Health Systems Approach to Population Health
Agenda

• What is Population Health?

• New Payment Transformation Models

• Impact of Population Health Across the Continuum
  – Care Coordination
  – Revenue Cycle

• What is the Future in Population Health?
Population Health 101
What is Population Health?

• Assuming accountability for the overall cost of care provided to a defined group of people. Whether you define “population” in the broadest sense, as all the lives in a given geographic area, or in a more defined sense, such as a patient population of assigned Medicare beneficiaries.

• Population health management will require healthcare providers to care more effectively, efficiently, and safely for more people—despite shrinking reimbursements and rising costs.

• Population health management involves improving and maintaining the health of a defined subset, or cohort, of patients. Effective population health management starts with clearly defining those cohorts and determining on which clinical processes to focus improvement efforts.
# Changing Landscape in Healthcare

## Payment Models
- Optimize cost structure
- Revenue transformation shifting risk
- Transition from volume to value

## Consumerism
- Employer as consumers
- Challenges of Healthcare Market Disrupters (retail)
- Portals for better access and scheduling

## Accessibility
- Expansion of Telehealth initiatives
- Enhanced outpatient access
- Strategic Partnerships for retail care

## Clinical Advancements
- Quality and Process Improvement
- Enterprise intelligence
- Innovations in research

## Demands on Organizational Structure
- Physician lead, professionally managed
- New entrants to the market
- Shift in provider relationships

## Population Health
- Management of the care continuum
- Understanding of the health needs of the population
- Learning and impacting social determinants of health
Transition to Risk Capability

Foundational Elements
- Innovation
- Clinical Assets
- Infrastructure
- Dynamic Modeling
- Governance
- Population Health
- Leadership & Culture

The Tipping Point
- Purchasing Pressure

Focus & Decision Making
- Transformational Agility

Fundamental Priorities
- Balanced Revenue Portfolio
- Economic Sustainability
- Targeted Clinical Transformation
- Deep Market Understanding
- Scalable Technology & Analytics
## It Starts With a Strategy…

<table>
<thead>
<tr>
<th>Foundational</th>
<th>Responsive</th>
<th>Progressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare our markets for performance based payments</td>
<td>Respond to federal and state mandated initiatives</td>
<td>Take leadership executing a Population Health Strategy</td>
</tr>
<tr>
<td>• VBC Assessments</td>
<td>• Strategic BPCI-A Participation</td>
<td>• Clinically Integrated Networks</td>
</tr>
<tr>
<td>• MACRA &amp; MIPS</td>
<td>• State Medicaid Bundles</td>
<td>• Selective ACO Participation</td>
</tr>
<tr>
<td>• Annual Wellness Visits</td>
<td>• PCMH model</td>
<td>• Network partnerships with payors</td>
</tr>
<tr>
<td>• Employee Management</td>
<td></td>
<td>• Comprehensive care management for employee population</td>
</tr>
<tr>
<td>• Collaborative Care Arrangements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 1. NETWORK FORMATION

Develop an aligned provider network with the right management structure

### 2. CARE MODEL

Implement clinical programs with scale & standards directed towards better quality, cost & experience

### 3. OPERATIONAL STRUCTURE

Develop an infrastructure of people, technology and workflow at local market

### 4. FINANCIAL MANAGEMENT

Craft a sustainable value-based payment strategy with a solid financial foundation for profitability and growth

### 5. INFORMATION TECHNOLOGY

Deploy IT to support care re-design, accountability, quality improvement & patient engagement
New Payment Transformation Models
Why are Hospitals Considering Medicare APM’s?

- Access to Medicare Claims Data
- Simple Contract Structure
- Gain Edge Over Slow-Adopting Competitors
- Assistance with MIPS and AAPM
- Improve Core FFS Business
- Formally Align with PCPs
- Customizable Insurance Risk
- Access to Valuable Medicare Waivers
- Earn Shared Savings
Where is MSSP in Place Today?

2018 Fast Facts

- 561 MSSP ACOs
- 82% of ACOs in Track 1
- Estimated 10.5 million Medicare beneficiaries (29%)
- Estimated Quality Score approx. 93%

BPCI Advanced Provider Participation

National BPCI-A Participation, announced 10/9/18

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hospital Participants/EIs</td>
<td>832</td>
</tr>
<tr>
<td># of PGP Participants/EIs</td>
<td>715</td>
</tr>
<tr>
<td>Top 5 Hospital-initiated EGs</td>
<td></td>
</tr>
<tr>
<td>• CHF (61% of participating hospitals are enrolled in CHF)</td>
<td></td>
</tr>
<tr>
<td>• Sepsis (58%)</td>
<td></td>
</tr>
<tr>
<td>• Simple Pneumonia &amp; Respiratory Infections (48%)</td>
<td></td>
</tr>
<tr>
<td>• Cardiac Arrhythmia (47%)</td>
<td></td>
</tr>
<tr>
<td>• UTI (44%)</td>
<td></td>
</tr>
<tr>
<td>Average Count of EGs at Hospital EIs*</td>
<td>6.33</td>
</tr>
<tr>
<td>Hospital Participants/EIs enrolled in 1 EG</td>
<td>104</td>
</tr>
<tr>
<td>Hospital Participants/EIs enrolled in 29 or more EGs</td>
<td>13</td>
</tr>
</tbody>
</table>

*Excludes EIs convened by unaffiliated third-party conveners
Population Health Across the Continuum
- Enhance Care Coordination
- Eliminate Waste and Inefficiencies
- Standardize Protocols and Care Pathways
- Reduce Variance
- Define, Measure and Report Quality
- Manage Utilization
- Preserve / Improve Market Position

Community Facilities

AMBULATORY
Independent & Employed; PCP & Specialists

PHYSICIANS

CMS, PAYORS, EMPLOYERS, EXCHANGES

Provider Network

Acute Care

Hospital(s) and Health Systems

Post Acute Facilities

Post Acute

Community-Based Care
Connecting the Dots—Better performance in each program positively impacts initiatives across the continuum of care.
Care Coordination
Care Coordination Best Practices

1. Risk Assessment
   LACE or other tool

2. Care Management Strategy
   Defined based on risk

3. Define Clinical Pathway
   Inpatient and Post Discharge

4. Discharge Planning
   To the most beneficial level of care

5. Post-Acute Management
   For the full episode
Revenue Cycle
Accurate Payment versus Accurate Portrayal of Patient Acuity

In our experience, grouping under an APR-DRG reveals 20-30% of cases contain an understatement of acuity in **Severity of Illness (SOI) and Risk of Mortality (ROM)** due to the lack of coding documented diagnoses and/or querying based on clinical indicators that support additional relevant diagnoses.

- Patient acuity directly:
  - Impacts **expected** readmission and mortality rates **AND**
  - Influences organizational ranking in mandatory quality programs where performance (**observed**) is comparative to other organizations
Because those diagnoses classified as CCs and MCCs do not typically capture the impact of multiple chronic conditions and the MS-DRG doesn’t reflect the interaction among diagnoses, organizations must understand Risk Adjustment as part of their Coding and Clinical Documentation activities.

- CMS uses the Hierarchical Condition Category (HCC) methodology to risk adjust the patient’s clinical status at the time of the indexed admission for most outcome measures.
- Patient Safety Indicators (PSI’s) use a different but similar methodology for risk adjustment.
- All of these methodologies are impacted by the totality of reported diagnoses (i.e., your claims) and their specificity requiring a more comprehensive Clinical Documentation review process than just the appropriate MS-DRG assignment.
The Risk Adjustment “Blind Spot”

ICD-10-CM Codes Classified as a CC or MCC

- 93%
- 7%

ICD 10 Codes Not a CC or MCC
ICD 10 Codes which are CC’s and/or MCC’s

Distribution of ICD-10-CM Codes Impacting Risk Adjustment*

- 60%
- 40%

CC or MCC
Non-CC or MCC

*Estimates using GEMS Mapping

*Estimates using GEMS Mapping
Clinical documentation is at the core of caring for patients. Goal is to have clinical documentation that best reflects the patient’s conditions across the continuum of care.
### CHF Episode Example: MS-DRG 293 Heart Failure & Shock

<table>
<thead>
<tr>
<th>Example #1</th>
<th>Example #2</th>
<th>Example #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt; 50 (age 76) 1</td>
<td>Age &gt; 50 (age 76) 1</td>
<td>Age &gt; 50 (age 76) 1</td>
</tr>
<tr>
<td>MS-DRG 293 (w/o CC/MCC)</td>
<td>MS-DRG 293 (w/o CC/MCC)</td>
<td>MS-DRG 293 (w/o CC/MCC)</td>
</tr>
<tr>
<td>HCC 111 COPD 0.346</td>
<td>HCC 111 COPD 0.346</td>
<td>HCC 111 COPD 0.346</td>
</tr>
<tr>
<td>CHF and COPD HCC Interaction 0.265</td>
<td>CHF and COPD HCC Interaction 0.265</td>
<td>CHF and COPD HCC Interaction 0.265</td>
</tr>
<tr>
<td>HCC Count 1-3</td>
<td>HCC 18 Diabetes w/chronic complication 0.368</td>
<td>HCC 18 Diabetes w/chronic complication 0.368</td>
</tr>
<tr>
<td></td>
<td>CHF and diabetes HCC Interaction 0.187</td>
<td>CHF and diabetes HCC Interaction 0.187</td>
</tr>
<tr>
<td></td>
<td>HCC 189 Amputation status, lower limb 0.779</td>
<td>HCC 189 Amputation status, lower limb 0.779</td>
</tr>
<tr>
<td></td>
<td>HCC Count 4-6</td>
<td>HCC Count 4-6</td>
</tr>
<tr>
<td>Estimated Target Price $15,343</td>
<td>Estimated Target Price $16,269</td>
<td>Estimated Target Price $17,758</td>
</tr>
</tbody>
</table>
A key step to managing patient health is to identify those patients that need services:

- Based on claims data, patient looked fairly healthy with conditions totaling .642 in risk score.
- Clinical Indicators and documentation demonstrated a very different picture.
  - Over 100% sicker than the claims data demonstrates.
- Capturing appropriate severity helps ensure appropriate resources and care.

<table>
<thead>
<tr>
<th>Condition</th>
<th>HCC #</th>
<th>Actual Claims Data</th>
<th>Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid Obesity</td>
<td>22</td>
<td>0</td>
<td>.262</td>
</tr>
<tr>
<td>COPD</td>
<td>111</td>
<td>.335</td>
<td>.335</td>
</tr>
<tr>
<td>Diabetes w/ Chronic Conditions</td>
<td>18</td>
<td>.307</td>
<td>.307</td>
</tr>
<tr>
<td>Amputation status, Lower Limb</td>
<td>189</td>
<td>0</td>
<td>.567</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>108</td>
<td>0</td>
<td>.305</td>
</tr>
<tr>
<td>Sum of condition risk scores</td>
<td></td>
<td>.642</td>
<td>1.776</td>
</tr>
</tbody>
</table>
Future of Population Health
What is the Future of Population Health?

Top Trends in Population Health Management

• Data collection
• Improvement around health and awareness (i.e. vaccinations and opioid crisis)
• Coding and Clinical Documentation activities are not synchronized
• Partnerships with community organizations
• Provider integration (Systems and Processes) among Acute and Non-acute settings

Healthcare organizations need to prioritize customers and innovation to set themselves up for population health success. In a changing healthcare landscape, data-driven organizations are going to be able to identify needs within the community and execute more efficient strategies in support of population health.
“Reform is not happening fast enough”

“Change is possible, change is necessary, and change is coming…one way or another…”

Alex Azar, HHS Secretary - Speech to hospital executives March 2018
QUESTIONS