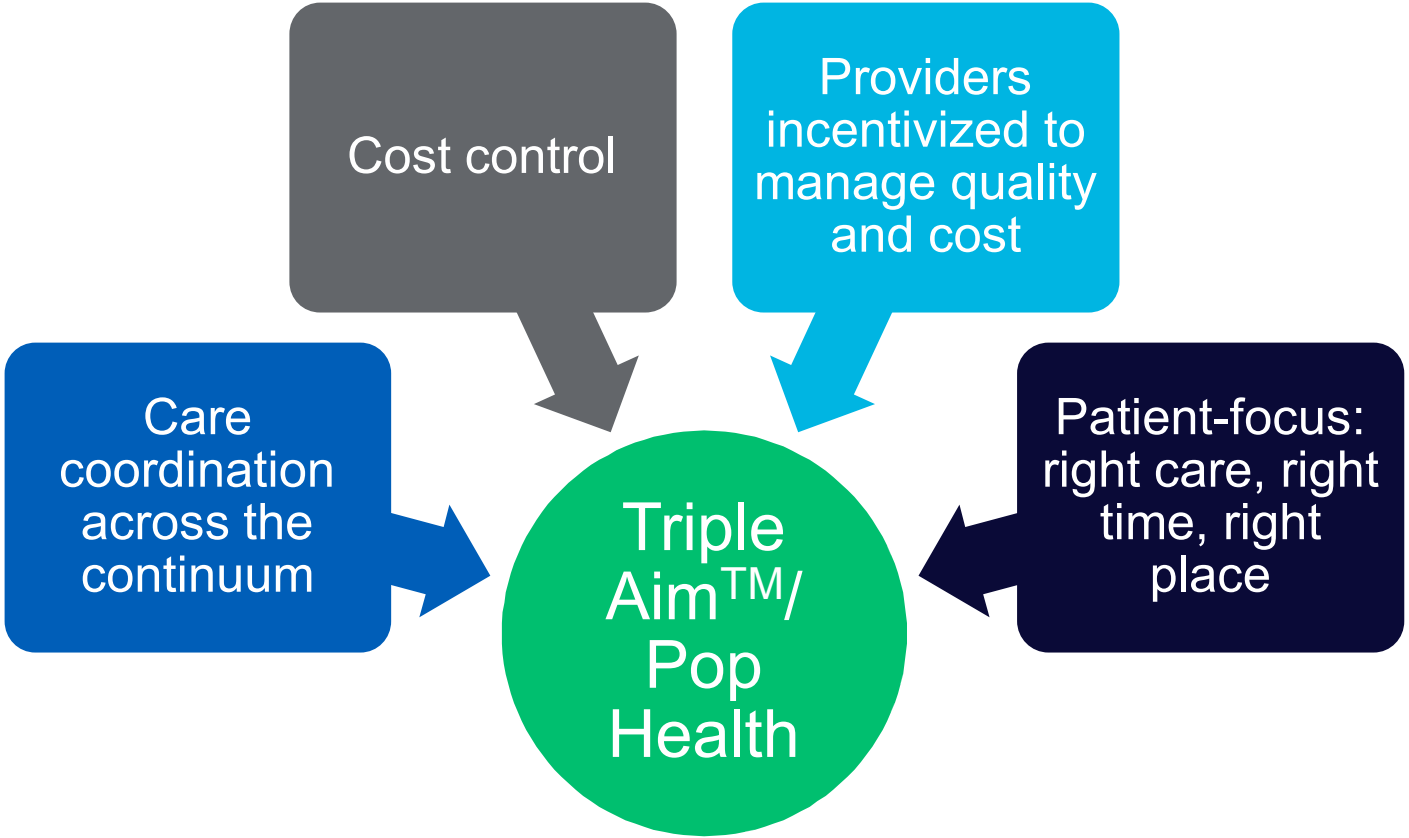
Change management

Population health management

Consumer-focused

Care model redesign

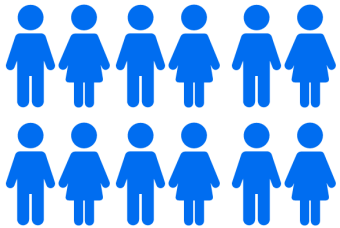
What Does the Marketplace Want?



Consider the facts…

31 percent of Medicare enrollees are in Medicare Advantage ("MA") plans

- 17.6 million MA enrollees; 22% increase between 2013-2016
- Nearly 1 in 5 MA enrollee is in a provider-sponsored plan



There are **838** active Accountable Care Organizations ("ACOs")

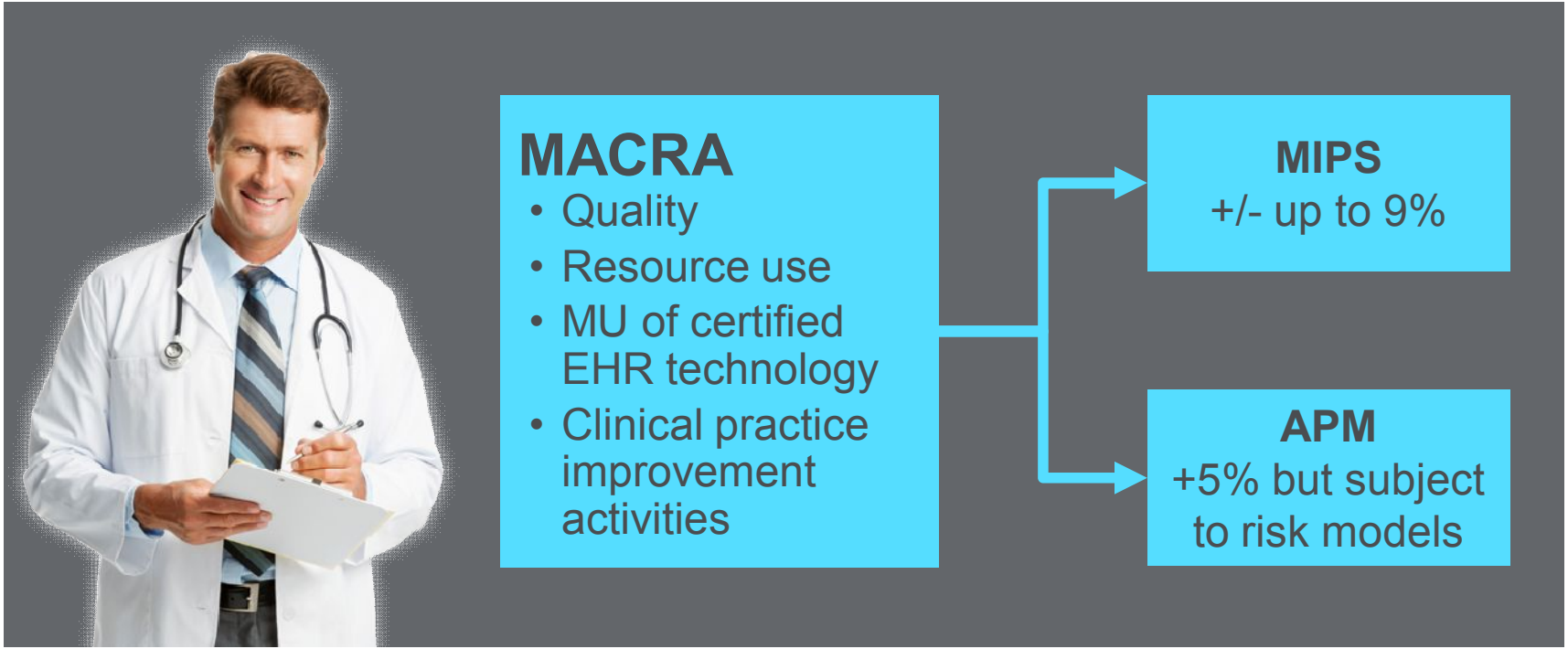
- 28.3 million individuals covered
- Commercial contracts represent the largest share: 61% or 17.2 million
- 75% of early MSSP participants are continuing with a Medicare ACO model

HHS and **CMS** still driving to alternative payment models

- Goal of 50% in risk by 2018
- ACOs and mandatory bundled payment initiatives, CPC+
- MACRA

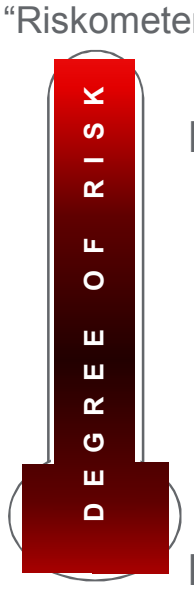
Source: Kaiser Family Foundation; Avalere; Leavitt Partners;

MACRA: Making it Real for Physicians



It’s not just two canoes anymore…

“Risk” Models Come in Many Flavors

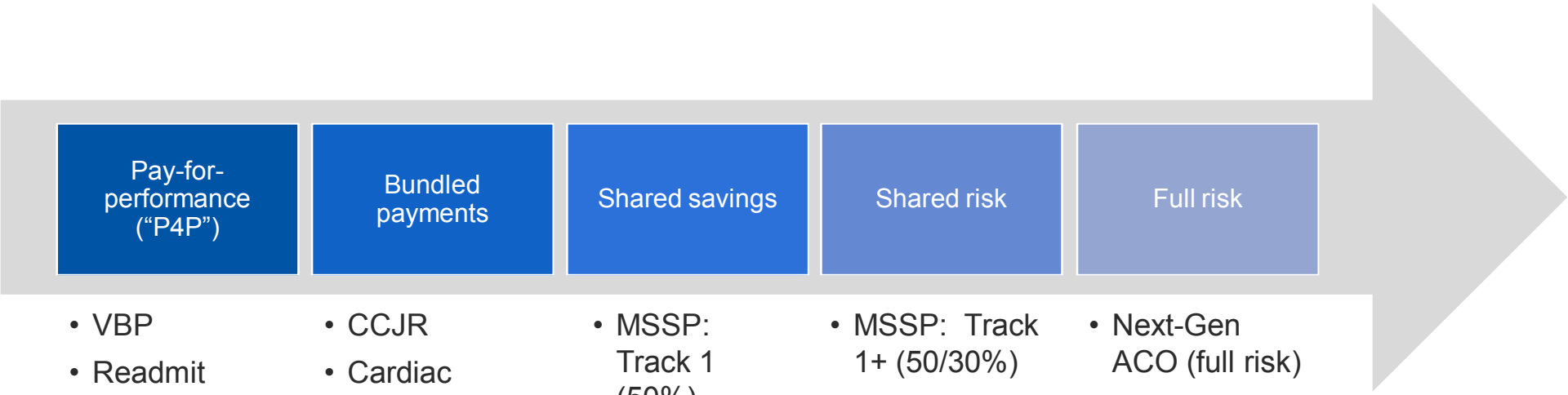


BREADTH OF RISK

Fee-for-Service	Episode of Care	Population Risk
Pay-for-Performance + Cost Management Incentive	Prospective Payment	Full/Global Risk
Pay-for-Performance/VBP	Bundled Payment 90 Days	ACO or Shared Savings – Upside and Downside
Pay-for-Reporting	Bundled Payment 30/60 Days	Professional OR Institutional Capitation
Discounted Fee Schedule	Retrospective Payment	ACO or Shared Savings– Up-side Only
Percent of Charges	“Shared Savings” Per Episode (e.g., Oncology)	Case Management Fee Plus Incentive (e.g., PCMH)
Full Charges	Case Rate or DRG	

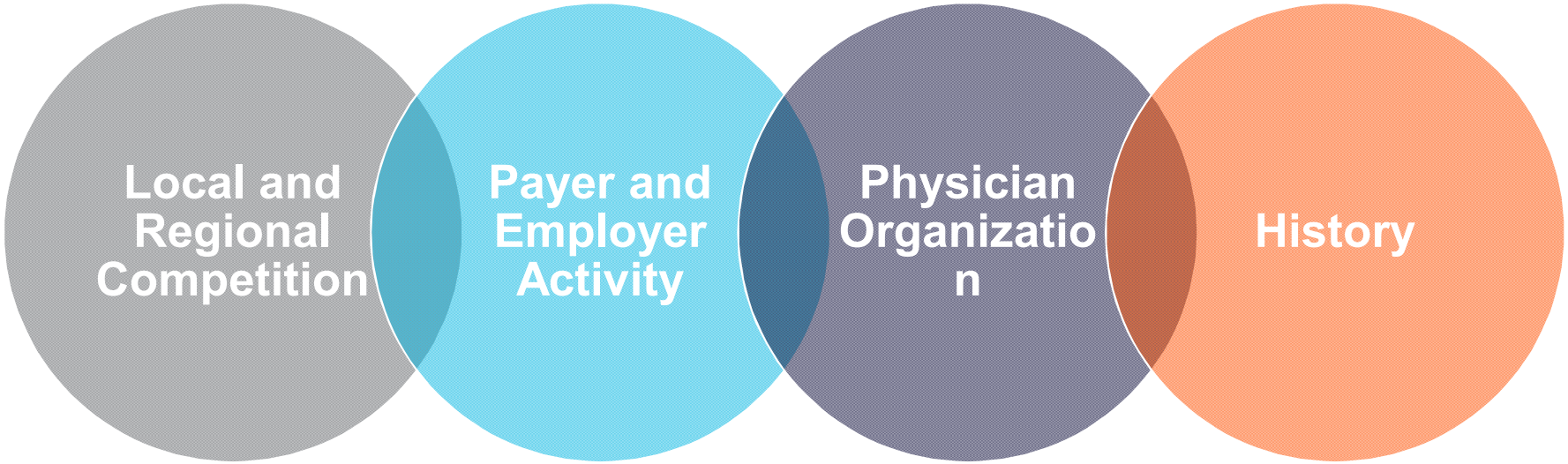
Critical Success Factors			
	• Cost Per Unit • Market Price Sensitivity • Volume • Billing/Coding • Patient Satisfaction	• Per Episode and Per Unit Cost • Case Volume • Care Coordination Across Continuum • Physician Engagement • Adherence to Protocols • Quality/Experience Outcomes	• Covered Population 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

Medicare Models Continue to Focus on Greater Risk



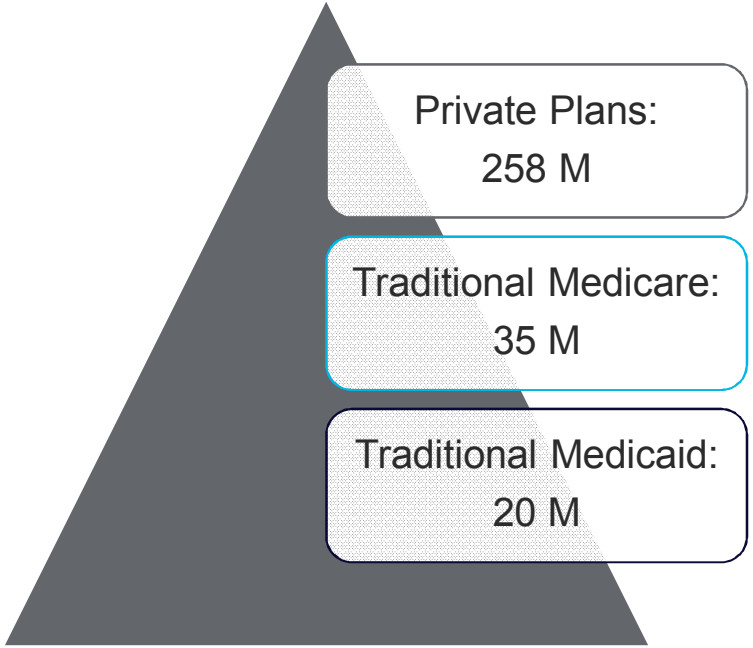
And employers are increasingly taking action...

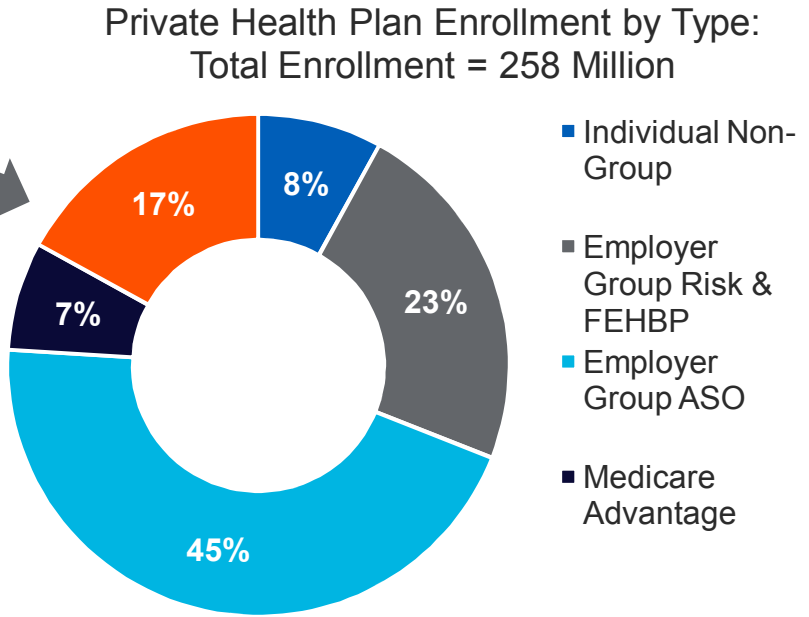
Market Factors to Consider



US Health Insurance Coverage by Type

What is the mix in your market?





Source: Mark Farrah and Associates, 2015. Note, enrollment may be counted in multiple products, therefore inflating total enrollment. Note: The current uninsured rate is estimated at 11.9% of the US Adult population, Gallup, 2015

Where do you start?

Establish the vision
- Is this a strategy or a new way of life?
- Where is the opportunity?

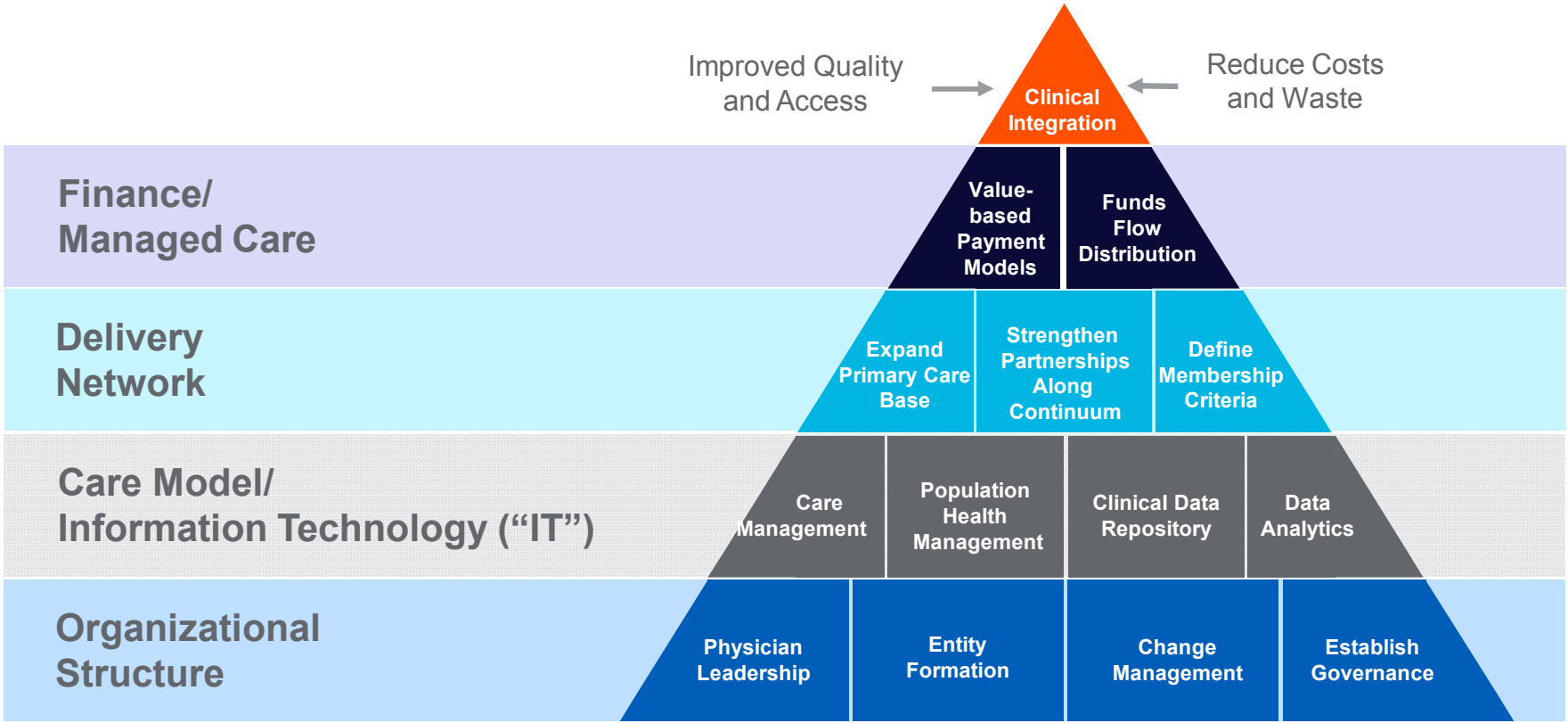
Identify the leadership
- Clinical and administrative leadership must be aligned

What is the strategy
- Objective assessment of capabilities
- Clear view of risk tolerance
- Experience and potential for culture, behavior, and clinical change

Determine the population focus

Establish the plan

Clinical Integration Building Blocks

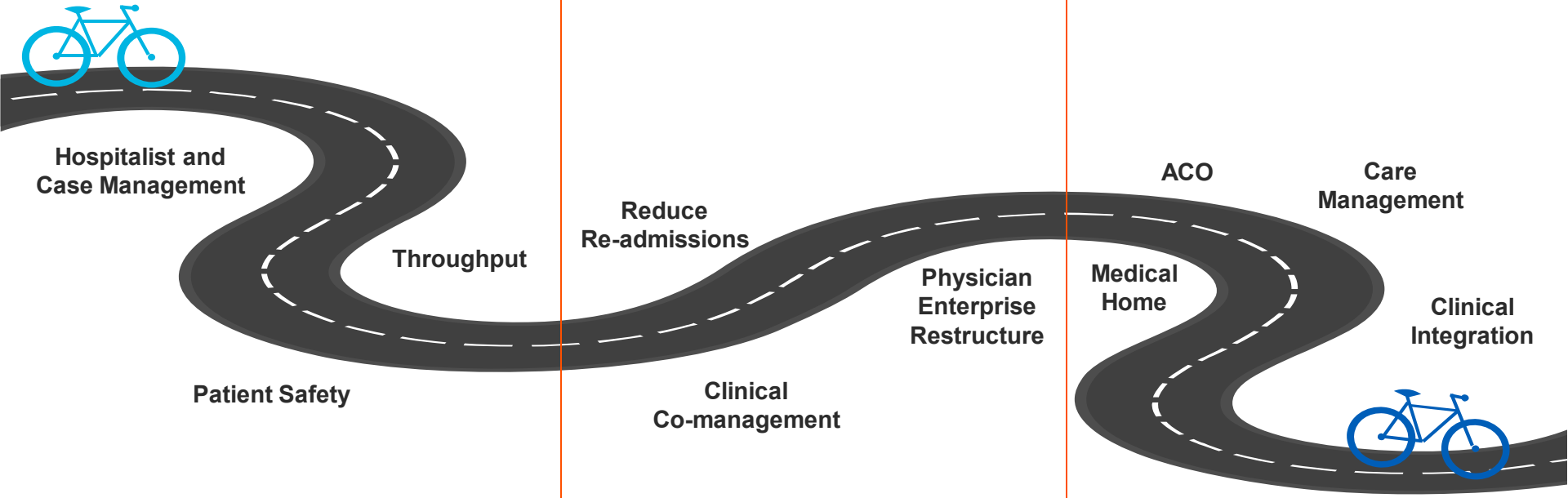


Evolving Leadership Requirements

Fee-For Service

Transition

Fee-for-Value



Key Leadership Requirements

"Lean" Management
Vision
Seek Growth

Change Management
Communication

Collaboration
Transparency

Value-based Critical Success Factors

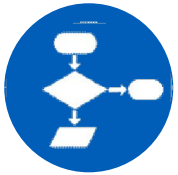
Strong Care Management Capabilities

Enabling Information Technology

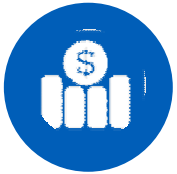
Effective and Engaged Care Teams

Larger Patient Population

Efficient Clinical Operations



Contracting Models Support Population Health



Physician Compensation Model that Aligns Incentives

Proactive patient engagement

Follow the Money: Value-Based and Risk-Based Payment Models

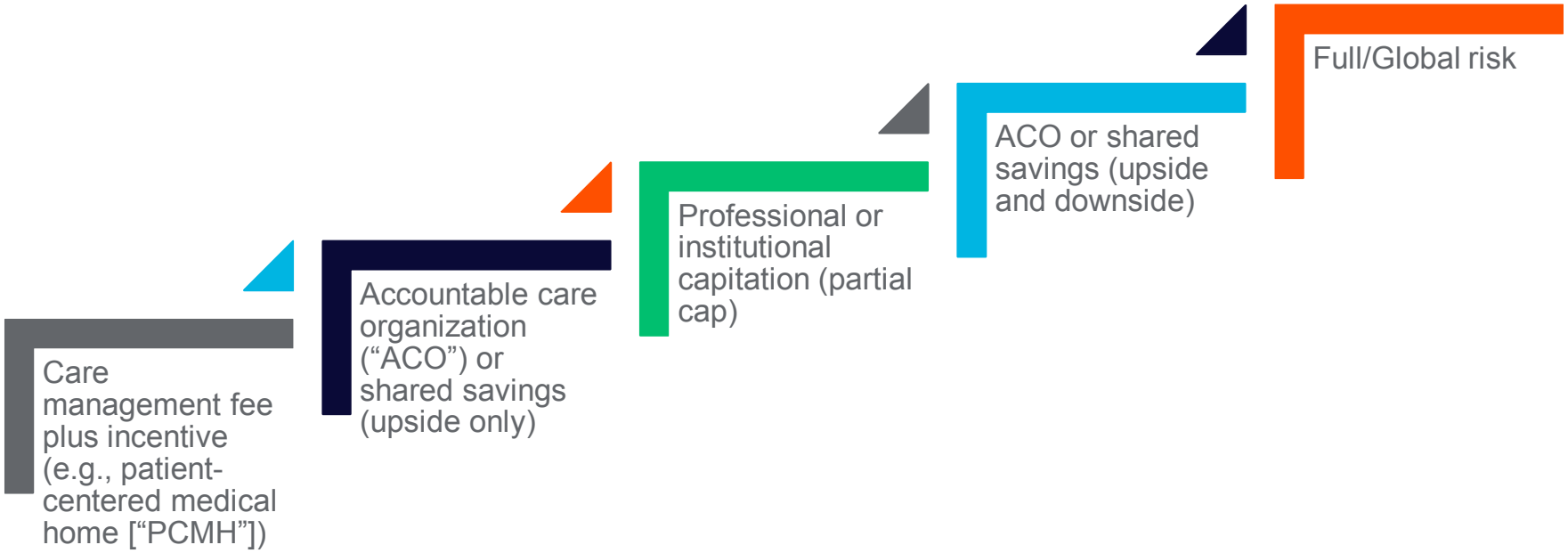
Is this what your journey feels like?

Haven’t we done this before?

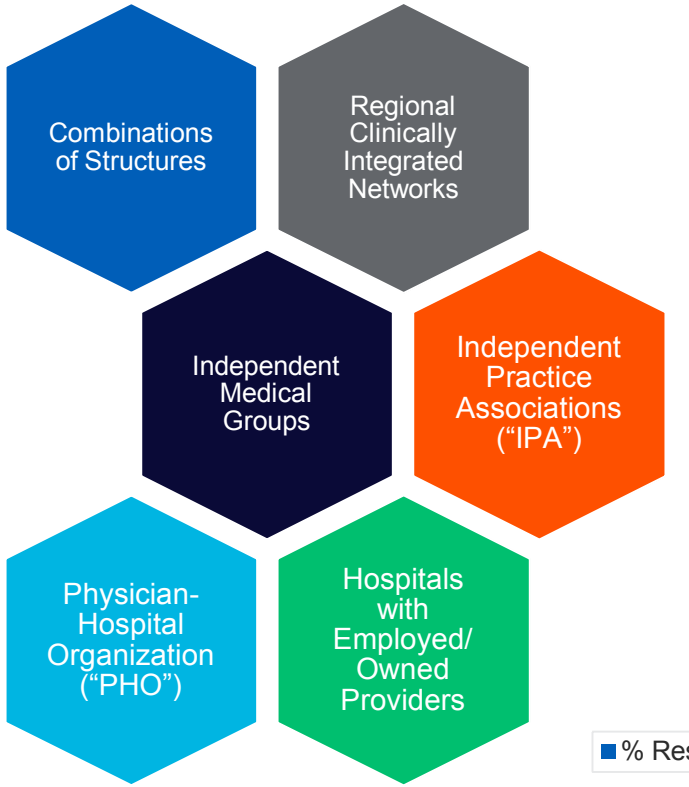
	1990’s Era Insurance Driven	ACA-Era Provider Driven
Economics	Discounts	Contracts at Current Price
	Withholds	Incentives
Management	Lower Utilization	Appropriate Utilization
	Prevention	Management of Chronic Disease
	Patients Enroll and then Gatekeeper	Attribution/Relationships and then Coordination
Market	Booming Economy	Slow Growth
	Limited Informatics	Robust Informatics

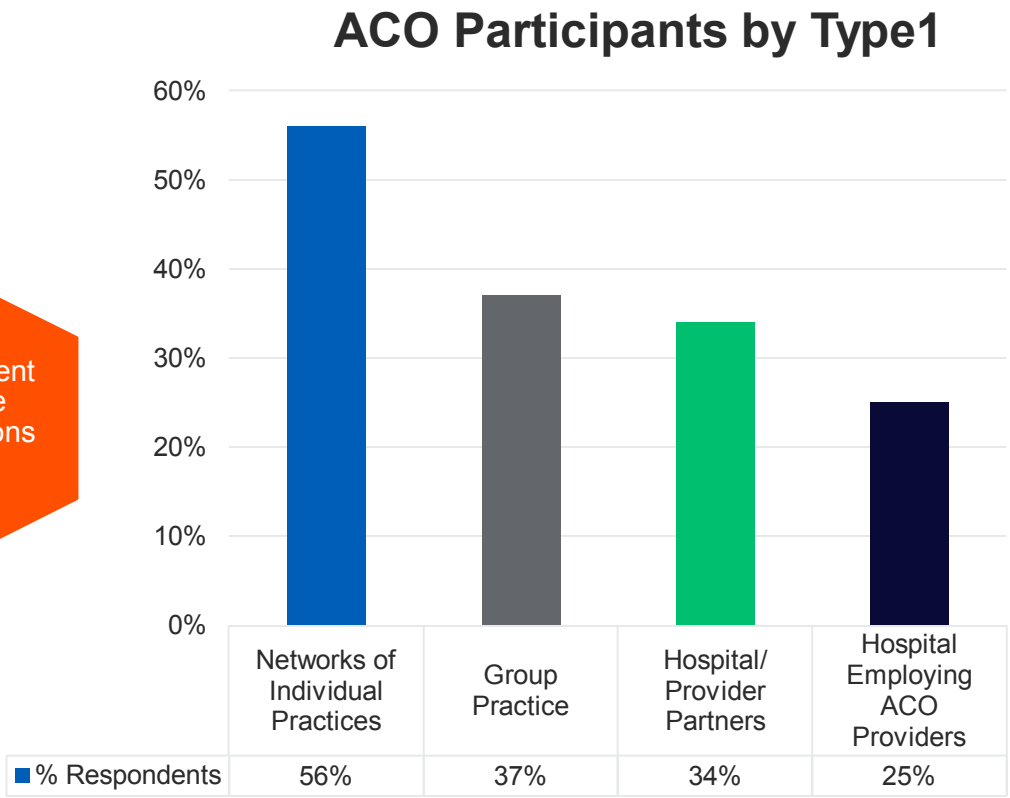
Population Risk

Each phase brings greater risk, but potentially greater rewards



Types of Organizations Taking Risk





Source: CMS, 2015. Note: ACOs could select more than one option.
1 Not reflective of all risk bearing organizations, representative of MSSP participants only

Clinical Integration/Risk Management Evolution

PHASE 1 Develop the Structure

- Build the organizational infrastructure
- Establish quality programs, incentive models, and outcome tracking
- Develop care management infrastructure
- Enter into limited risk-based contracts

PHASE 2 Establish Partnerships

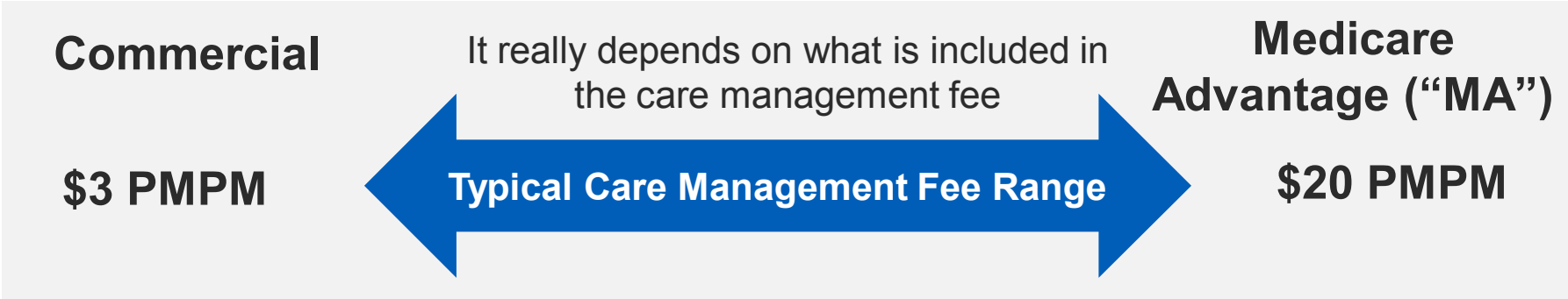
- Leverage infrastructure with providers in new markets
- Develop products
- Partner with payer(s) (carrier as the middle-man)
  - Larger provider network
  - Access to membership
  - Direct to employer contracts

PHASE 3 Management of Risk

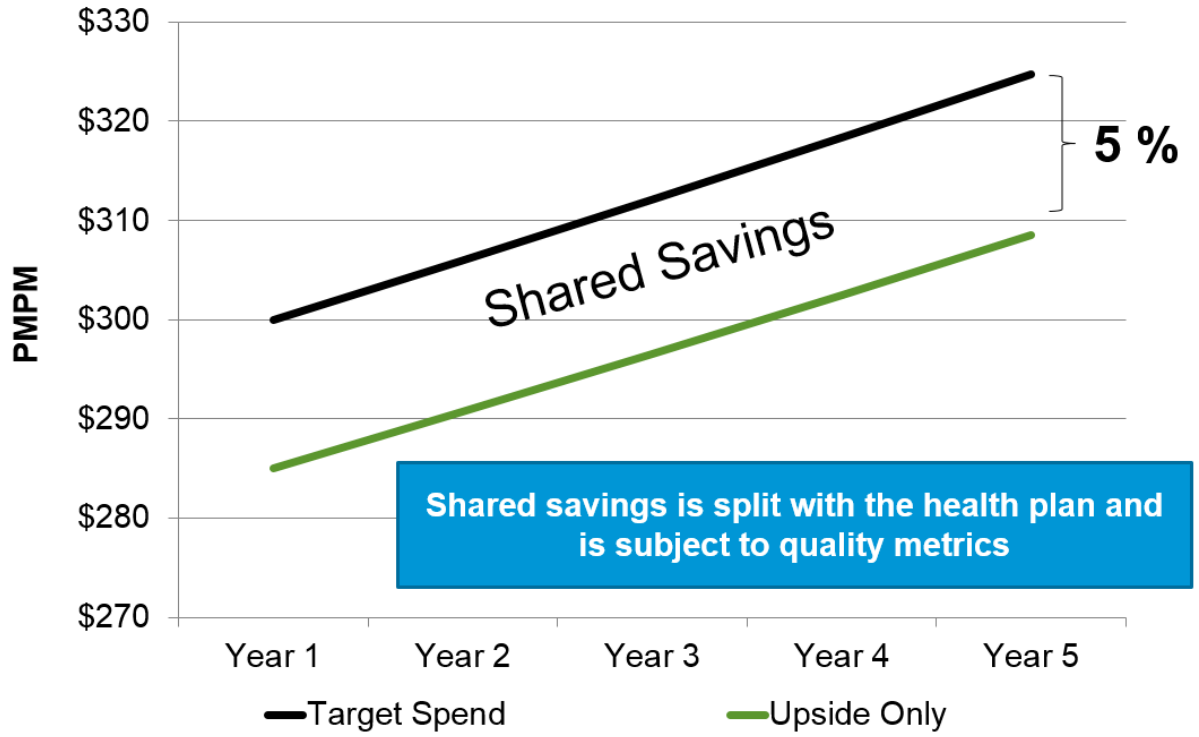
- Full-service provider of population health services
- Offer insurance products direct to the market or partner with major payers to manage professional or global risk
- Commoditize products and services direct full risk-contracting with employers
- Advanced benefits designs

Care Management Fees

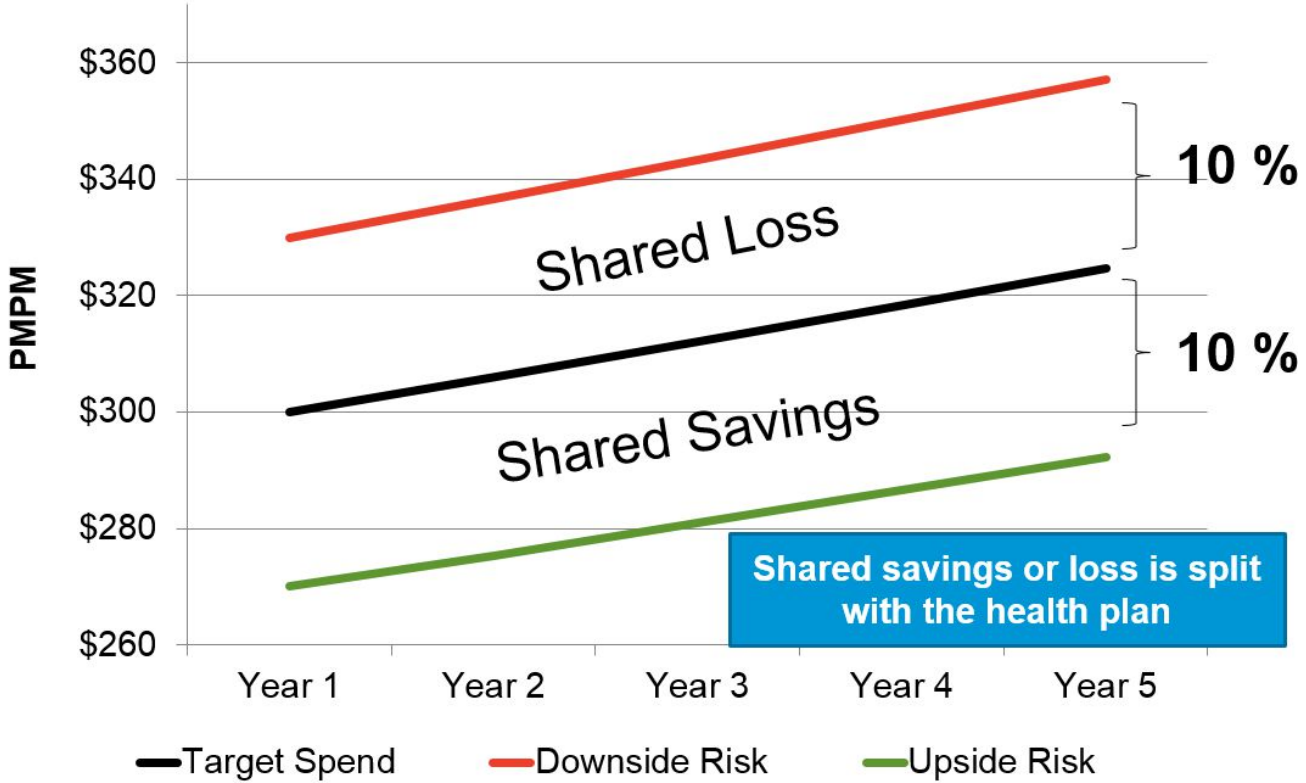
- Fees paid by the health plan to physicians for the provision of care management services.
  - Typically risk-adjusted and paid on a per-member-per-month ("PMPM") basis.
- Requires critical mass of patients to be effective.
- Should be done in conjunction with a shared savings program.
- Part of medical expenses or administrative expenses?



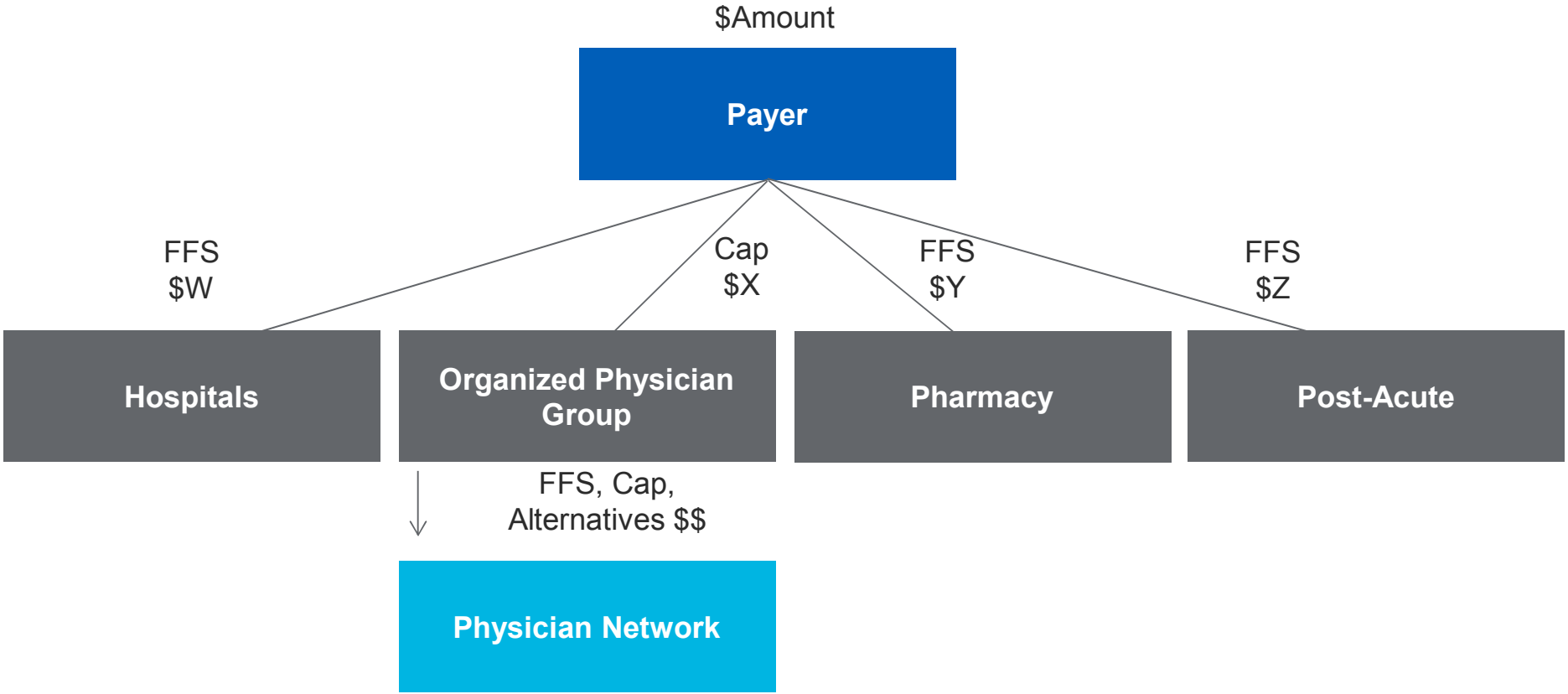
Shared Savings: Upside Only



Shared Savings: Upside and Downside



Professional Risk



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

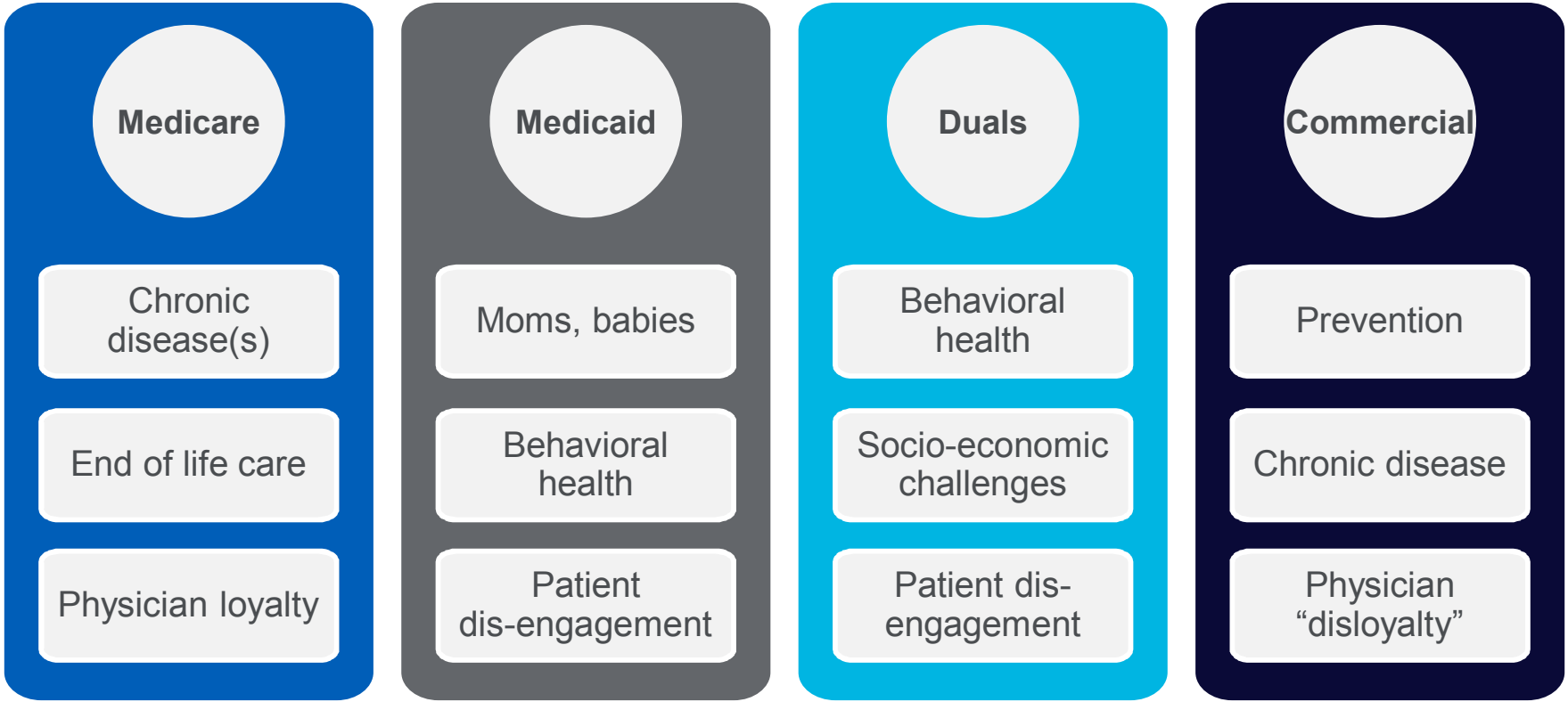
- Single entity receives all funding and pays all claims.

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.

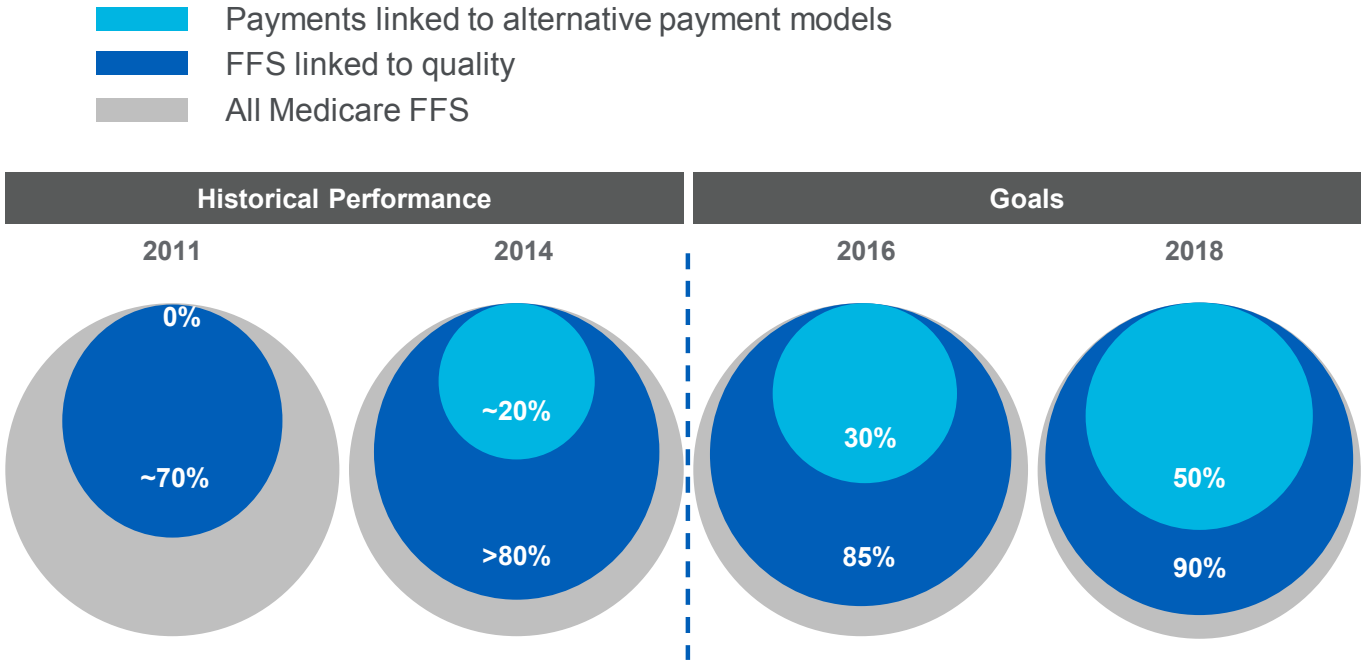
Consider the Population Characteristics



Medicare

CMS Timeline For Transition to Value-based Reimbursement

By 2018, 50 Percent of Payments Will Be In Alternative Payment Models



Source: Centers for Medicare and Medicaid Innovation ("CMMI") Center, Bundled Payment Summit, June 2015

Medicare Shared Savings Plans

Track 1	Track 1+	Track 2	Track 3
Upside Risk Only	Upside and Limited Downside Risk	Upside and Downside Risk	Upside and Downside Risk
Shared Savings of 50%	Shared Savings of 50%/Loss at 30%	Shared Savings/Loss Rate of 60%	Shared Savings/Loss Rate of 75%
10% Savings Cap	10% Savings Cap/Loss Cap 8% of FFS Rev or 4% of Benchmark	15% Savings Cap/ 5% to 10% Loss Cap	20% Savings Cap/ 15% Loss Cap
Minimum Attribution: 5,000	Minimum Attribution: 5,000	Minimum Attribution: 5,000	Minimum Attribution: 5,000

Next Generation ACO

Track 1

- Upside and Downside Risk
- Shared Savings of 80% for Years 1-3; 85% for Years 4 to 5
- 15% Savings/Loss Cap
- Minimum Attribution: 10,000

Track 2

- Upside and Downside Risk
- 100% Risk for Part A and Part B Expenditures
- 15% Savings/Loss Cap
- Minimum Attribution: 10,000

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.

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 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

Commercial Products and/or Private Plans With Government Products

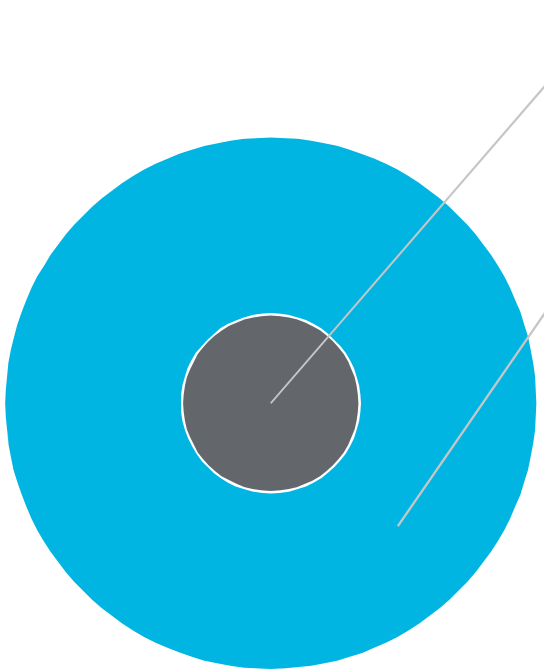
Why is Value More Important Now?

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.

Commercial Carrier Programs

Often a Combination of Methodologies

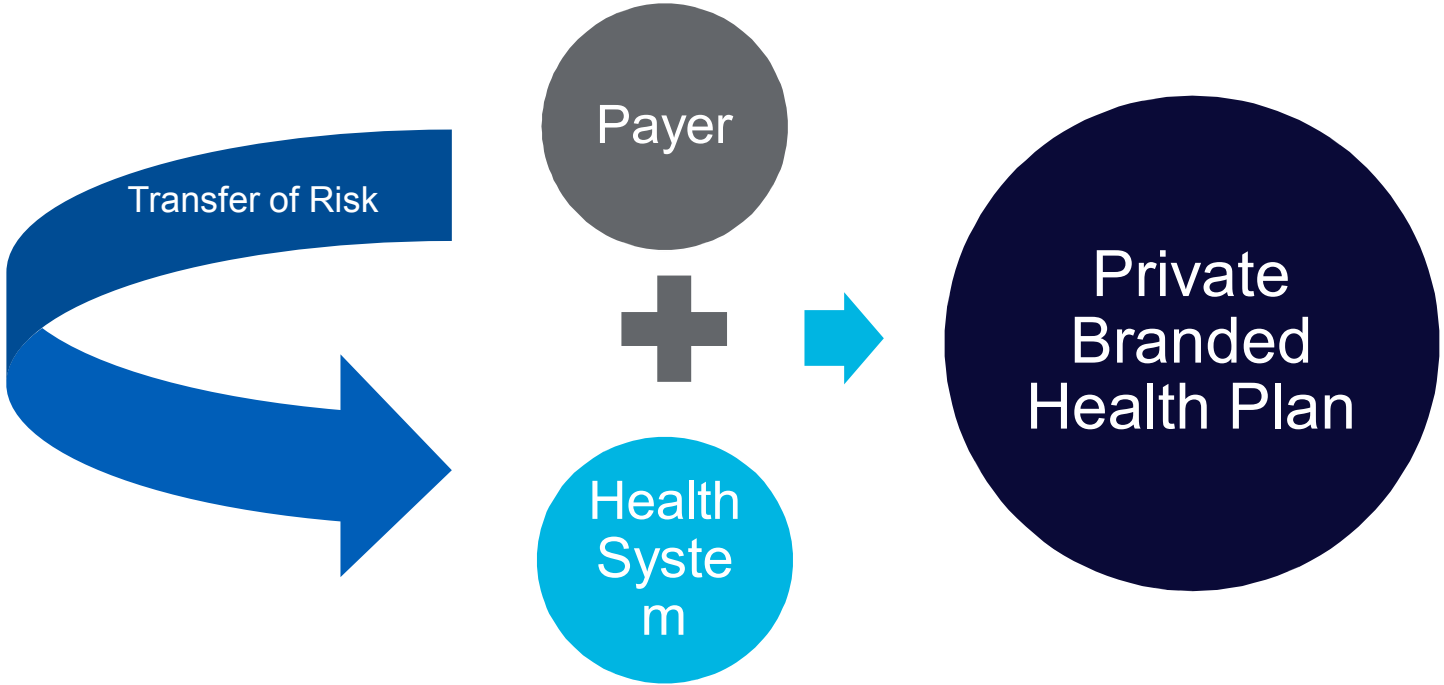


- Some level of formal PCMH accreditation may be required.
- Care management fees paid on a PMPM basis are negotiable and often deducted from any savings (also negotiable).
- Number of attributed lives requirement may be lower (e.g., 1,500)
- Quality metric performance and STAR rating (MA) are important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

Commercial Risk

Medicare Advantage

- Enrollment growth, attractive option for health systems to:
  - Partner with payers - private branded plan



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

Additional 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 • **R**e-insurance • **R**isk corridors

- If pursuing partial capitation, what are carveouts (e.g., pharmacy, mental health, transplants, etc.)
- If shared savings, how are benchmarks established?
- What is the 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.
Performance Year	Patients are attributed to organizations at the end of the year based on patients' use of care during the actual performance year.
Hybrid	Preliminary prospective assignment methodology with final retrospective reconciliation where there is prospective attribution initially; followed by retrospective reconciliation.

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.
- Do you have a seat at the table for benefit design?

Critical Success Factors – Population risk

Financial

- Cash reserves
- Stable history
- Pricing
- Tolerance for risk
- Population risk profile
- Contract language

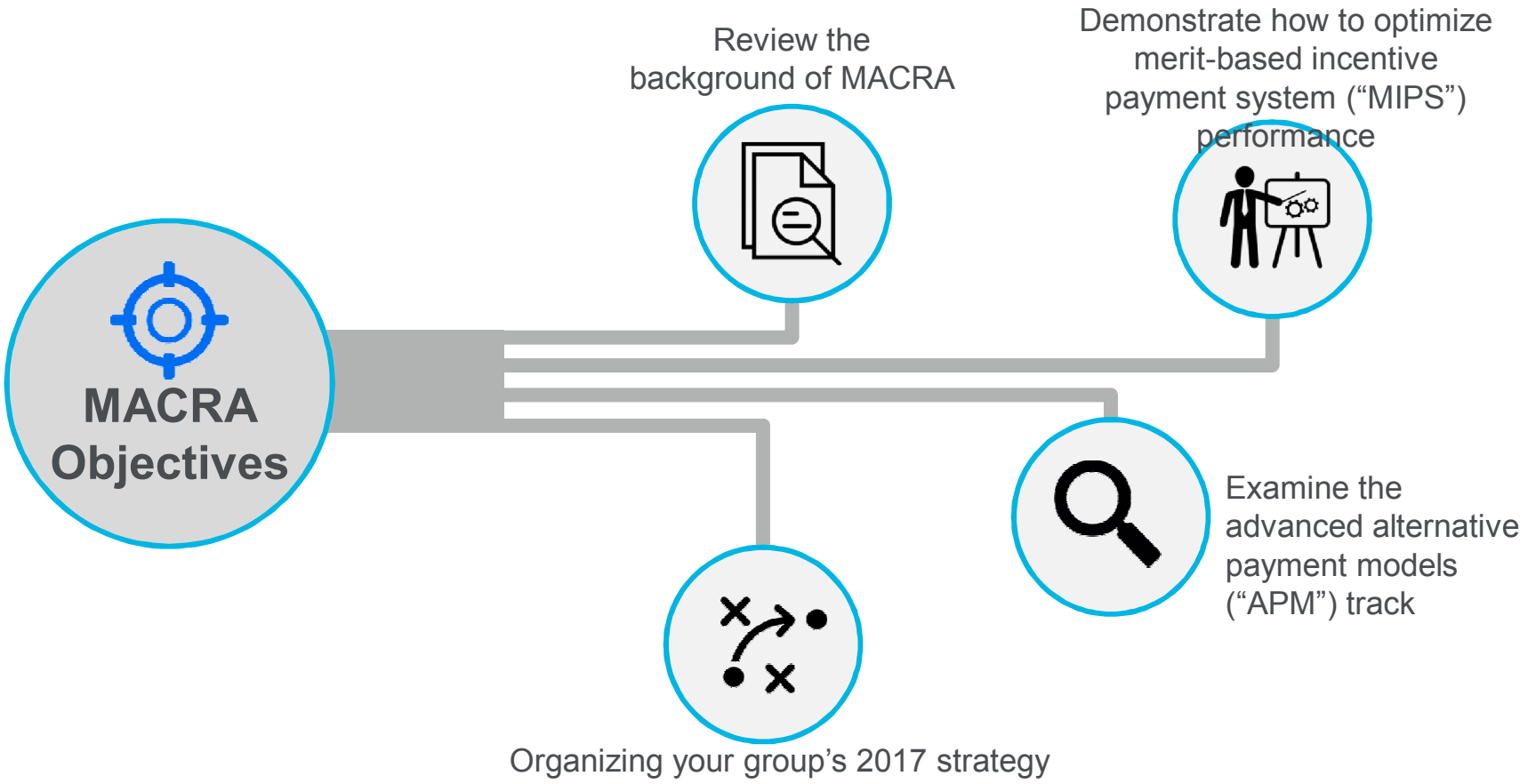
Functional

- Experience
- Population size
- Geographic coverage
- Analytics and data capture
- Actionable reports
- Care management and patient activation

Cultural

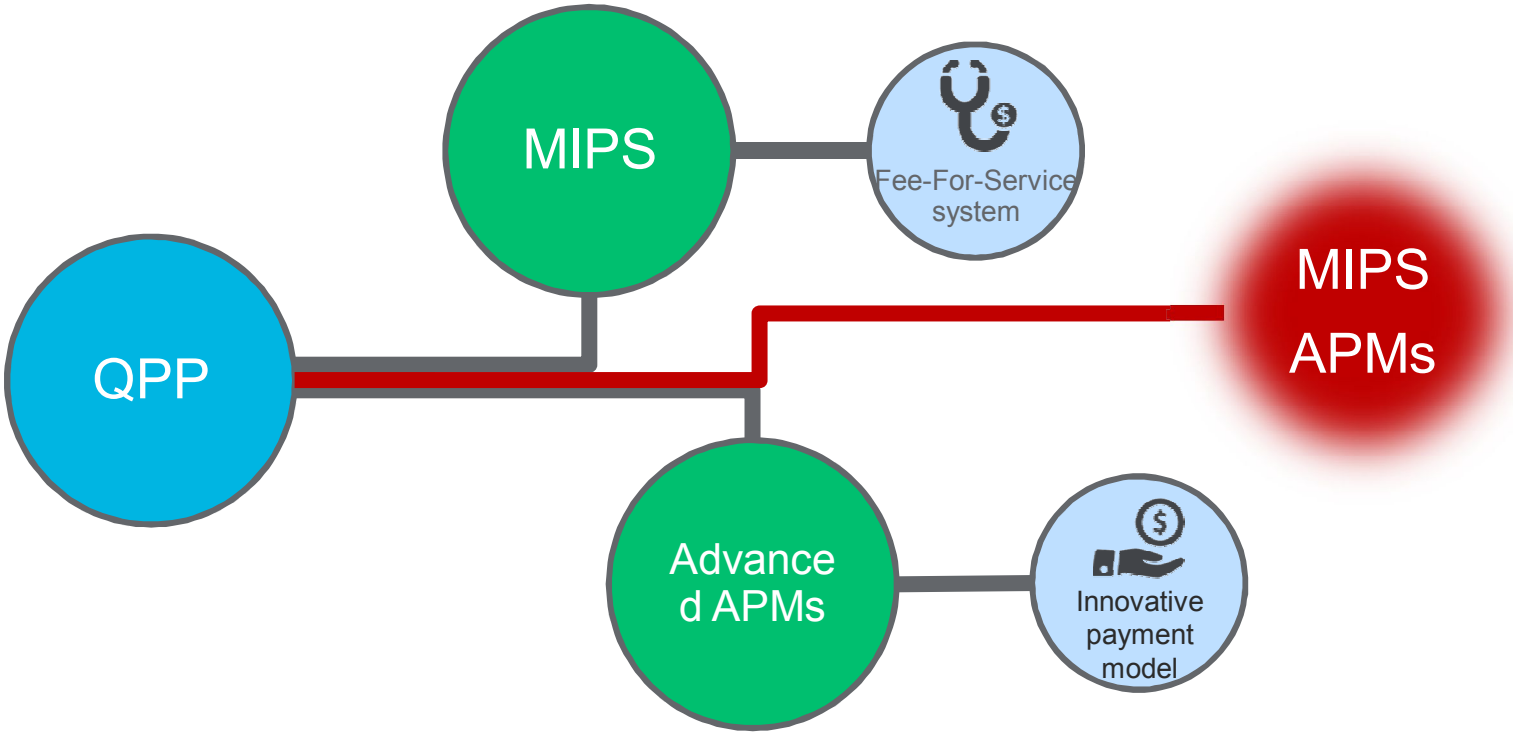
- Population focus (vs. provider-centric)
- Constructive collaboration among providers
- Accountability
- Stamina to respond to competitive forces (internal and external)

MACRA



MACRA: Quality Payment Program (“QPP”)

2 Tracks



MIPS Eligibility

Eligible Clinicians

Physicians
Physicians Assistants
Nurse Practitioners
Clinical Nurse Specialists
Certified Registered Nurse Anesthetists

with

Patient volume

More than 100 Medicare patients per year

or

Medicare billing

More than $30,000 annually

"CMS estimates that 32.5% of Medicare clinicians (representing just 5% of Part B spending) will be exempt from MIPS requirements"

MIPS Categories

Quality

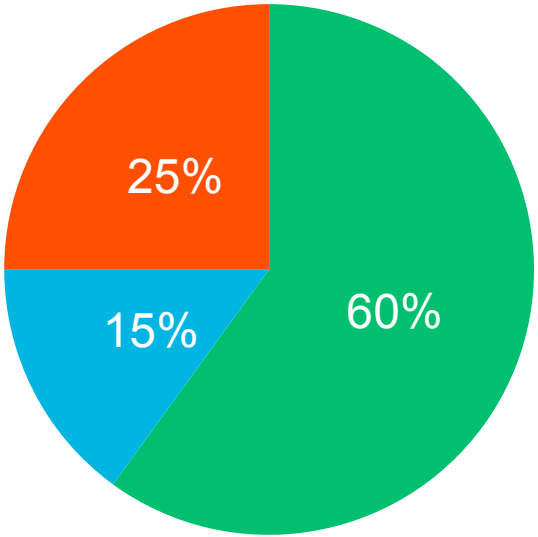
Cost

Improvement Activities

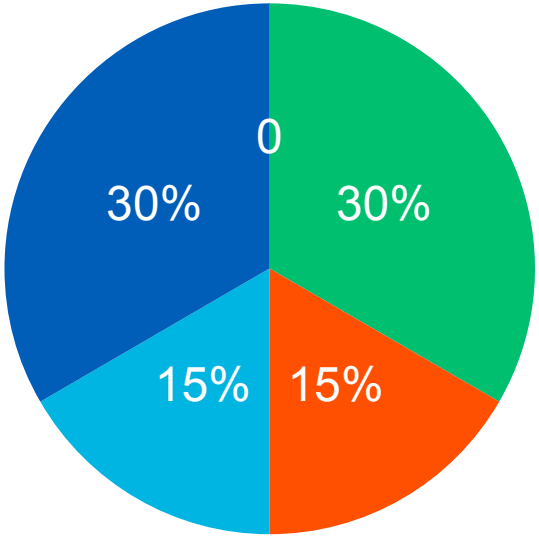
Advancing Care Information

The Score Calculation Changes Over Time

Performance Year 2017



Performance Year 2019



Quality | Advancing Care Information (MU) | Clinical Practice Improvement Activities | Resource Use

MIPS Scoring in 2017 (Sample)

Cost 0%	N/A	**Advancing Care Information 25%**	Security Risk Analysis e-Prescribing Patient Access Send Summary of Care Request/Accept Summary of Care Optional Measures Bonus Credit
Improvement Activity 15%	High-weighted activity Medium-weighted activity Medium-weighted activity	**Quality 60%**	Quality Measure Quality Measure Quality Measure Quality Measure Quality Measure Quality Measure Outcome Measure

Composite Score = 3 to 100

MIPS: Quality

60%

- Report measures
  - –6 measures, including at least 1 outcomes measure

  OR

  - –1 specialty-specific measure set
- Bonus points for reporting CAHPS data (or other patient experience measures)

MIPS: Quality

Specialty-Specific Measure Sets

MIPS: ACI

25%

- Emphasis on information exchange and use of CEHRT to support patient engagement and improved quality
  - 4 to 5 required measures; submit up to 9 measures for additional credit
  - Bonus score for improvement activities that utilize CEHRT and for reporting to public health or clinical data registries

Security Risk Analysis

Provide Patient Access

Request/Accept Summary of Care

Electronic Prescribing

Send Summary of Care

MIPS: Improvement Activities

15%

Choose from list of more than 90 Improvement Activities to earn Target 40 Points

Examples of medium-weighted (10 points) and high-weighted activities (20) points).

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement	Patient Safety Practice Assessment	Alternative Payment Models
• Same day appointments for urgent needs (High) • After hours clinician advise (High) • Telehealth services – participation in remote specialty consults (Medium)	• Participation in a systematic anticoagulation program (High) • Participation in a qualified clinical data registry (High) • Monitoring health conditions and providing timely intervention (Medium)	• Participation in the CMS Transforming Clinical Practice Initiative (High) • Timely communication of test results (Medium) • Timely exchange of clinical information with patients AND providers (Medium)	• Access to an enhanced patient portal (Medium) • Establishing care plans for complex patients (Medium) • Participation is a QCDR (Medium)	• Consolidation of Prescription Drug Monitoring Program prior to issuance of controlled substances (High) • Administration of the AHRQ Survey of Patient Safety Culture and submission (Medium) • Use of surgical checklists (Medium)	• Participation in an APM will also count for Improvement Activities

Participation in a certified PCMH earns the maximum 40 points.

Resource Use

0%

Total per capita costs and Medicare spending per beneficiary

Include payments under both Part A and Part B, but do not include Medicare payments under Part D for drug expenses- yet

Resource Use is 10% of the composite score in Performance Year 2018/Payment Year 2020 and 30% starting in 2019/2021

10+ to-be-determined clinical episode-based measures

- Heart Failure, Chronic
- Ischemic Heart Disease (IHD), Chronic
- Asthma/Chronic Obstructive Pulmonary Disease (COPD), Chronic
- Atrial Fibrillation (AFib)/Flutter, Chronic
- Heart Failure, Acute Exacerbation
- Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)
- Knee Arthroplasty (Replacement)
- Spinal Fusion
- Pneumonia, Community Acquired, Inpatient (IP)-Based
- Acute Myocardial Infarction (AMI) without PCI/CABG
- Percutaneous Cardiovascular Intervention (PCI)
- Ischemic Stroke
- Knee Arthroplasty (Replacement)

MIPS: Sample Financial Impact

Reporting Years 2017 to 2020

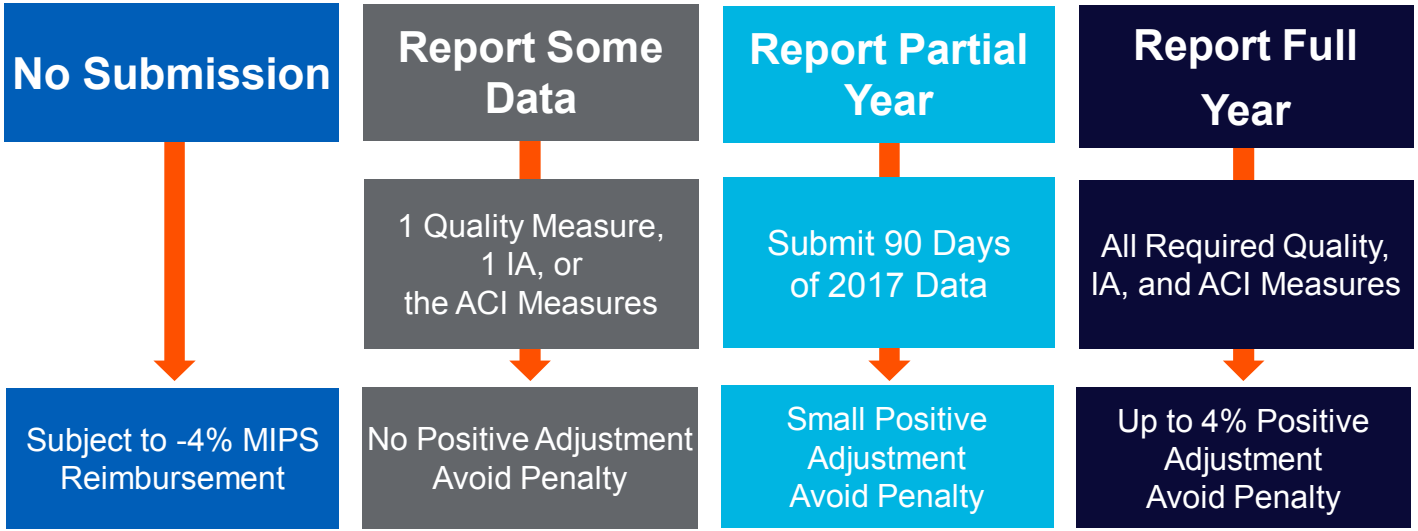
Reporting Year	Payment Year	MIPS Adjustment	Financial Impact[1]($) (+-) 1 Clinician	10 Clinicians	20 Clinicians
2017	2019	-/+ 4%	8,000	80,000	160,000
2018	2020	-/+ 5%	10,000	100,000	200,000
2019	2021	-/+ 7%	14,000	140,000	280,000
2020	2022	-/+ 9%	18,000	180,000	360,000

- $500 million available annually between 2019 and 2024 for “exceptional” performance
- Score > 70 in 2017

Quality Payment Program

"Pick your Pace" for MIPS

Final Rule offers options to avoid penalties, partially participate in positive adjustments or fully participate



Maximizing MIPS Performance

MIPS Performance

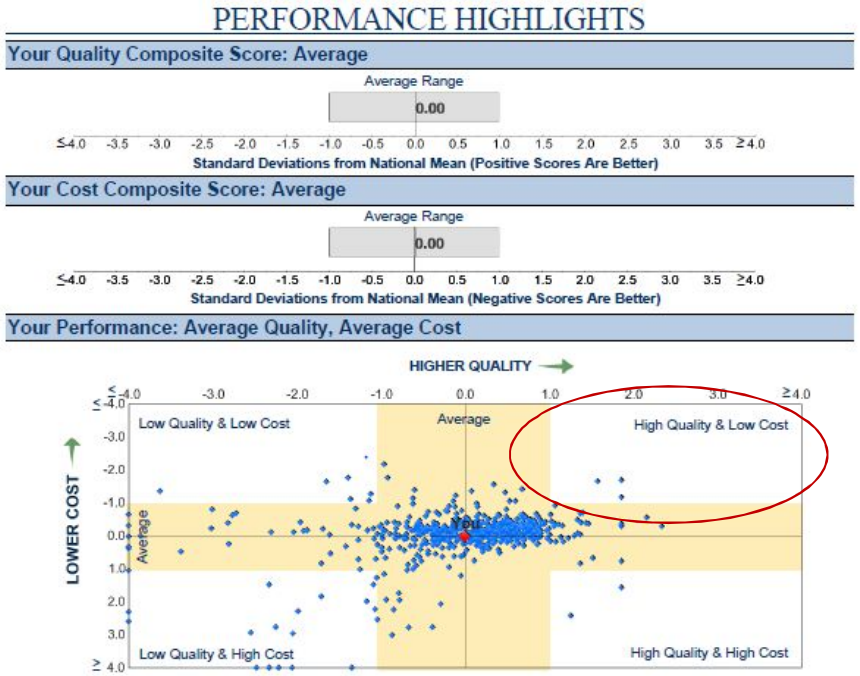
Strategies to Optimize the Composite Score

1. Retrieve and analyze Quality and Resource Use Report (“QRUR”) reports
2. Review current performance of MU (“ACI”) and PQRS measures
3. Compare current performance of PQRS quality measures to CMS benchmarks
4. Determine the optimal 2017 reporting and submission (individual or group level) methods

CMS Quality and Resource Use Report

2015 QRURs are Available by Tax Identification Number ("TIN")

- Enterprise Identity Management System ("EIDM") account is required to access the report
- Access report on the CMS Enterprise Portal (https://portal.cms.gov)
- More information on www.cms.gov



MIPS Performance

Physician Quality Reporting System (PQRS) Measures

2014 PQRS Measure Number and Measure Name		2014 Mean	2014 Standard Deviation	2014 Reporting Options					
				Claims	Registry	EHR	Measures Group	GPRO Web Interface/ACO	QCDR
Effective Clinical Care		-	-	-	-	-	-	-	-
1* *(GPRO DM-2, CMS122v2)*	Diabetes Mellitus (DM): Hemoglobin A1c Poor Control	28.42%	22.83%	X	X	X	X	X	X
2 *(CMS163v2)*	Diabetes Mellitus (DM): Low Density Lipoprotein (LDL-C) Control	51.27%	23.25%	X	X	X	X	-	X
5 *(CMS135v2)*	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	83.01%	15.94%	-	X	X	X	-	X
6	Coronary Artery Disease (CAD): Antiplatelet Therapy	89.48%	16.92%	X	X	-	X	-	X
7 *(CMS145v2)*	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVSD) (LVEF < 40%)	88.37%	26.85%	-	X	X	-	-	X
8 *(GPRO HF-6, CMS144v2)*	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	86.35%	16.04%	-	X	X	X	X	X
9 *(CMS128v2)*	Anti-Depressant Medication Management	64.21%	27.32%	-	X	X	-	-	X

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2015-Prior-Year-Benchmarks.pdf

Physician Compare Site

Publicly Reported Data

https://www.medicare.gov/physiciancompare/search.html

What Does it Take to Be a High Performer?

Monitor performance of measures compared to historical values and past CMS benchmarks in an effort to:

Exceed performance threshold on **quality** measures

Exceed performance on **ACI** measures

Align Improvement Activities to support performance

In 2017, earning 70 of a possible 100 points will qualify as high performance.

Sample MIPS Composite Score

Category	Measure	Target
Quality (60%)	Quality Measure	10
	Quality Measure	10
	Quality Measure	10
	Quality Measure	10
	Quality Measure	10
	Quality Measure	10
	Outcome Measure	10
ACI (25%)	Security Risk Analysis	10
	e-Prescribing	10
	Patient Access	10
	Send Summary of Care	10
	Request/Accept Summary of Care	10
	Optional Measures	
	Bonus Credit	10%
Improvement Activities (15%)	Medium Weighted	10
	Medium Weighted	10
	Medium Weighted	10
	Medium Weighted	10
Cost (0%)	NA	0

Advanced APM Track

APM Trajectory – Long-term Goal

Category 1

FFS

No-link to Quality and Value

Category 2

FFS

Link to Quality and Value

A – pay for reporting

B – pay for performance

Category 3

APMs

Built on FFS architecture

A – APMs upside gainsharing

B – APMs with upside/downside risk

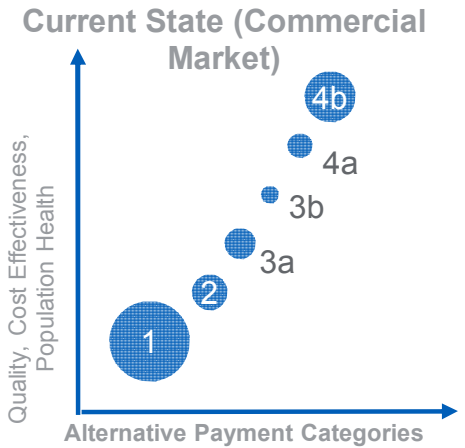
Category 4

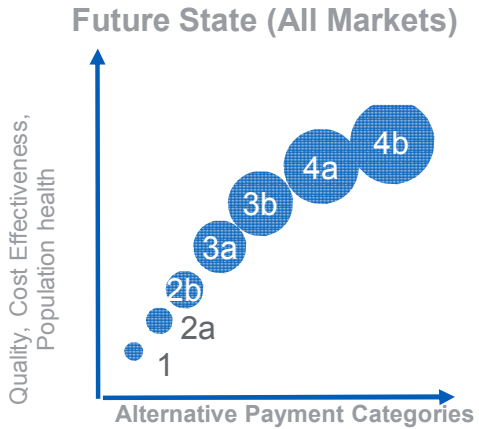
Population based payment

No link to volume

A – condition specific payment

B – Comprehensive population-based payment





*Source: CPR 2014 National Scorecard on Payment Reform, based on the National commercial market using 2013 data.

Criteria

Use a Certified EHR

Meet Qualified Participant Threshold

Tie Clinician Payment to Quality Measures comparable to those under MIPS

Satisfy Requirements for Risk

Participate in an Eligible APM

Eligible Advanced APMs for 2017

Innovative payment models

- Medicare Shared Savings Program (“MSSP”) Tracks 2 and 3
- Next Generation ACO (“NGACO”) Model
- Comprehensive Primary Care Plus (“CPC+”) only for organizations with less than 50 clinicians
- Comprehensive ESRD Care Model (Large Dialysis Organization Arrangement)
- Oncology Care Model (two-sided risk arrangement)

Possible Future Advanced APMs

Innovative payment models

- ACO Track 1+
- New Voluntary Bundled Payment Model
- Advancing Cardiac Care Coordination through Episode Payment Models (Cardiac and Joint Care)

Benefits

Advancements with clinical integration

Earn a bonus payment of 5%

Higher base rates beginning in 2026

Not subject to MIPS reporting requirements and potential negative payment adjustments

MACRA Roadmap

1. 2017 MACRA Roadmap

Completed?

- Create Steering Committee
- “Pick your Pace” for 2017
- Develop 2017 MACRA work plan
- Implement change management program

2. MIPS Implementation

January 2017

- Focus on:
  - Workflows
  - Measures
  - Performance
  - Compliance
  - Change management

3. Reporting and Tracking

Q1 2017

- Test or track MIPS performance monthly
- Perform internal 90 day Test

4. MIPS Selection and Monitoring

CY 2017

- Monitor Individual provider and TIN performance
  - Improve performance
  - Select measures for reporting

5. Strategic Alignment and Planning

Q1 2018

- Define reporting period and review performance
- Understand cost of care
- Evaluate opportunities to advance to APM track

Summary

The Path to Success

- MACRA fundamentally changes the way physicians are paid
- Reimbursement will increasingly be tied to value-based performance
- There will be winners and losers
- Now is the time to chart your course for success from an operational, strategic, and financially focused approach.

Tactical Approaches to Achieve Clinical and Cultural Transformation

Burning Platform for Change

Accelerating costs and financial burden to individuals, companies, states, and federal government

Changing nature of competition; new entrants; changing scale

Clinical advances; innovations in science and technology

Societal behaviors, changes in expectation; demographics

Internet; data transparency; the democratization of health information

Dissatisfaction with “the healthcare system”: Uneven access/high rates of uninsured; sub-optimal quality, patient experience; significant variability in use rates and outcomes

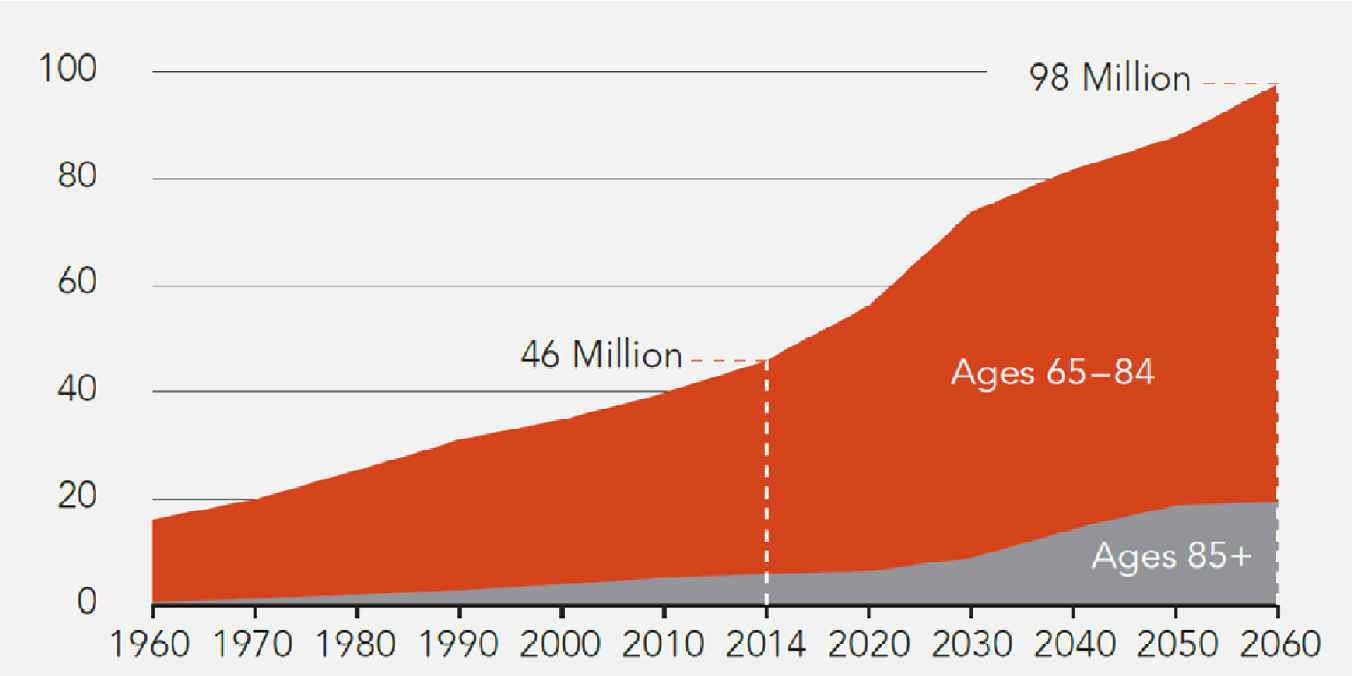
Changing use rates; locations of care; structural changes to healthcare field

Indictments of healthcare quality, access, and cost

Politics

The Number of Americans ages 65 and Older Will More Than Double by 2060.

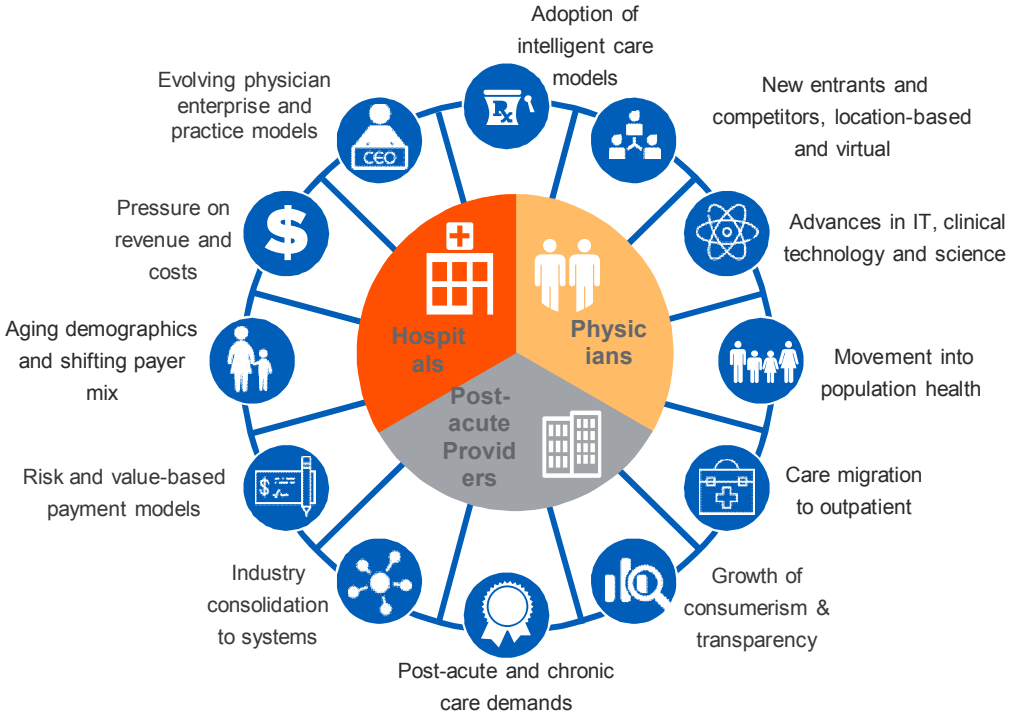
U.S. Population Ages 65 and Older, 1960 to 2060



Source: PRB analysis of data from the U.S. Census Bureau.

Multiple Challenges Are Impacting Healthcare

All Sectors of Healthcare Are Affected

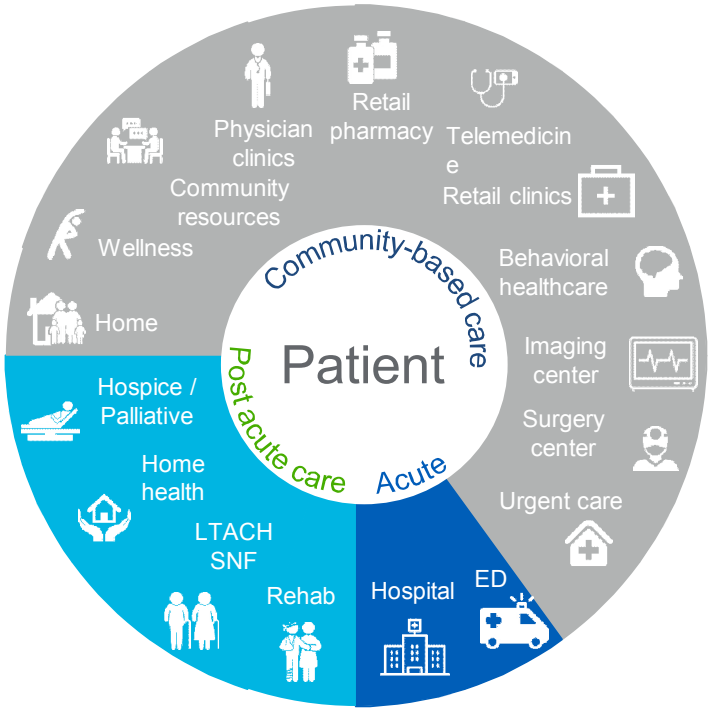


Reality Check

- 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

Destination: Whole System Activation

Organized System of Care



- High-performing integrated model
- High quality, efficient care across the continuum and community
- Standardized process for care coordination
- Evidence-based practice and programs
- Engagement and empowerment of patients and providers
- Information technology (“IT”) infrastructure for data driven care

Building Blocks: Value-Based Critical Success Factors

Finance and Payer Contracting

Payer strategy and negotiation, risk-based methodologies, physician compensation and incentives, funds flow, and financial performance of organization

Care Model Redesign

Patient centered medical home ("PCMH"), care management, disease management, Lean/Clinical process redesign

Health Information Technology ("HIT") and Data Analytics

Data aggregation and analytics for population health, tools for care plan, risk stratification, and integrated communication (health information exchange ["HIE"])

Quality and Outcomes

Quality metric selection and performance, cost-of-care analysis, transparency of quality and financial information

Leadership and Governance

Selection of physician and administrative leaders, governance design of organization, partnerships, and agreements

Network and Access

Design and selection of an appropriate provider network, criteria for participation, recruitment and enrollment, gap analysis, and engagement

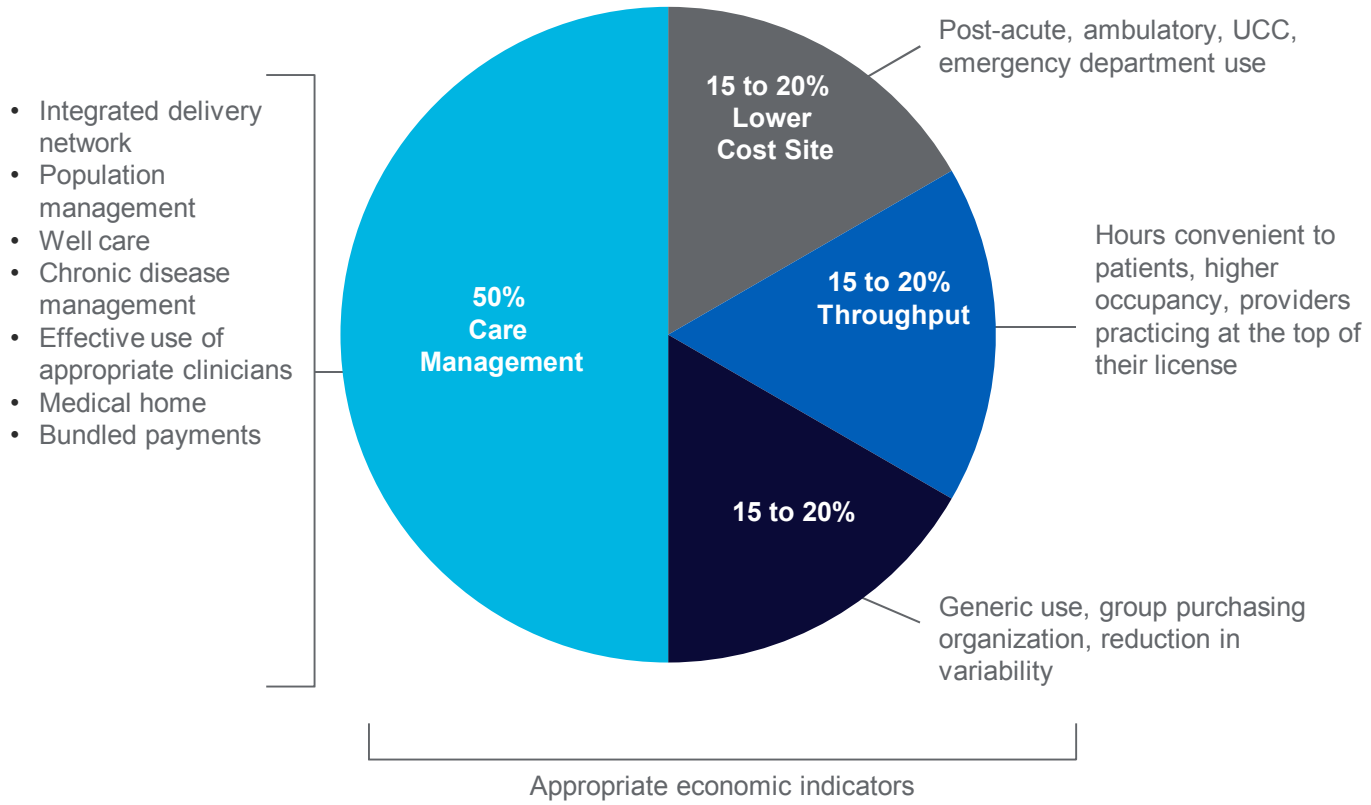
Patient Engagement

Monitoring of patient experience, access to care, ongoing performance improvement, patient engagement via portals, apps, and other outreach

Transformational Strategy

Organization-wide strategy and value proposition, continual transition to value-based system, and drivers of successful transformation

Foundation: Care Management is at the Heart of Care Model Redesign

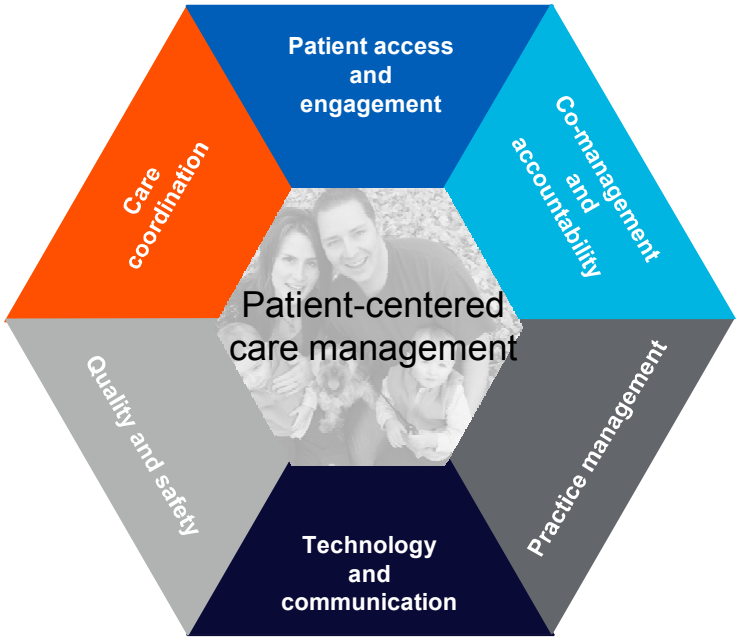


Care Management: What is it and are its Guiding Principles

"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

- Care management infrastructure:
  - Care management organization
  - Hospital-based clinicians
  - Inpatient care management
  - Ambulatory case management
  - Post-acute care settings
  - High-risk clinics
  - Disease management
  - Pharmacy management
  - Transitions management
  - Referral and centers
  - Utilization management
  - Health education/promotion
  - IT



Care Management Functions

- Care plan development and management
- Education/Self-management
- Care coordination across networks
- Support to patient and caregivers
- Referral to community-based resources
- End-of-life support
  - Advanced directives
  - Palliative care and hospice referrals

Old Care Management Model

Parallel Play

"It is kind of nice to have you around, but you do your thing and I will do my thing…and do not be interfering with my thing!"

New Care Management Model

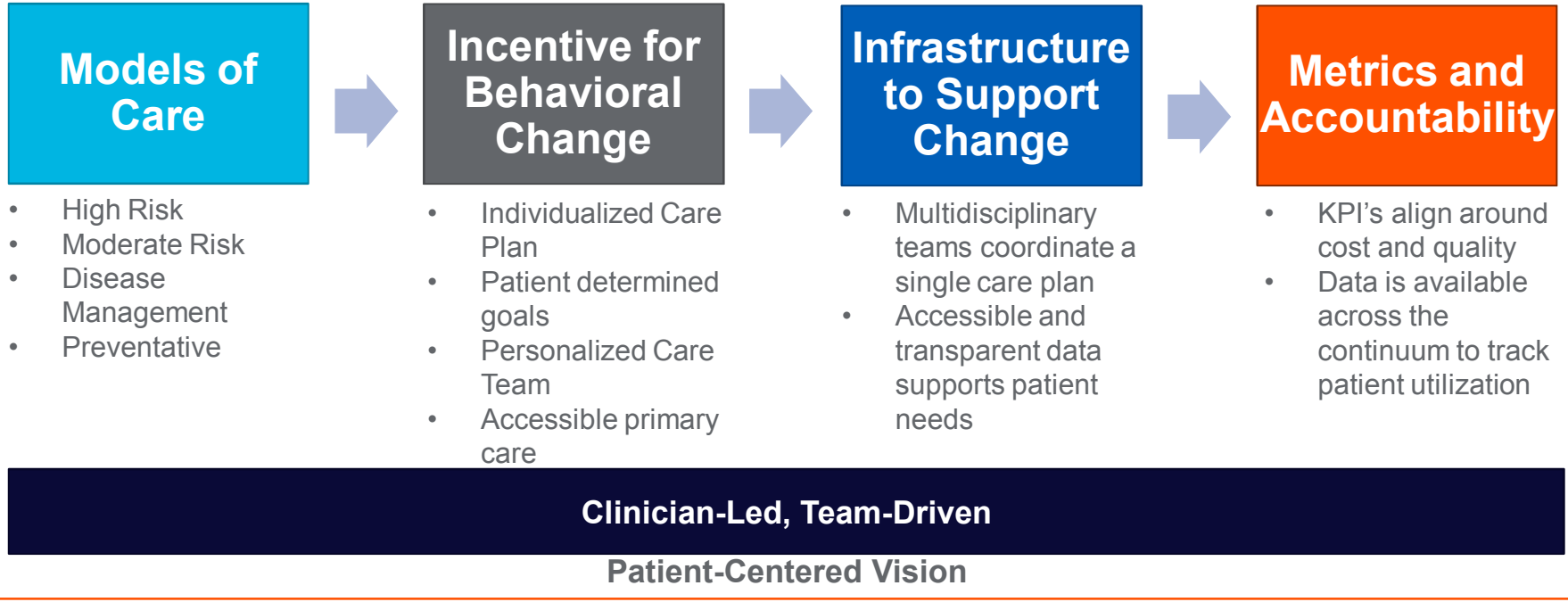
Coordinated, Simple, Harmonic

Care Management is the Common Thread

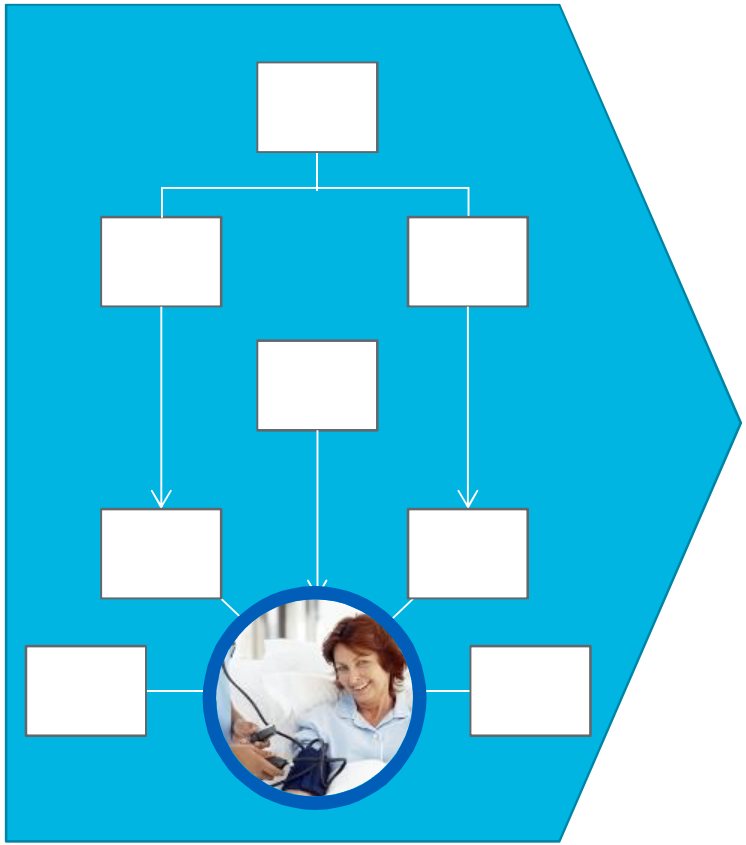
Linking the Patient Through Every Setting

Optimal Care Management Characteristics

Across the Continuum



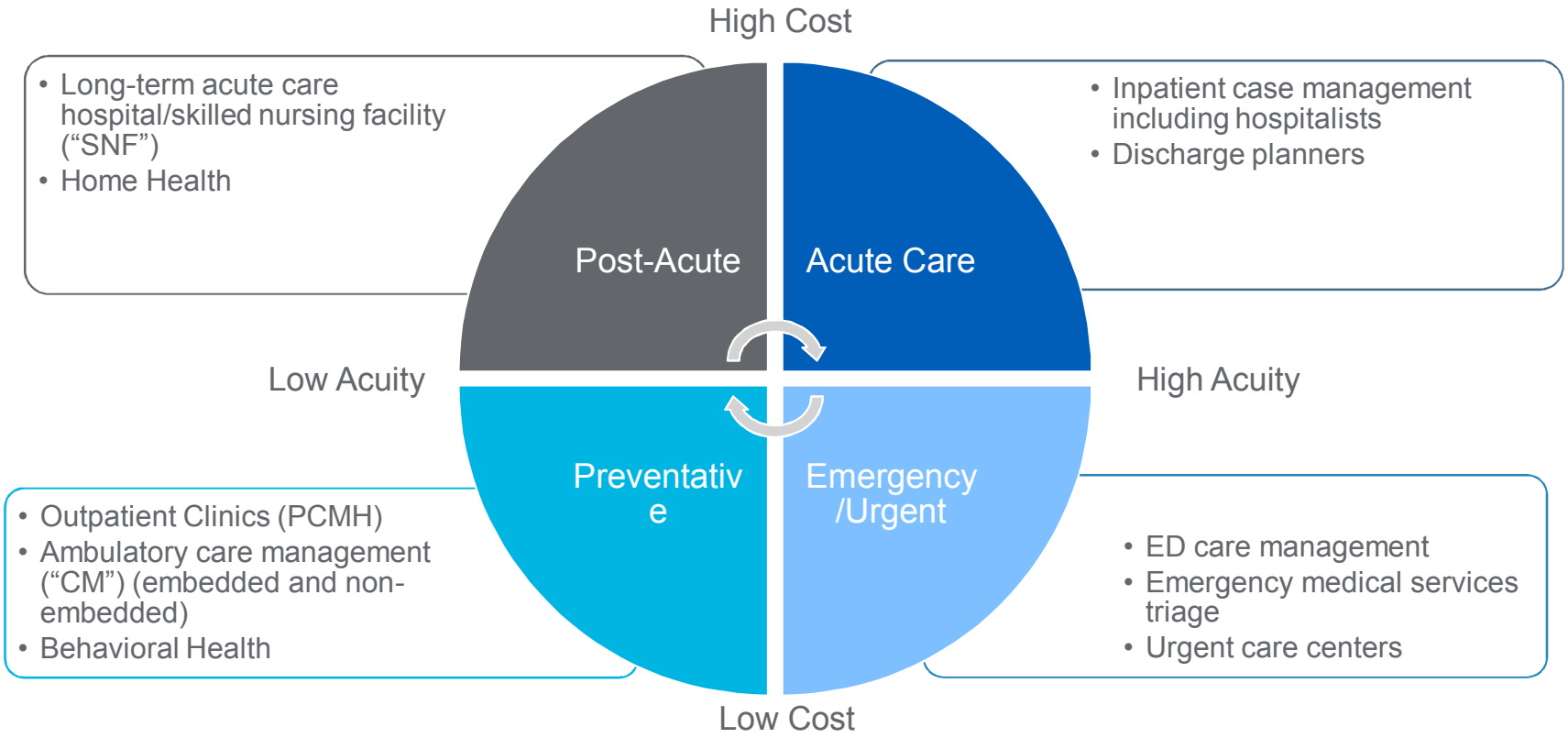
Rethinking Our Organizational Orientation



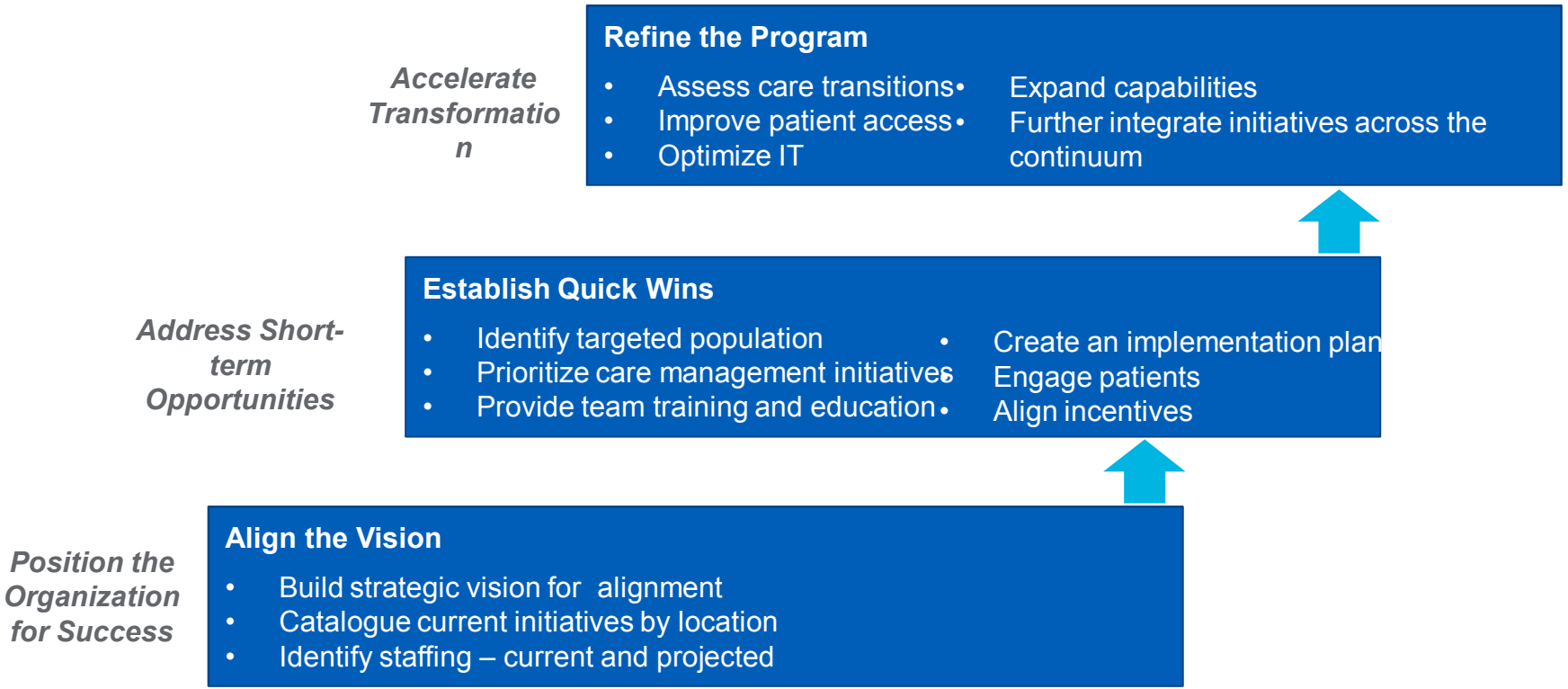
Focus Areas: What Are the Opportunities?

- Preventive health
  - Gaps in care
- Disease Management
  - Diabetes
  - Heart failure
  - COPD
  - Asthma – adult and pediatric
  - Behavioral health
- Care transitions between settings
  - Appointments scheduled prior to discharge
  - (home visits, PCP, Specialist, etc.)
  - DME and medications ordered/coordinated
- Utilization management:
  - Preventable ED utilization
  - Ambulatory-sensitive conditions
  - Post acute care
  - Readmission prevention
- Care coordination/navigation
  - Transportation
  - Referrals
  - Community resources
  - Health education

Focus Areas: Where Are Patients Managed?



Expand Care Management Capabilities Incrementally



Care Management Program Design

Patient identification through:
- Population stratification
- Clinical qualifiers
- Disease states
- Frailty
- Coordination needs

Right patient

Right place

Patient engagement at:
- Home
- Hospital, SNF
- Care transitions
- Telephonic

Patient outreach when:
- New patient
- After primary care physician visit
- 30 days post-acute
- New diagnosis
- New prescription

Right time

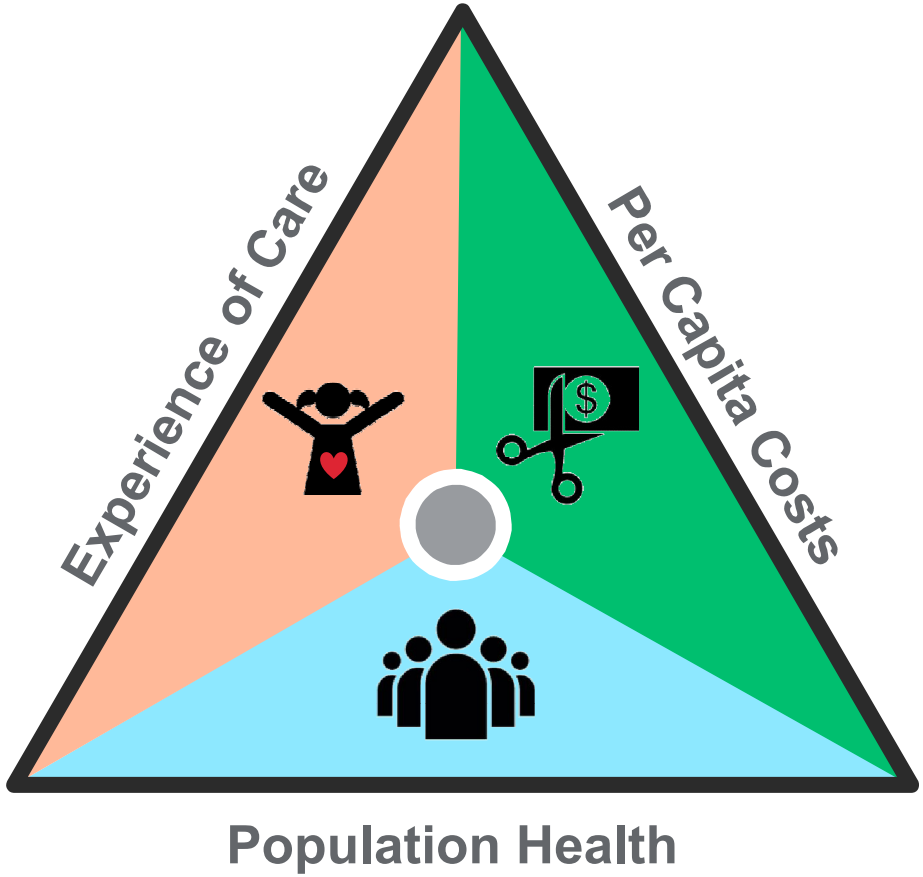
Right role

Patient care delivery by:
- Appropriate individual, based on training
- Care team member with expertise who fulfills patient needs

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.

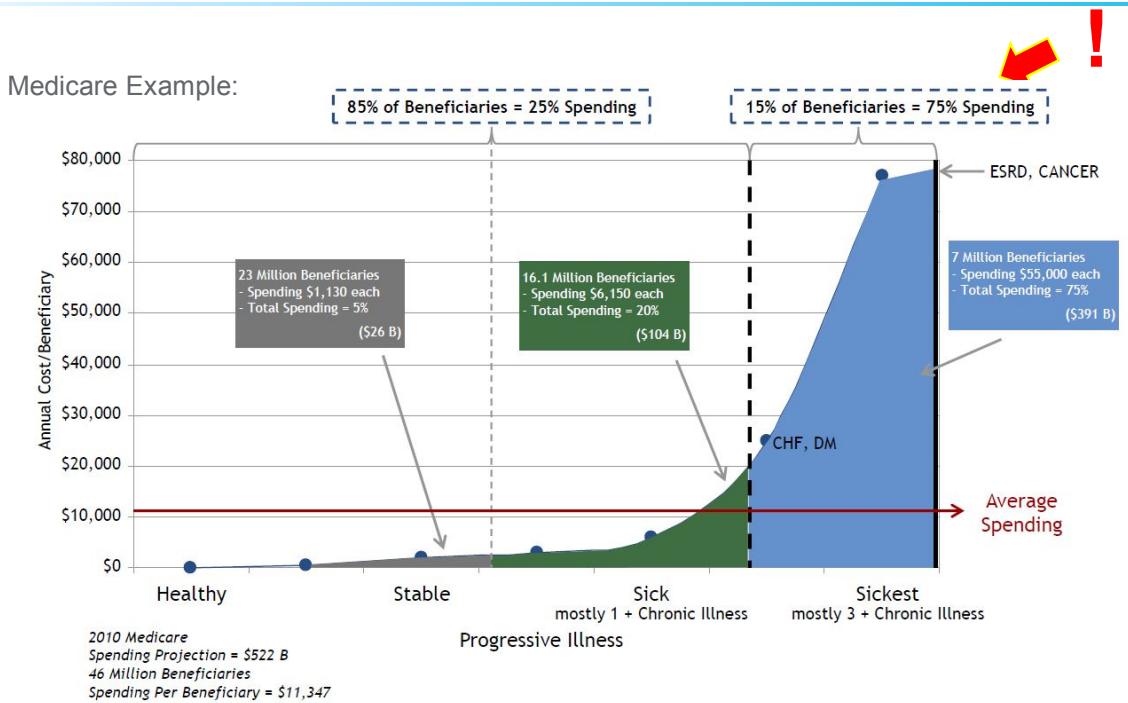


Why Is It important?

- 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

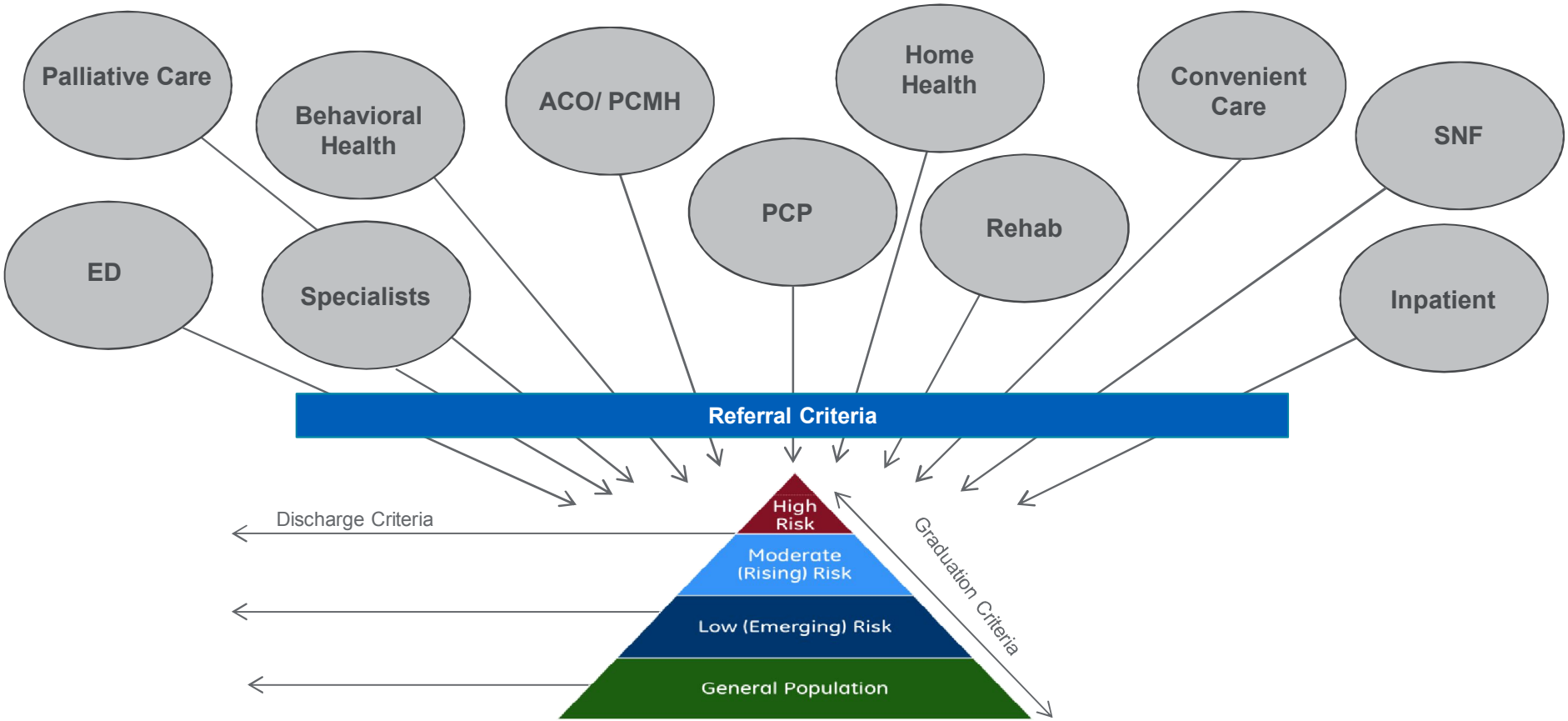
Healthcare's Care Redesign Challenges

Concentrated in 15% of the Population



Source: CareMore Presentation; Morgan Stanley Town Hall, March 2012

Patient Identification Process



Triggers or Patient Criteria

Inpatient Triggers

- 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

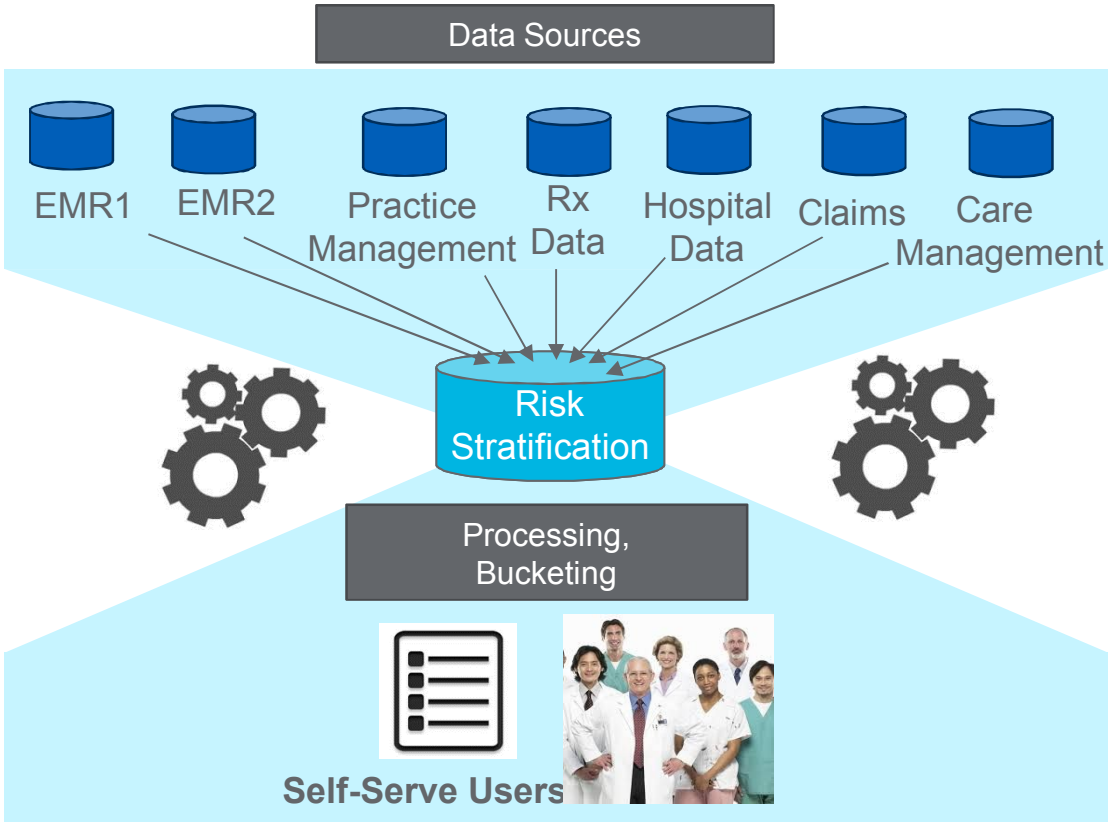
Outpatient Triggers

- 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

Data-driven 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 v
  - Number of medications
  - Variability in providers (e.g., number of unique PCPs)

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)

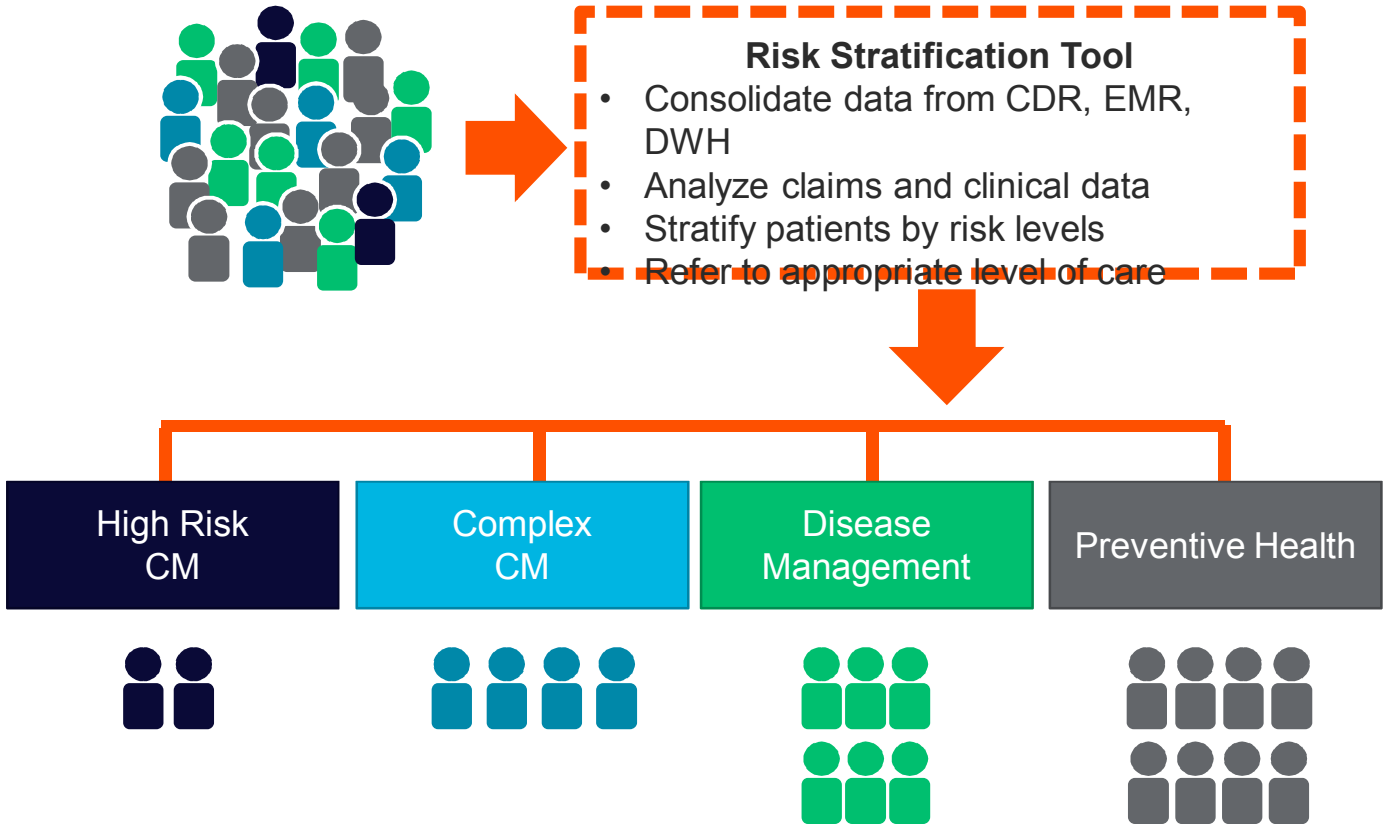
Total Costs

- 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 hospitalist

Complex CM

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

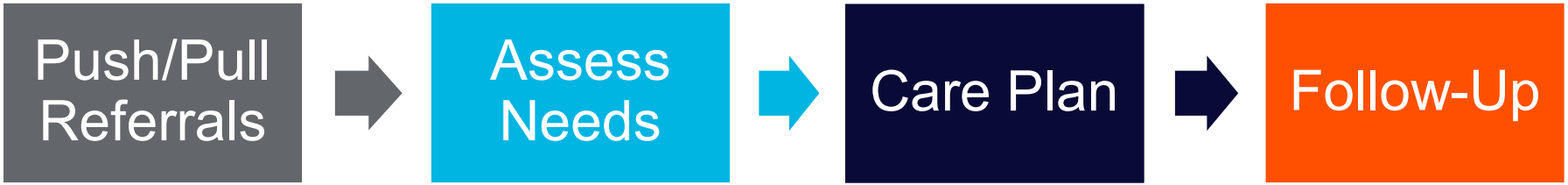
Disease Management

- 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



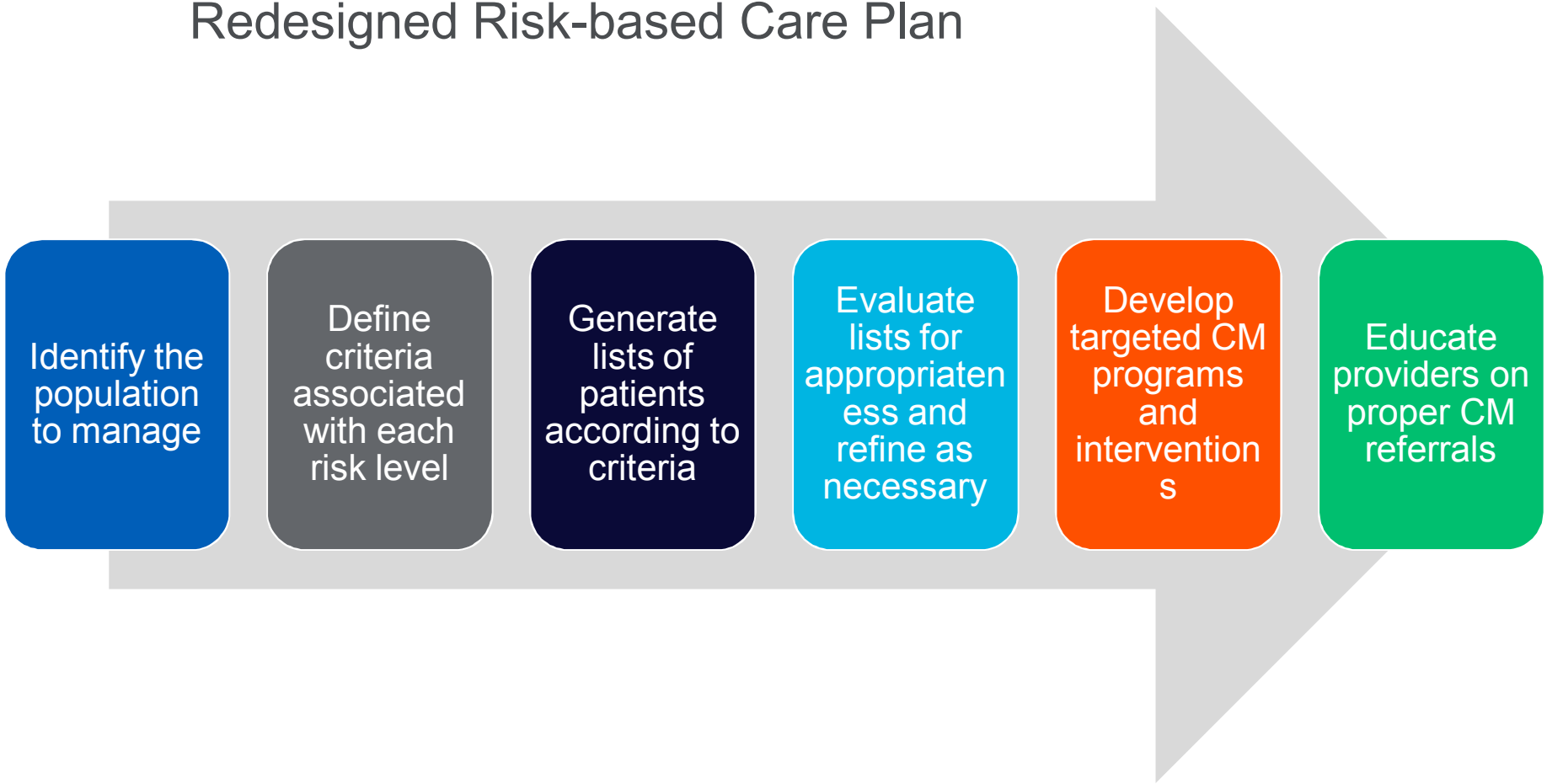
- Educate referral sources which may include data, providers, and case managers
- Establish a process via telephone, fax, technology

- Assess patients' needs (ADLs, IADLs, PHQ-9)
- Consider scoring and tracking progress
- Identify frequency of assessments
- Develop protocols for interventions based on assessment results

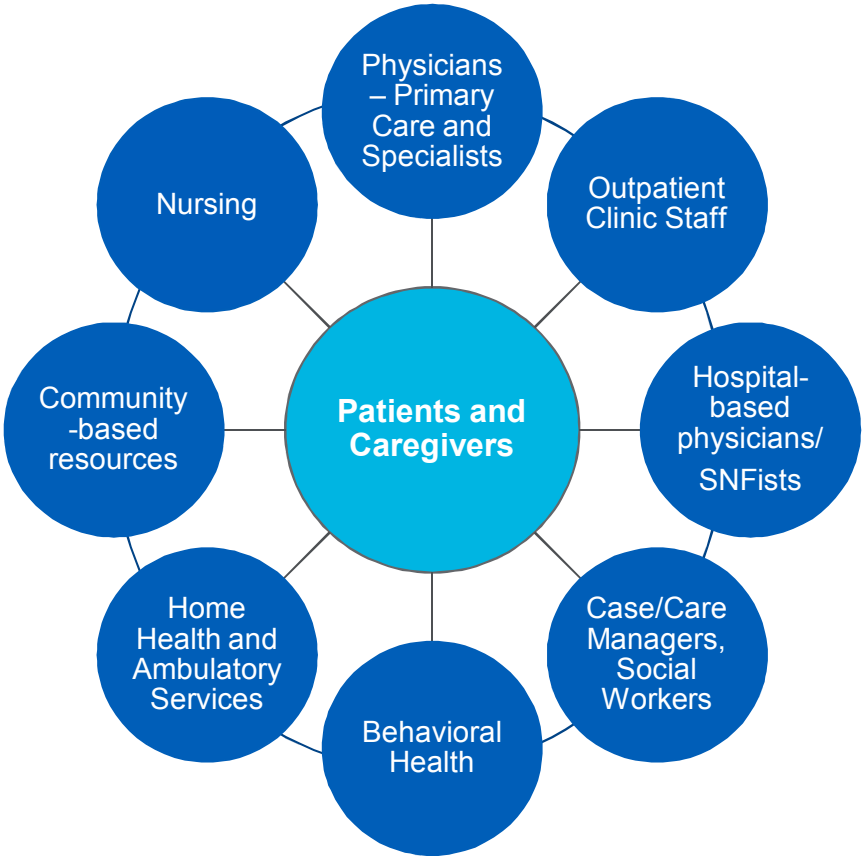
- Set goals with the patient and caregivers
- Develop action items and interventions
- Identify barriers
- Track progress

- Track progress
- Adjust care plan as needed
- Continually assess patient for right level of care and clinical program

Redesigned Risk-based Care Plan

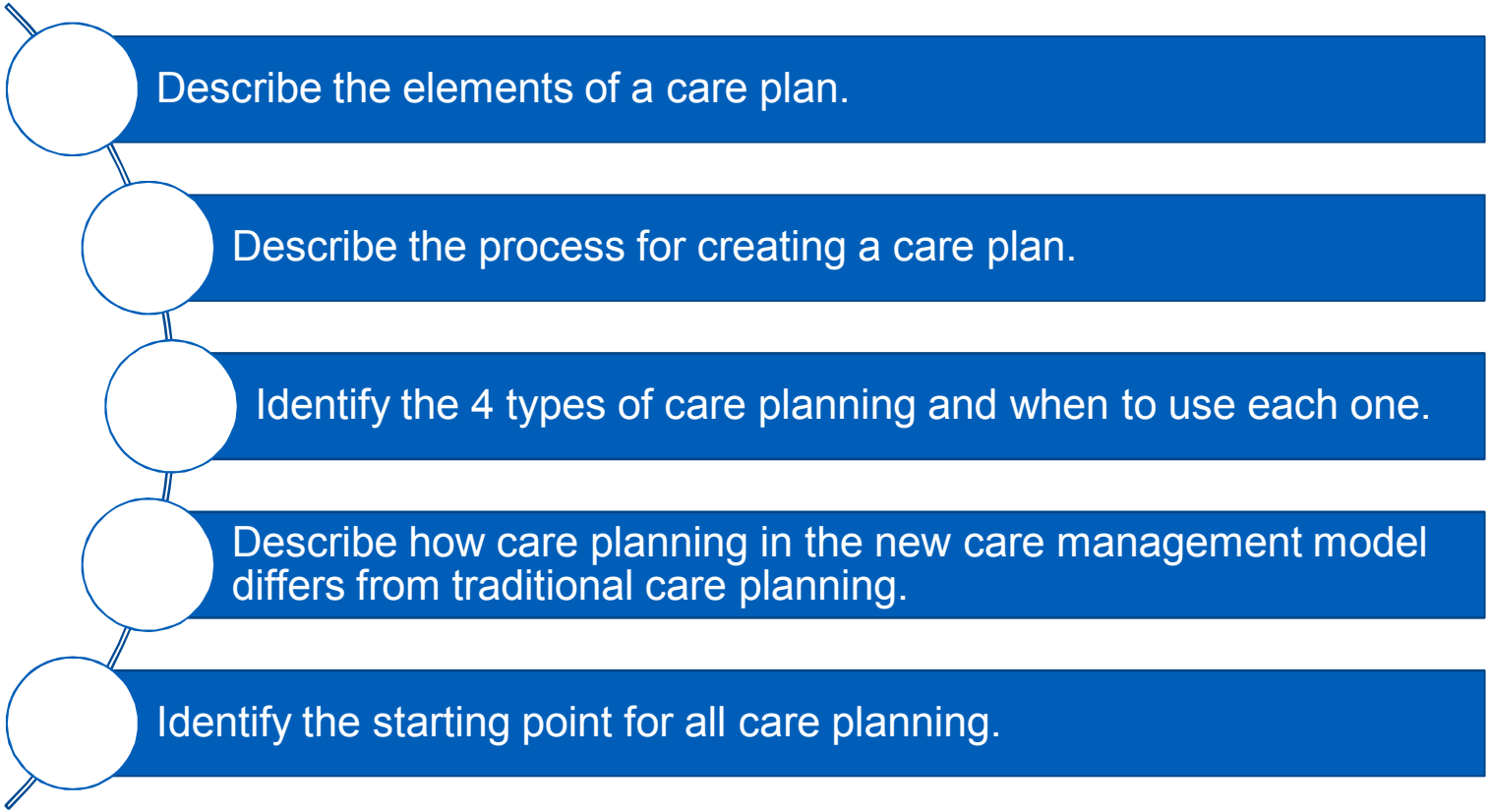


Redesigned Care Team



Show Me the Money: Building a Plan of Care and Getting Rewarded for the Improvement in Value

Developing and Activating a Care Plan



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

The Role of a Care Manager

Imagine that you are an architect…

…and your patient wants to build a house!

- The patient may or may not have a clear idea of what they want
- They may not have considered all of the factors involved in the process
- It is you role as the “architect” to organize and guide the process and bring everyone together

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

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.

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

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

Make Sure Goals Are S.M.A.R.T.

Can YOU spot it?

There is only one goal (not necessarily in the goals section) that meets the S.M.A.R.T. criteria. Can you find which one it is?

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.

Can YOU spot it?

Answer: “Exercises to progress knee flexion to 80° by discharge.”

- Specific: Knee flexion
- Measurable: 80°
- Attainable: This is a modest, attainable goal
- Realistic: The standardization of knee replacement surgery and results allows us to determine whether this goal is realistic.
- Timely: “By discharge.”

4 Types of Care Plans

Remember: No matter how complex the diagnosis and treatment, the care plan should be clear and concise!

Simple

- Episode-based
- Prior to an anticipated episode of care
- Surgical procedure with likely post-surgical needs
- Anticipated

Routine

- Focused on annual wellness exam
- Discussion of patients goals for the year and options available
- Planned

Complex

- For patients suffering from Chronic Conditions
- Includes patient and family/caregiver and multi-disciplinary team
- All team members work with the patient to achieve goals
- Care plan in communicate to the next care setting

Advanced

- End-of-Life Issues
- Starts with patient perception of their health and treatment options
- Combines medical and non-medical interventions

Evaluating the Need for a Care Plan

- New complex acute or chronic diagnosis
- Change in status of an existing diagnosis
  - Sudden change (example: AMI in the presence of longstanding coronary heart disease)
  - Gradual change: Overall change in disease trend, markers or outcomes.
- Lack of progress in current diagnosis: this is especially important in the physician practice setting
- Life changing event: Birth, death, disability, trauma, stroke, etc.
- Patient or family/caregiver request

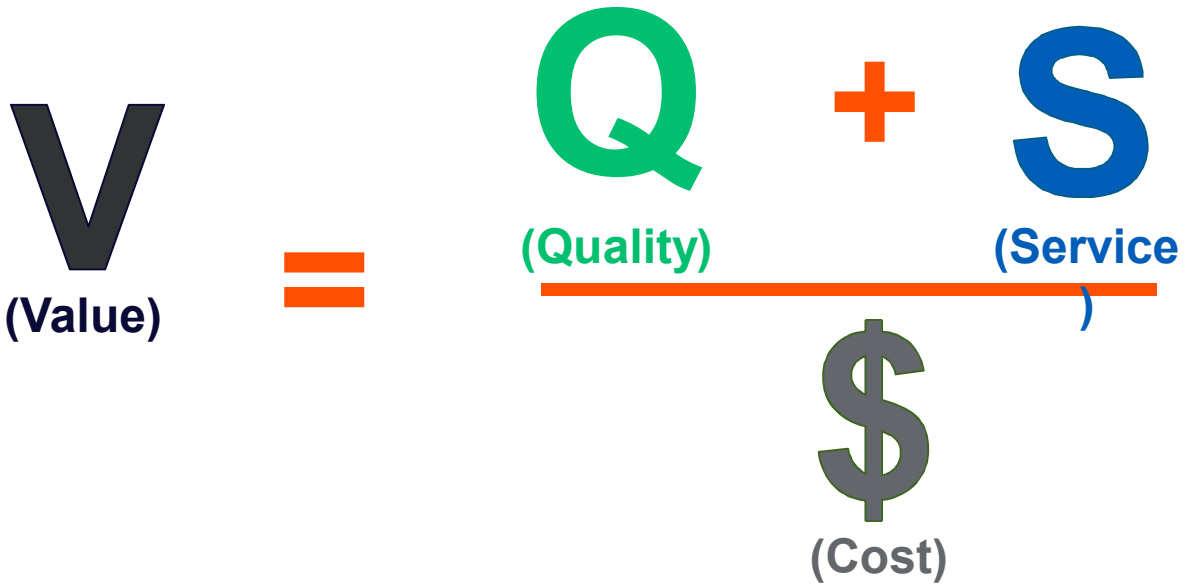
Effective Care Plans

- 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
  - Use pictures and visuals whenever possible

Aligning Incentives

Effective Design of Incentives is Integral to Change

Provider Value Equation



Which Factors Are Important to Success?

Revenue

HCC/RAF

Quality

Clinical metrics and outcomes

Expense

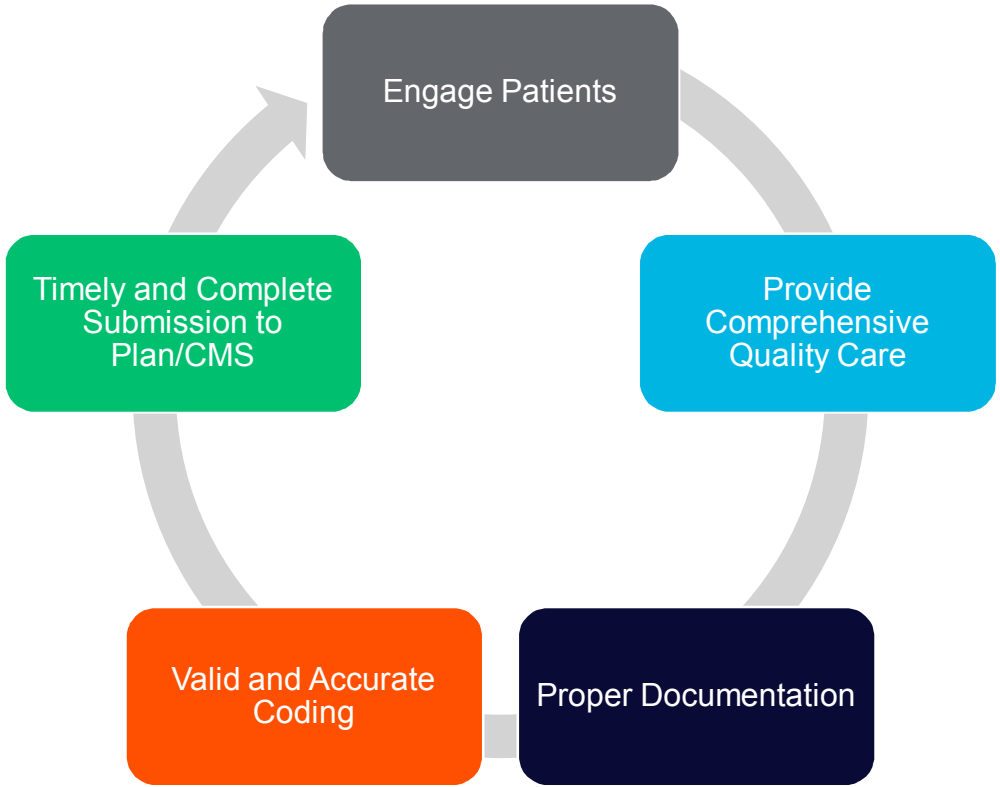
Manage utilization and appropriate sites of care; implement care model redesign

Service

Patient experience

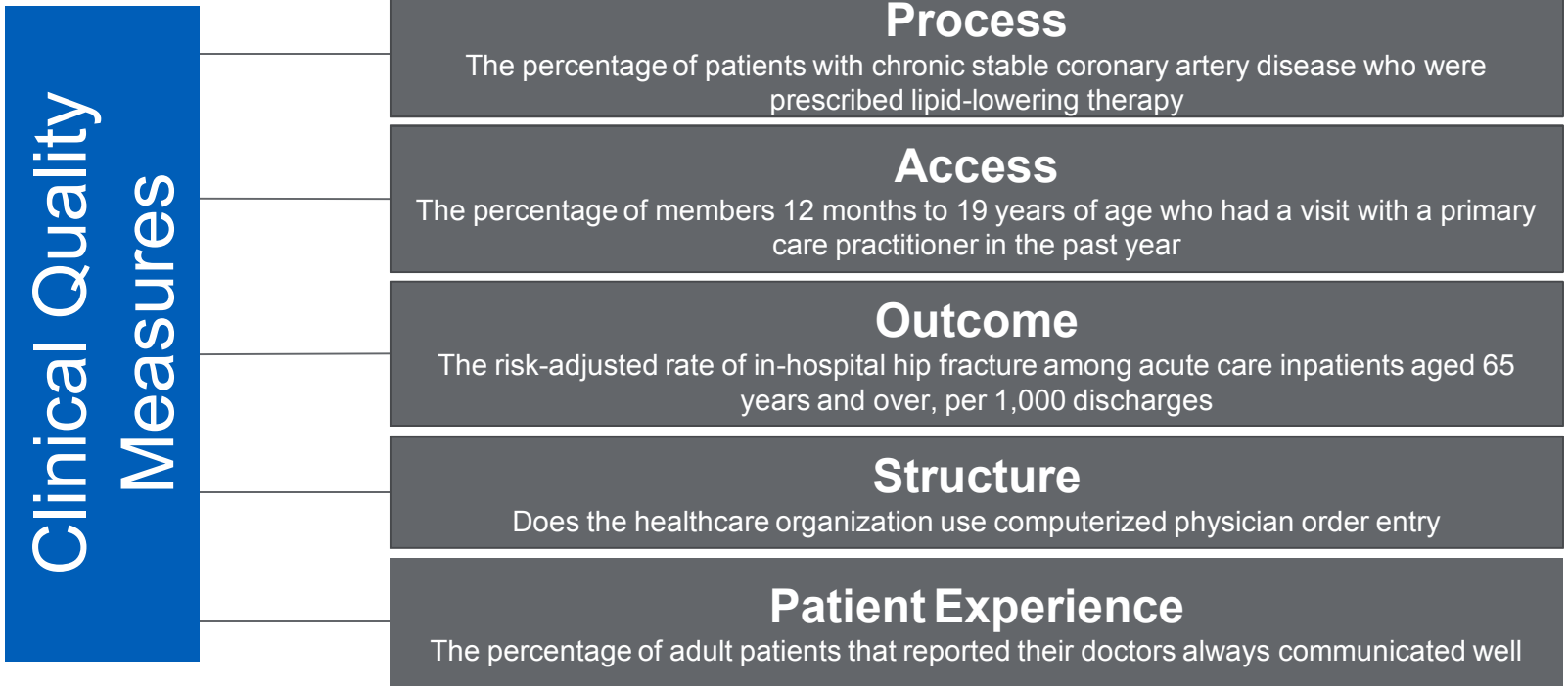
Holistic Approach to HCC Programs

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



Selecting Clinical Metrics and Measures

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

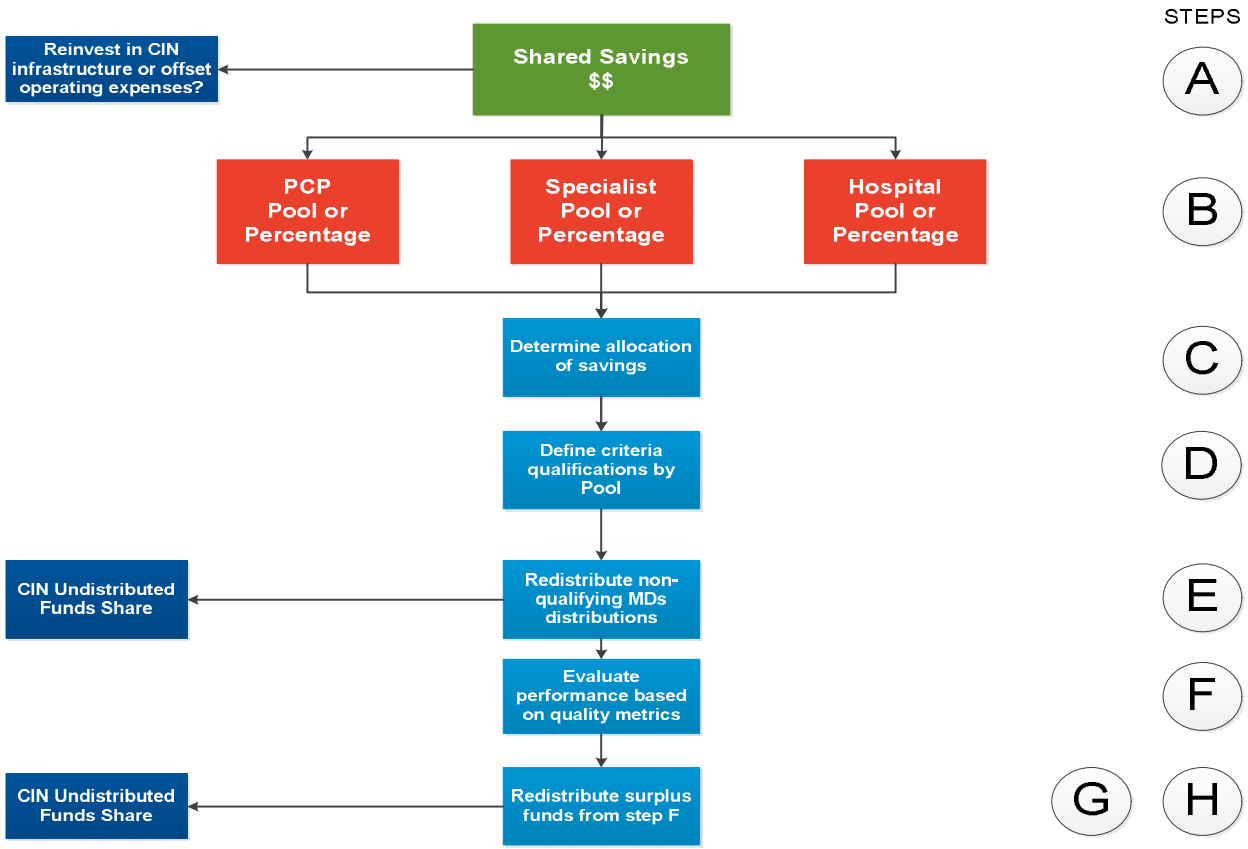
Everyone is Rating Physicians

You've achieved savings, now what?

Funds Flow Considerations

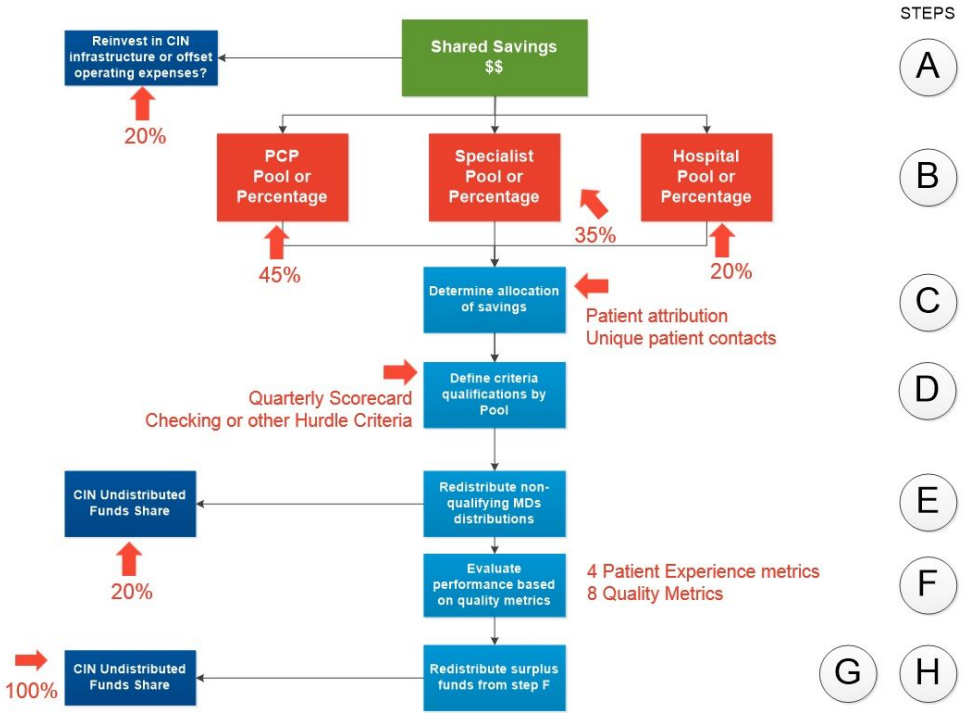
- Once you have achieved savings or "profit," how are the funds distributed back to the providers of care that are working to improve the delivery system?
- Depending on the structure, your organization may not have the authority to distribute back to individual providers, diluting the impact of the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

Shared Savings: Funds Flow Model Decision Points



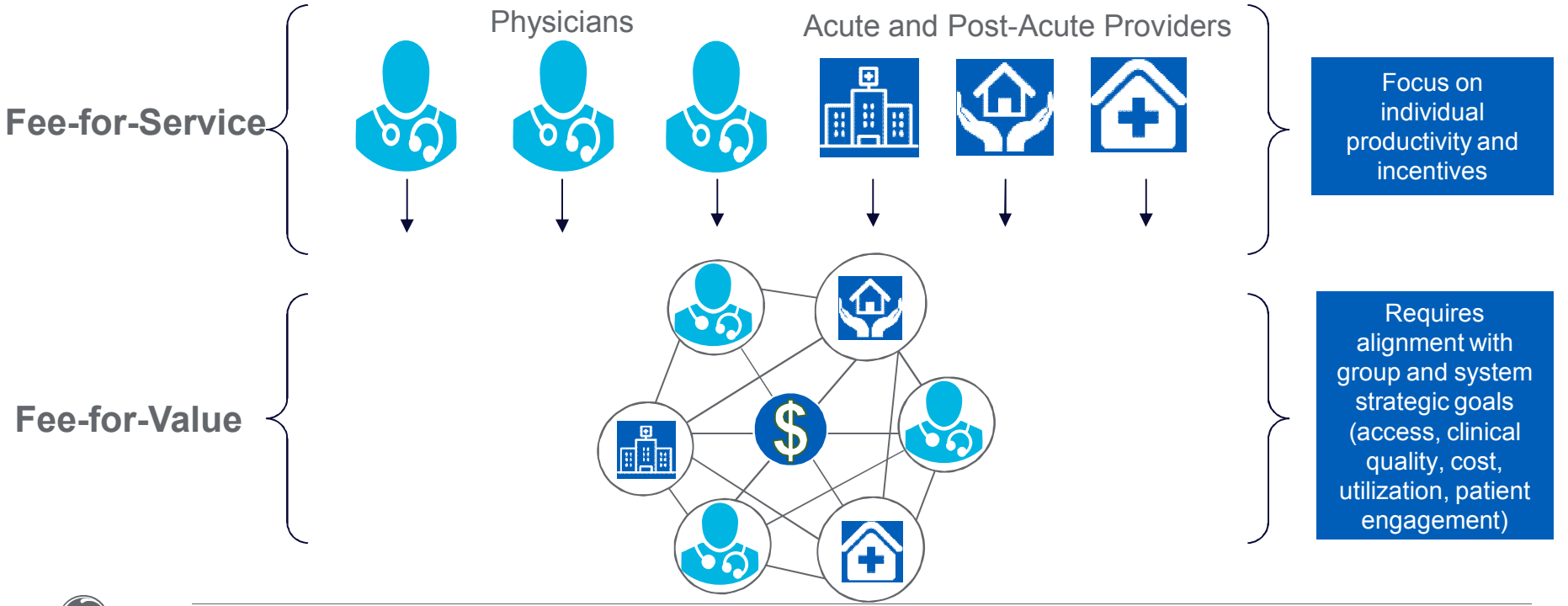
Shared Savings

Funds Flow Model Decision Points Example



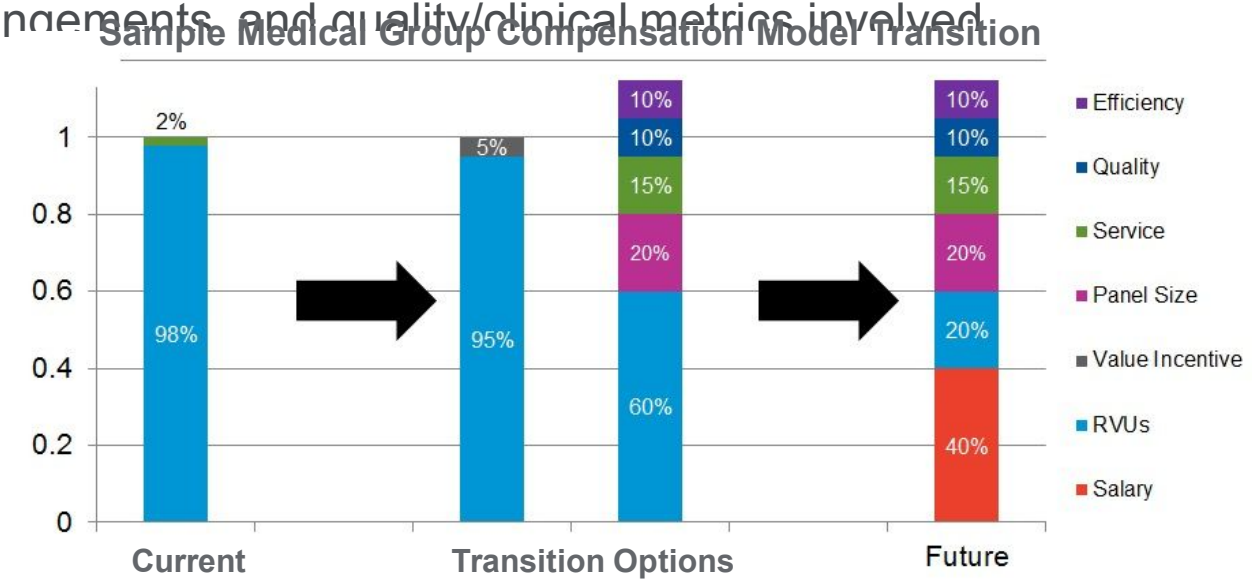
Effective Physician Compensation and Incentives

Effective compensation under value-based reimbursement requires a shift from individual performance to group and individual performance



Aligned Incentives: 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.

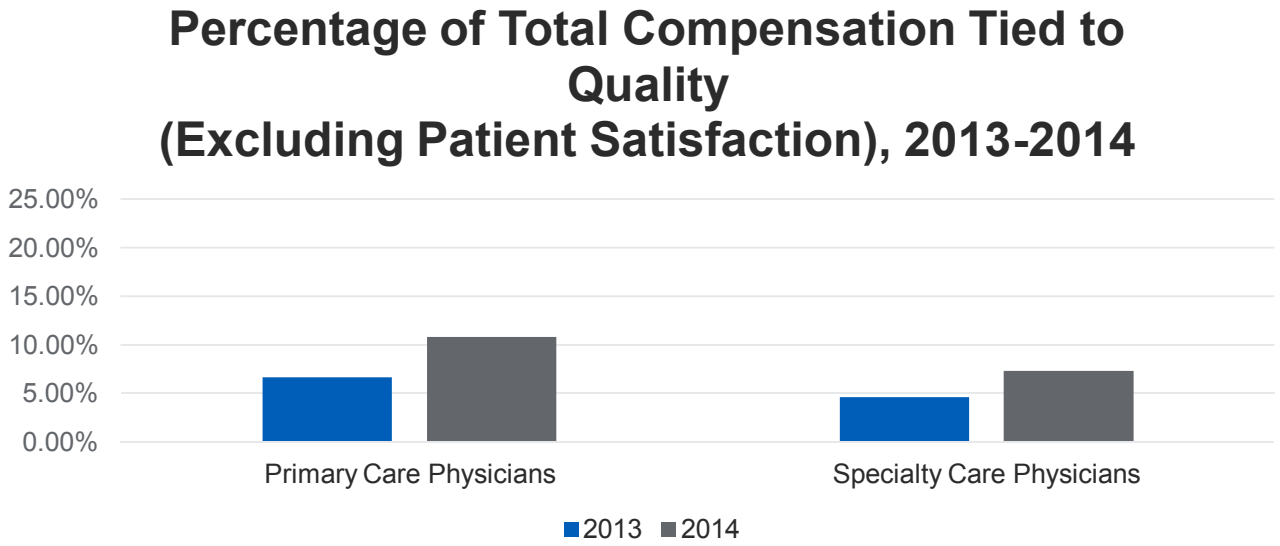


If Taking Full or Partial Risk (Capitation)

Physician Reimbursement

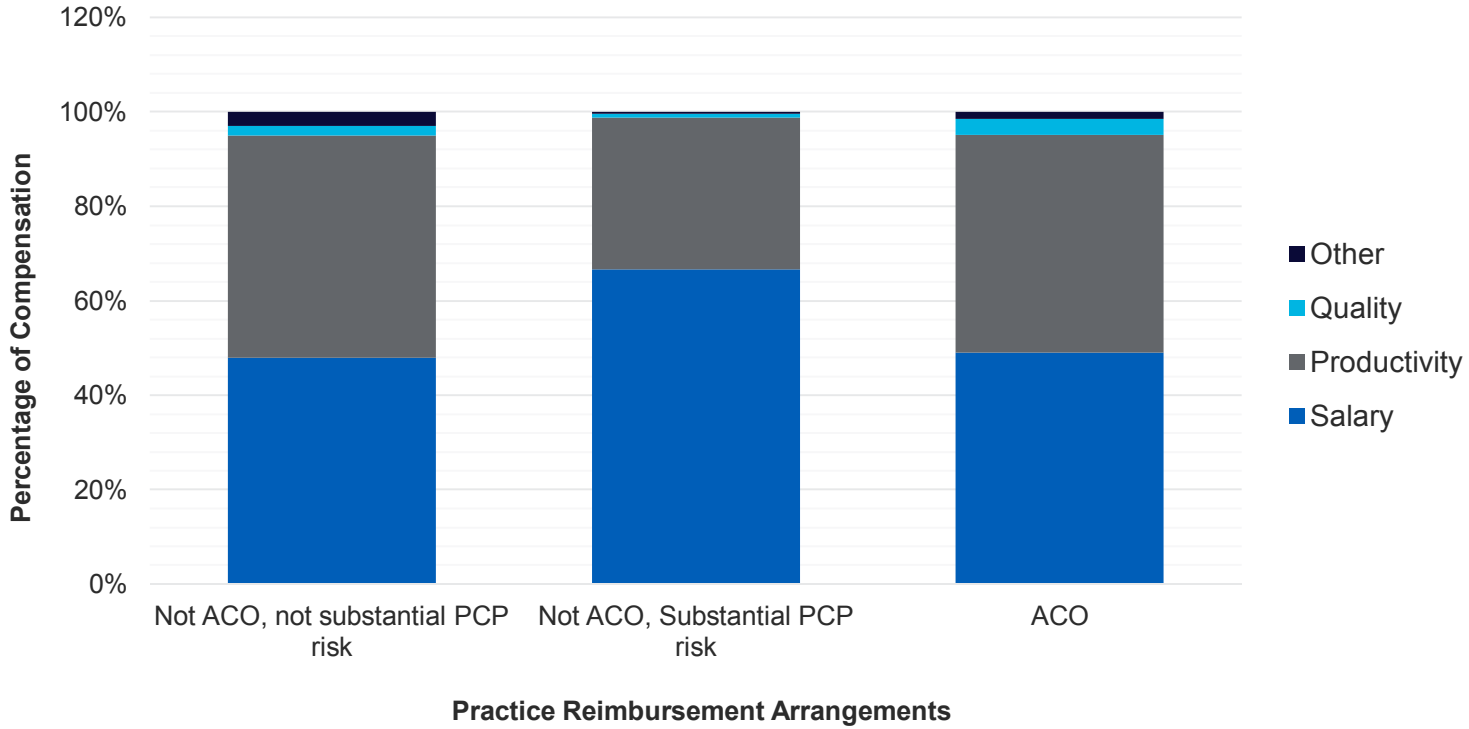
- Structure of organization will impact how this is handled.
- For PCPs:
  - Continue FFS with optional withhold
  - Capitation - flat fee by product line; or age/sex differentiated by product line
  - Percent of premium
- For specialists:
  - FFS
  - Sub-capitation

Physician Compensation



Source: MGMA 2015 Physician Compensation and Production Report

Physician Compensation Under Different Practice Arrangements

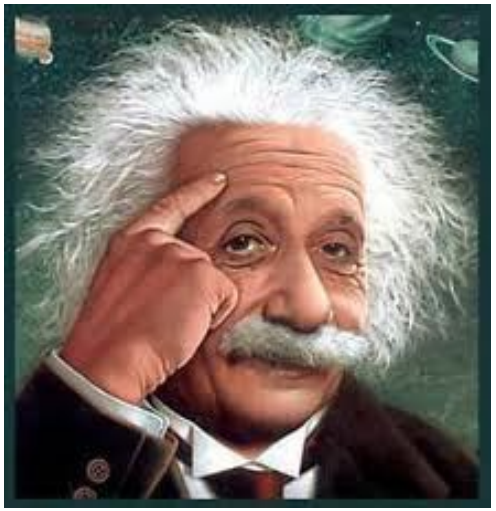


Source: Ryan, et al (2015) Annals of Family Medicine

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.

Leadership and Governance: Clinical Engagement



"The significant problems we face cannot be solved by the same level of thinking that created them."

- Albert Einstein

(1879-1955; Theoretical Physicist, Father of Modern Physics; Prolific Intellectual)

Challenges of Clinical Engagement

- Individualism
- Personal responsibility and accountability
- Lack of time, capacity, interest, knowledge
- Multiple competing priorities
- Work pace/chaos
- Initiative fatigue
- Burn out
- Misinterpreting data
- Confusion
- Financial pressure
- Broken promises
- Lower degree of control regarding work
- Values alignment between physicians and administration
- Unable to appreciate value to themselves and their patients

46% of physicians report signs of burnout > matched controls in other professions

Shanafelt TD, Boone S, Tan L, et al. Burnout and Satisfaction with Work-Life Balance Among U.S. Physicians Relative to the General U.S. Population. Arch Intern Med 2012;172:1377-85.

Stressed, burned out or dissatisfied physicians report a greater likelihood of making errors and more frequent instances of suboptimal patient care.

Williams ES, Manwell LB, Konrad TR, Linzer M. The Relationship of Organizational Culture, Stress, Satisfaction and Burnout with Physician Reported Error and Sub Optimal Patient Care: Results from the MEMO Study. Health Care Management Review 2007; 32 (3): 203-212

"I think the most important struggle clinicians have at the end of the day is with themselves when they feel ineffective providing appropriate care to their patients. One of my colleagues left medical practice… the final straw was when her patient had a heart attack while waiting to get in to see a cardiologist despite all she could do to try to arrange for the visit."

UCSF Health Physician, Provider Experience Focus Group, 2014

Methods to Develop Clinical Engagement

Understand physician perspective	Actively listen and create forums for conversation, shared learning and decision making
Ensure physicians have some control	Embrace physician-led governance leadership committees
Keep physicians informed	Communicate frequently, openly and clearly
Involve physicians and ask for their guidance and support in some decision-making	Dismantle cultural barriers
Identify and mentor physician-leaders	Celebrate quality and success
Enlist and nurture allies	Identify physician champions
Ensure support staff and streamlined clinical care	Organize for performance and reduce administrative hassles
Give physicians a reason to get and stay engaged	Demonstrate value proposition
Validate data before presenting to physicians… and then validate again…	Optimize technology and manage expectations
Stay ahead of the competition in designing innovative compensation models	Emphasize fairness and transparency
Make care model change a partnership, not a mandate	Position conversation as collaboration

Genuinely focus on improving clinical care and ethical centering (instead of just costs)


UNACCOUNTABLE
What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care
MARTY MAKARY, M.D.

“Every patient is my patient”

An MD

Patient Engagement

What is Patient Engagement?

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

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

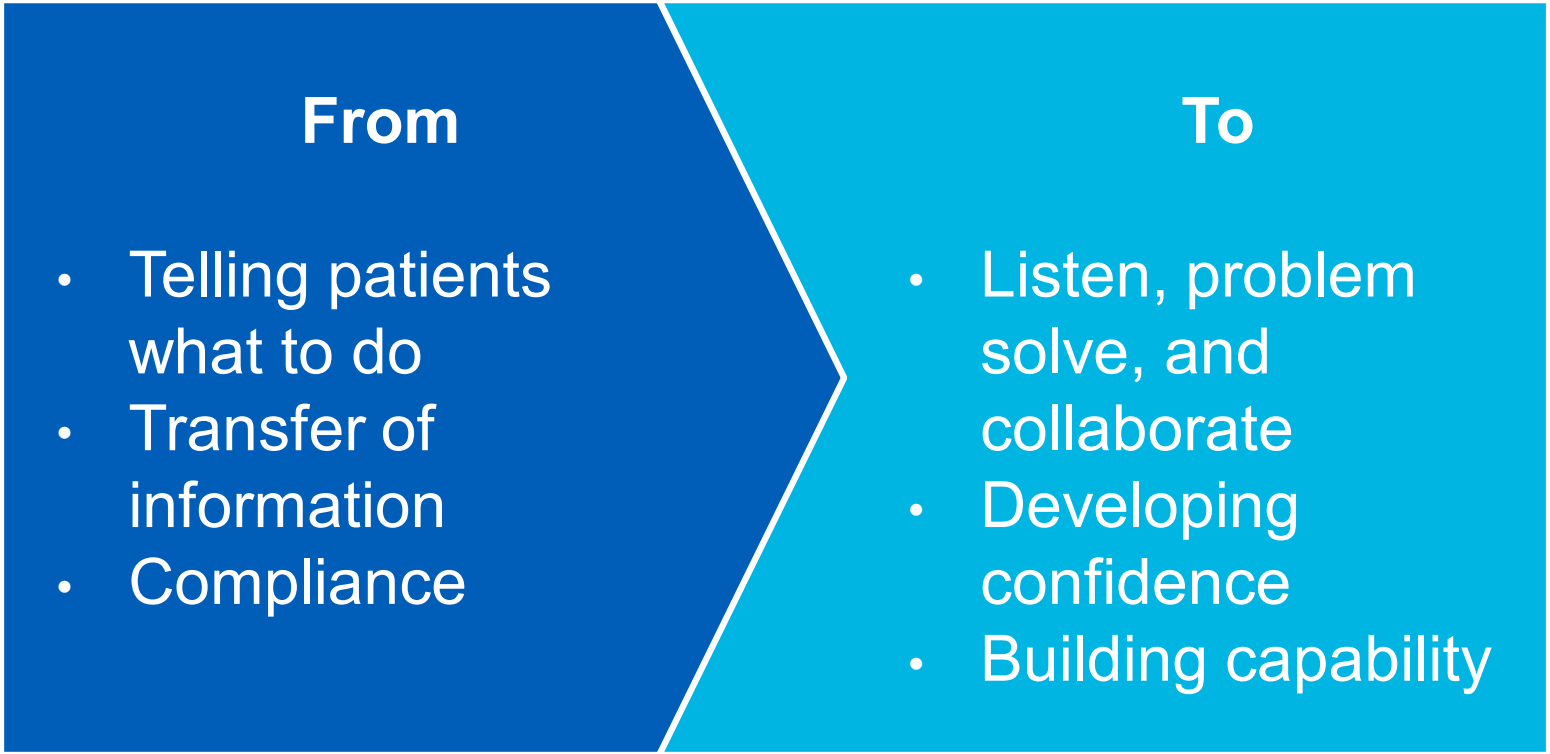
Individual synchronizes information and professional advice with their own needs, preferences, and abilities.

How is Patient Engagement different from Patient Activation?

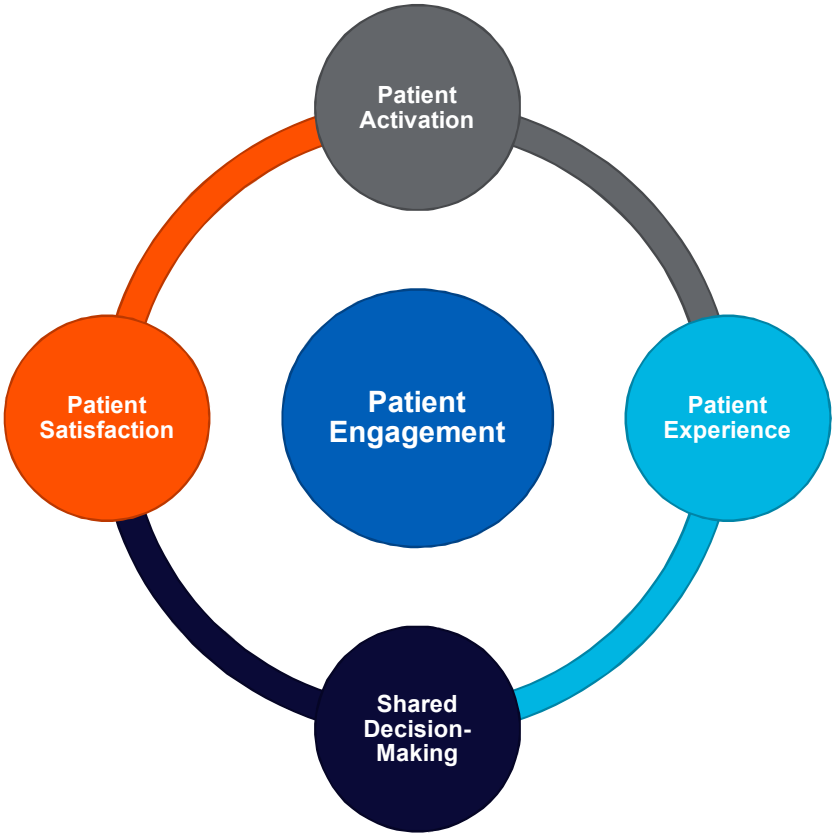
Definitions

- **Patient Engagement** – acquisition of knowledge, skills and confidence to manage one's health that leads to self-reinforcing repeated interactions across multitude of healthcare channels
  – *Education oriented*
- **Patient Activation**– the activities and interventions that are used to support increased participation and personal accountability in their own health by patients and consumers
  – *Action oriented*

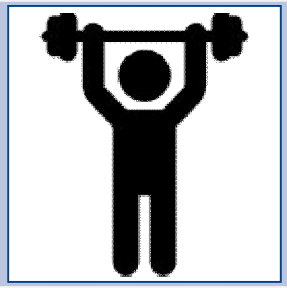
Patient Engagement Paradigm Shift

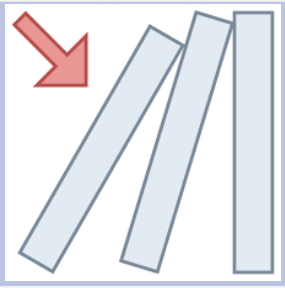


Components of Patient Engagement



Framework for Successful Patient Activation





Motivation

- Patient-dependent factors (i.e., what makes one want to engage and stay activated)

Ability

- How easy is it for the consumer to be engaged and for the system to deliver easy-to-use methods for engagement/activation
- This is dependent on healthcare provider/system (i.e., goal is to make it easy for patients to be engaged and activated)

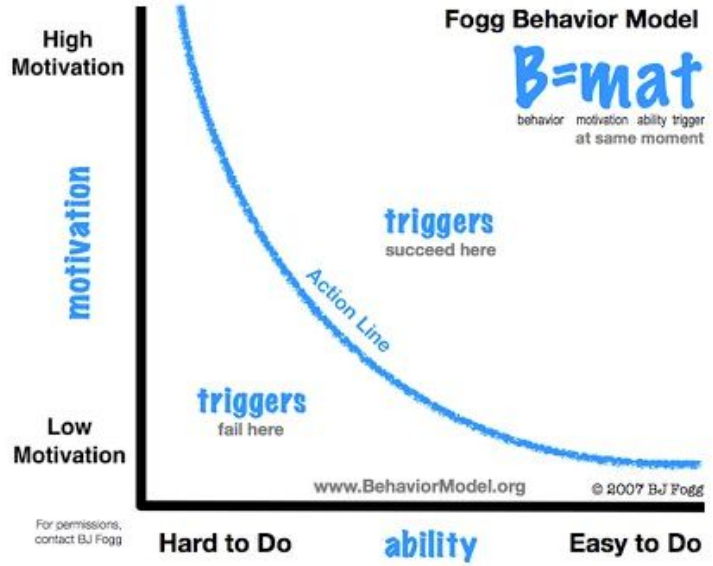
Triggers

- These are conditions, life events, illnesses or other events that induces one to get motivated to get engaged

Solution Design and Development

Fogg method of Behavior Design (Motivation, Ability, Triggers)

- Designing engagement initiatives for healthy populations must be **easy to do** for the patients, as it is likely that their motivation is low.
- The ability to be engaged and activated must also be assessed because regardless of the level of motivation, **without the ability to act, there will be no actionable behavior**.



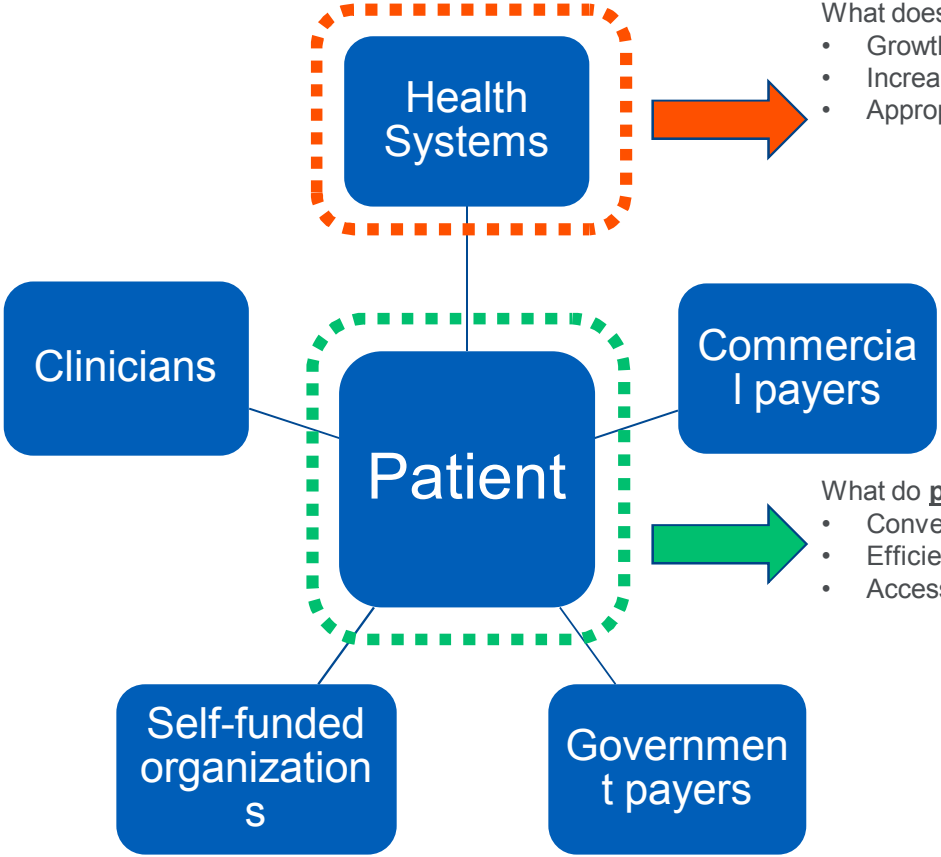
Sources: https://www.pharosinnovations.com/; http://www.foggmethod.com/.

Is There Evidence?

Growing body of research indicates that patient activation scores can be a significant predictor of most health behaviors, many clinical indicators, and some costly service utilization such as emergency department use and hospitalizations.

- Increases in patient activation scores over 4 years were correlated with improvement in medication adherence, self-management knowledge, health behaviors, functional health and number of emergency department visits. When activation levels change, many health-related outcomes change in the same direction.

Who Are the Key Stakeholders?



What does a **health system** care about?

- Growth in market share
- Increased in-network utilization = loyalty
- Appropriate utilization of less costly resources

What do **patients** care about?

- Convenience
- Efficiency
- Access
- Staying healthy
- Communication
- (Quality is mostly assumed)

“Tell me and I will forget. Show me and I will remember. Involve me and I will understand. Step back and I will act.”

Old Chinese Proverb

All of the components discussed just now are crucial in being prepared to meeting challenges and converting them into exciting opportunities…

Are you prepared?

Questions and Discussion