Executive Population Health Primer

Care Coordination, Population Analytics and Financial Management Services in the Age of Value-based Reimbursement

Author: Greg Badras, Innovation Discovery Center

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The Challenge

- The critical issue facing healthcare organizations is the management of complex patient care and managing the cost of providers and caregivers participating in the care management/coordination process
- The total cost of managing care coordination, building an information-based infrastructure, and compliance reporting are exceeding the financial benefits associated with shared savings and future risk models
- Technology is a just one key element to solving this issue, but ACOs, CINs, MCOs and provider entities that are moving towards an integrated model of care coordination must align their organizations and roles, and ensure that the political and social will to integrate their processes produce the desired results

The Goals

- The overall objective of ACOs, CINs, MCOs and integrated care coordination is the movement of providers from a fee-for-service payment & process model (aka MIPS) to a fee-for-value, or shared risk payment, or delegated risk payment, or capitated payment model, or alternative payment model (aka MACRA)
- Hospitals and specialists need to increase in-patient efficiencies, reduce adverse events, and reduce preventable readmissions
- Primary care practices (and their specialist partners) need to improve overall practice efficiency through improved prevention and early diagnosis, reduce unnecessary testing and labs, and reduce preventable ER visits and admissions

Burning Platform

- The necessity of moving to value-based reimbursement is eerily similar and disturbing as getting ready for a disaster
- You don't want to invest the time and energy when there is no disaster but you know if you're not ready when it hits, the potential for catastrophe is high
- Warning: Life in the healthcare industry is difficult and the images on the following page may be disturbing to some – unfortunately, you need to see and understand them

Recent Developments

UnitedHealth's $43 Billion Exit From Fee-For-Service Medicine

Continuing the health insurance industry's march further away from fee-for-service medicine, UnitedHealth Group UNH -1.12% (UNH) executives said this week they will increase value-based payments to doctors and hospitals by 20 percent this year to "north of $43 billion."

UnitedHealth, considered a barometer for the health insurance industry given its size, is rapidly departing from the traditional fee-for-service approach that can lead to overtreatment and unnecessary medical tests and procedures. Value-based pay is tied to health outcomes, performance and quality of care provided.

"We are expecting about a 20% increase in the concentration of value-based reimbursement," Dan Schumacher, chief financial officer of UnitedHealth's UnitedHealthcare subsidiary, told Wall Street analysts on the company's fourth-quarter and 2014 full-year earnings call earlier this week. "We ended the year at about $36 billion of spend in value-based arrangements and we're looking to drive that north of $43 billion in 2015."

UnitedHealth's pronouncements are in keeping with its previously stated commitment to increase payments that are tied to value-based arrangements to $65 billion by the end of 2018.

Value-based payments come in a variety of forms. They include: pay-for -performance programs, patient-centered medical homes and accountable care organizations, a rapidly emerging care delivery system that rewards doctors and hospitals for working together to improve quality and rein in costs. UnitedHealth said it is generating 1 percent to 6 percent in savings from its various value-based reimbursement approaches.

HHS Lays Out Path Away From Fee-for-Service Medicare Payment

February 04, 2015 03:11 pm News Staff – HHS is accelerating the pace of change in Medicare physician payment by setting new goals and deadlines for alternative payment models that reward health care professionals for performance instead of volume.

Overall, half of Medicare fee-for-service payments should change to the new models before 2019, according to goals that were laid out during a roundtable discussion(www.youtube.com) the agency hosted on Jan. 26. HHS Secretary Sylvia Burwell announced a detailed timeline for moving toward payment models that encourage care coordination, a concept she termed "volume to value," which the AAFP supports.

"We need to change the way we deliver care, we need to change the way we pay providers, and finally, we need to change the way we distribute information," Burwell said.

HHS wants to convert 30 percent of Medicare fee-for-service payments to alternative payment models such as accountable care organizations (ACOs), patient-centered medical homes or bundled payment arrangements by the end of 2016, according to a news release(www.hhs.gov) about the announcement. By the end of 2018, the agency's goal is that 50 percent of payments will be tied to such models.

Story highlights

HHS announced it intends to convert a majority of Medicare payments to performance-based measurements in the next three years.

HHS Secretary Sylvia Burwell said the agency wants to support payment models that encourage care coordination.

As envisioned, Medicare payments will be divided into four categories, some of which are tied to fee-for-service and some of what are not.

HHS also hopes to tie 85 percent of all traditional Medicare payments to quality or value measurements by 2016 and 90 percent by 2018. Officials acknowledged that the goal is aggressive and might be difficult for small physician practices or large hospitals to implement quickly.

Regardless of what happens to the ACA, CMS is moving ahead and will eventually influence the way commercial insurance carriers reimburse providers!

The Obstacles

- Physicians don't want to change the way they deliver care
- Physicians don't want to change the way they are reimbursed
- Insurance companies and large hospital systems currently have the financial advantage and will continue to use this as leverage in ACO and CIN contract negotiations
- For ACO's and for anyone moving to an alternative payment model (APM), the data collection process is onerous and CMS doesn't always provide clarity on interpretation of rules that must be implemented regarding quality measures
- The capital investment requirements to move to APM are higher than expected due to the people, workflow, technology, compliance and financial thresholds established by CMS and the commercial payers
- Everyone underestimates both the complexity of and the time required to re-negotiate risk-based contracts – especially with the commercial insurers
- The EHR data collection process is highly structured and directly impacts the quality reporting process to CMS and other payers
- Executive administrators are behind-the-curve in understanding the delay in the financial reimbursement cycle and connecting the dots back to the EHR data collection process and the up-front capital-intensive investments

The Critical To-Do List

- Educate physicians, executive administrators and staff regarding the need for population health transformation as a new approach to delivering care for ALL patients
- Establish social policy and governance tied to care coordination, role definitions and shared savings process design
  - Provider-to-provider interactions (Can't we just get along?)
  - Patient-to-provider interactions (I'm Internet positive, Doctor)
  - Patient-to-care team interactions (Didn't you just call me about that?)
- Leverage mobile technology for providers and care teams (BTW - your patient is already using it)
- Enable big data, cloud infrastructure for data sourcing and reporting (It's cheaper)
- Monitor internal and external compliance as well as financial unit cost metrics (ACO, GPRO and Insurers want to know and your payments require accurate reporting)
- Mine data warehouses for new opportunities that create targeted growth for providers and patients (while analytics are table stakes, the use cases surrounding care plans will drive innovation)

Key Technologies that will lower cost of operations

- Mobile devices
- Mobile-enabled applications
- Automated workflow that can push and monitor queues for providers, care teams and patients
- Social solutions to enable providers, care teams and patients with on-going, interactive dialogues
- Data analytics that converge all sources of clinical data (pharmacy, ambulatory, hospital, SNF, lab, radiology) into meaningful and useful information
- Continuously available, secure and easily expandable infrastructure

The Start-up Plan

- A Multi-track, concurrent effort that engages the following critical elements:
  - Clinicians and caregivers
  - Administrators
  - Quality departments
  - Hospitals and skilled nursing facilities
  - Ambulatory and administrative clinical operations
  - Analytics and reporting
  - Provider, Insurance, and Hospital contracts
  - Revenue cycle and financial administration
  - Insurance-like capabilities
  - IT (applications, data, infrastructure)
- Use of agile methods directed by proven managers of highly complex, cross-functional programs
- Use of subject matter experts for each domain area
- Real-time evaluation of results by the decision-makers

The Future Forecast

- While ACOs/CINs are currently focused on the Medicare population due to government incentives, the future implications for reductions in overall clinical costs and use of new technologies is profound for any MCO or provider organization looking to gain a strategic market advantage in the delivery of care across their patient populations
- Critical investments in operations, infrastructure and financial management is the correct formula for achieving success in the arena of integrated care coordination and management
- Any proposed changes or lack of changes to Federal or Commercial insurance healthcare policies will still require efficient and effective clinical and financial operations – the need for transformation is both a long-term program and commitment

Triple Aim Investments

- The three triple aim objectives in healthcare are:
  - Manage internal administrative and clinical costs
  - Manage clinical outcomes
  - Manage patient and member satisfaction
- The investments required to achieve these objectives are multi-year, complex and integrated
- An overall strategy and plan that identifies the sequence, priorities, cash flow and resources is paramount to increasing an organization's capabilities and realizing scalable success towards APM reimbursement

Next Steps? Establish a Population Health Transformation Initiative

1. Confirm that organizational goals are aligned to triple-aim objectives
2. Determine use rate benchmarks to further align organizational goals
3. Create a high-level business and technology design
4. Identify process owners
5. Identify, prioritize and select specific programs that will drive the organization towards the goals
6. Create business cases for selected programs that are all-inclusive and create budgets for each program
7. Align program budgets, by department, to the budget cycle
8. Create a governance process to oversee the program portfolio
9. Establish a formal program management approach to the portfolio
10. Adopt an agile process for delivering results
11. Pause and measure outcomes progress and adjust as needed

Key Reminders

Population Health = Care Delivery and Financial Management Transformation for all populations including:

- Medicare
- Medicaid
- Commercial
- Self-Insured
- Uninsured
- Cash

This is not a “point solution” and it should not be relegated to a functional silo within the enterprise

About the Author

Greg is a healthcare technology partner with Innovation Discovery Center and has over 30 years of experience managing and consulting with start-up, mid-market, and large healthcare institutions.

A transformative and results-driven Business and Technology executive, Greg has extensive knowledge in the healthcare industry with a unique blend of medical provider and health plan operations experiences leading both technology and process improvements in EHR, Population Health Management & Analytics, Risk Management, and Care Coordination in support of strategies to move to value-based reimbursement.

Greg has worked for premier healthcare organizations such as Wellpoint Health Networks, HealthCare Partners (now Davita HealthCare Partners), and Kaiser Permanente. His experience also includes working with early stage management service organizations to create technology-enabled services to support moving physician organizations to value-based care transformation and reimbursement models.