PRISMA HEALTH

62nd Annual Greenville Postgraduate Seminar
Spotlight: Primary Care

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Value-based care and population health
What a primary care physician should know
Tich Changamire, MD, PhD, MBA
About the speaker

Tich Changamire, MD, PhD, MBA

- Medical Director, Humana Office of the Chief Medical Officer
- Associated Residency Program Director, Greenville Health System Family Medicine Residency
- Assistant Professor, USC School of Medicine Greenville
- Family Medicine Faculty, Cambridge Health Alliance
- Assistant Professor, Tufts Family Medicine Residency
- Family Medicine Residency, University of Washington
Agenda

01 | Pretest: What do you know about value-based care?
02 | Patient case: Meet Joe
03 | What is insurance?
04 | The need for VBC
05 | What is VBC?
06 | Patient case: What’s best for Joe?
07 | Wrap up: Q&A
Pretest: What do you know about value-based care?

What is value-based care?

A. Reimbursement model designed to increase the services provided to patients
B. Reimbursement model designed to increase quality of healthcare and decrease costs
C. Not sure
Pretest: What do you know about value-based care?

Value-based care includes:

A. Fee-for-service + bonuses
B. Shared savings
C. Upside risk
D. Capitation
E. Bundled payments
F. All of the above
Pretest: What do you know about value-based care?

Value-based care 
doesn’t apply 
to me

A. True
B. False
Pretest: What do you know about value-based care?

Whose idea was VBC?

A. Private insurance  
B. Physicians  
C. Federal government  
D. Not sure
Pretest: What do you know about value-based care?

Value-based care is the best reimbursement model for patients

A. True
B. False
C. Too soon to tell
Meet Joe: A patient case

HPI
Joe is a 72-year-old white male with diabetes, hyperlipidemia, hypertension, osteoarthritis and obesity presenting to clinic for his annual physical. He reports a recent ED visit for chest pain while mowing the lawn, discharged with angina diagnosis and instructions to follow up with our clinic.

Medications
Aspirin, Losartan, Metformin, Pravastatin, Naproxen

Allergies
Cough with Lisinopril, no other known allergies

Surgical Hx
Inguinal hernia repair 2017, L total hip 2015, R total hip 2014

Family Hx
Father STEMI at 70, died of complications from CHF; Mother died of pneumonia during hospitalization for hip fracture.

Social Hx
Smokes 1ppd, some alcohol use (1 beer/day), denies other substances. Wife died January 2017, now lives alone. One adult son living out of state with his family. Retired school bus driver, struggling to afford medications.
Let’s discuss Joe

• Thinking about the best possible care for Joe, what resources would you need?
• Who is responsible for coordinating Joe’s care?
• What are the barriers to that type of care?
How insurance plans work in general

Pooling of losses
Spreading the costs of a few over a large group

Financial restoration
Insured person is restored to their financial position prior to the event

Risk transfer
Insurance company is now responsible for the cost of an event

Payment of claims
Pay costs attributed to the insured person or group
What insurance companies do

Assess a population
How likely is it that something will go wrong?
How often will it go wrong?
How severe will it be when it goes wrong?

Price premiums
What will the likely cost be of an event?
What does the premium need to be to cover those costs?

Work to reduce chance of loss
What programs can reduce the likelihood of something going wrong?
How can contracts be negotiated to lower the cost when an event occurs?
Health insurance plans of today

- Commercial
- Medicare
  - Original Medicare
  - Medicare Advantage
- Exchange
  - Private Exchange
  - Public Exchange
- Medicaid
- Uninsured
Healthcare spending as a percentage of GDP, 1980 - 2013

We are spending 2X more than any other country with no better outcomes
- Lowest life expectancy
- Highest obesity rate
- Highest % 65+ with 2+ chronic conditions

* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.
The government’s policy response: MACRA

HHS and CMS focus on ‘value’

HHS strategic goal D: “Reduce the growth of health care costs while promoting high-value, effective care.”

Medicare payments tied to quality:

• March 2016: 30%
• Goal for 2018: 50%

MACRA is here to stay

Medicare Access and CHIP Reauthorization Act (MACRA) passed in April 2015.

• Changes the way Medicare rewards clinicians for value over volume
• Streamlines multiple quality programs under the new Merit-Based Incentive Payments System (MIPS)
• Provides bonus payments for participation in eligible Alternative Payment Models (APMs)

Private payers are shifting reimbursement models

Value-based care

<table>
<thead>
<tr>
<th>Fee-for-service</th>
<th>2016</th>
<th>2018 (Projected)</th>
<th>2023 (Projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitated/global payment</td>
<td>52%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>Pay for performance</td>
<td></td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td>Bundled payment</td>
<td></td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Shared savings, upside</td>
<td></td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Shared savings, downside</td>
<td></td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Projected payment model mix

http://mhsinfo2.mckesson.com/journey-to-value/
Value-based care models

Progressively more financial responsibility for cost of care

- **FFS**: Pays for the services a patient receives. No incentives.

- **Bonus and shared savings**: FFS + bonus + portion of shared savings in Medicare Parts A, B and D. Performance bonus.

- **Limited value**: FFS + bonus + care coordination fee + higher portion of shared savings in Medicare A, B and D. Bundled Payments. Shared accountability.

- **Full value/global value**: Full: FFS + 100% responsible for Medicare Part B expenses and sharing of Part A (may have shared savings or complete responsibility for Part D). Global: Full responsibility for Medicare Parts A, B and D through monthly capitated payments.

Full value:

- **FFS**: Full responsibility for Medicare Part B expenses and sharing of Part A (may have shared savings or complete responsibility for Part D). Global: Full responsibility for Medicare Parts A, B and D through monthly capitated payments.

- **Limited value**: FFS + bonus + care coordination fee + higher portion of shared savings in Medicare A, B and D. Bundled Payments.

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Value-based care or fee-for-service?

Patients are treated for illness or disease

Value-based care

and

Fee-for-service
Value-based care or fee-for-service?

Physicians are paid for providing health care

- Value-based care
  - and
  - Fee-for-service
Value-based care or fee-for-service?

Physicians are paid for the quality of patients’ outcomes
Value-based care or fee-for-service?

Physicians are incentivized to increase their volume of patients

Value-based care

or

Fee-for-service
Value-based care or fee-for-service?

Care coordination and care management are emphasized.

- Value-based care

  or

- Fee-for-service
Value-based care or fee-for-service?

System of health financing in which doctors are paid a fee for each particular service rendered.
Value-based care or fee-for-service?

Incentivizes overutilization. Has been proven to increase procedures.
Value-based care or fee-for-service?

Incentives for better care at lower cost; focus on quality and efficiency; coordinated and integrated care
This changes the way physicians practice

<table>
<thead>
<tr>
<th>Fee-for-service</th>
<th>Value-based care</th>
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<tbody>
<tr>
<td>Based on volume of care</td>
<td>Based on quality of care</td>
</tr>
<tr>
<td>Focused on sickness episodes</td>
<td>Focused on prevention and long-term wellness</td>
</tr>
<tr>
<td>Can result in fragmented care</td>
<td>Centered on coordinated care</td>
</tr>
<tr>
<td>Focus on individual utilization and cost</td>
<td>Focus on population utilization and cost</td>
</tr>
<tr>
<td>Care mostly provided by physician</td>
<td>Care provided by team</td>
</tr>
<tr>
<td>Health care providers have no financial accountability for care</td>
<td>Health care providers are partially to fully responsible for the cost of care delivered</td>
</tr>
</tbody>
</table>

Capabilities needed by a practice to successfully take care of Joe

- Expertise in practice process
- Leveraging patient data
- Human capital investment
- Technology infrastructure
Capabilities needed by a practice to successfully take care of Joe

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<tr>
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<tr>
<td>• Quality improvement strategies: quality measures, root cause analysis, Lean Six Sigma</td>
<td></td>
</tr>
<tr>
<td>• Clinical protocols, supported by evidence-based medicine</td>
<td></td>
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| Human capital investment | Technology infrastructure |
Capabilities needed by a practice to successfully take care of Joe

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<tr>
<td></td>
<td>• Minimum number of patients needed</td>
</tr>
<tr>
<td></td>
<td>• Accurate documentation</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive knowledge of patients</td>
</tr>
<tr>
<td></td>
<td>• Identification of high-risk patients</td>
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<td>Human capital investment</td>
<td>Technology infrastructure</td>
</tr>
<tr>
<td>- Fulltime care management staff</td>
<td></td>
</tr>
<tr>
<td>- Care coordinators and coders</td>
<td></td>
</tr>
<tr>
<td>- Social workers/behavioral health</td>
<td></td>
</tr>
<tr>
<td>- Pharmacists, exercise physiologists and financial counselors</td>
<td></td>
</tr>
</tbody>
</table>
Capabilities needed by a practice to successfully take care of Joe

- Expertise in practice process
- Leveraging patient data
  - Electronic medical records
  - Data analytics
  - Telemedicine
  - Smartphone applications
- Human capital investment
  - Technology infrastructure
## AAFP – Humana study
### Family physician responses

<table>
<thead>
<tr>
<th>Barriers to value-based care</th>
<th>Percent agreeing in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of staff time to implement care functions that support VBC</td>
<td>90%</td>
</tr>
<tr>
<td>Ability to understand the complexity of financial risk</td>
<td>75%</td>
</tr>
<tr>
<td>Substantial investment in health IT</td>
<td>86%</td>
</tr>
<tr>
<td>VBC will increase work for physicians without a benefit to the patient</td>
<td>58%</td>
</tr>
<tr>
<td>Quality expectations are easy to meet</td>
<td>8%</td>
</tr>
<tr>
<td>Value-based care models are easy to execute</td>
<td>4%</td>
</tr>
</tbody>
</table>
Change is possible, change is necessary, and change is coming…. There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward – for HHS to take bolder action, and for providers and payers to join with us.

HHS Secretary Alex Azar
Social determinants and population health
5 hours out of 8,760 hours are spent in a doctor’s office.

What about the other 8,755 hours?
We need to invest in the whole person

What the U.S. spends

- 88% Medical services
- 8% Other
- 4% Healthy behaviors

What actually makes people healthy

- 50% Healthy behaviors
- 20% Genetics
- 20% Environment
- 10% Access to care
- 2% Other

96% Other
What are social determinants of health?

Social determinants of health are the conditions in the environments in which people live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.
We must address clinical and non-clinical needs to improve health

- Food insecurity
- Transportation
- Housing
- Loneliness and social isolation
- Unemployment
‘Always on methodology’
Thank you