CliftonLarsonAllen

Can Population Health Really Be a Better Business Model?

Dive Deeper Into Health System Finance to Explore How Emerging Team-Based Models of Care Impact Health System Total Cost of Care

Presented by: Dave Schuh & Tammy Kritzer

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  - Your questions can be submitted via the **Questions Function at any time during the presentation.**

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- A professional services firm with three distinct business lines
  - Wealth Advisory
  - Outsourcing
  - Audit, Tax, and Consulting
- More than 4,500 employees
- Offices coast to coast

Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC.

Speaker Introductions

- **Tammy Kritzer, Principal**

  Tammy is a principal at CliftonLarsonAllen with more than 20 years of experience in the healthcare industry. In addition to supporting client efforts related to strategic planning, operational improvement, and revenue cycle enhancement, she brings enhanced capabilities to support population health planning and service redesign to healthcare clients during this transformational period in healthcare.

- **Dave Schuh, Principal**

  David Schuh is a principal at CliftonLarsonAllen LLP specializing in strategic financial and capital planning services. He has extensive experience in the financial integration and analysis of hospitals and hospital based clinic services.

Learning Objectives

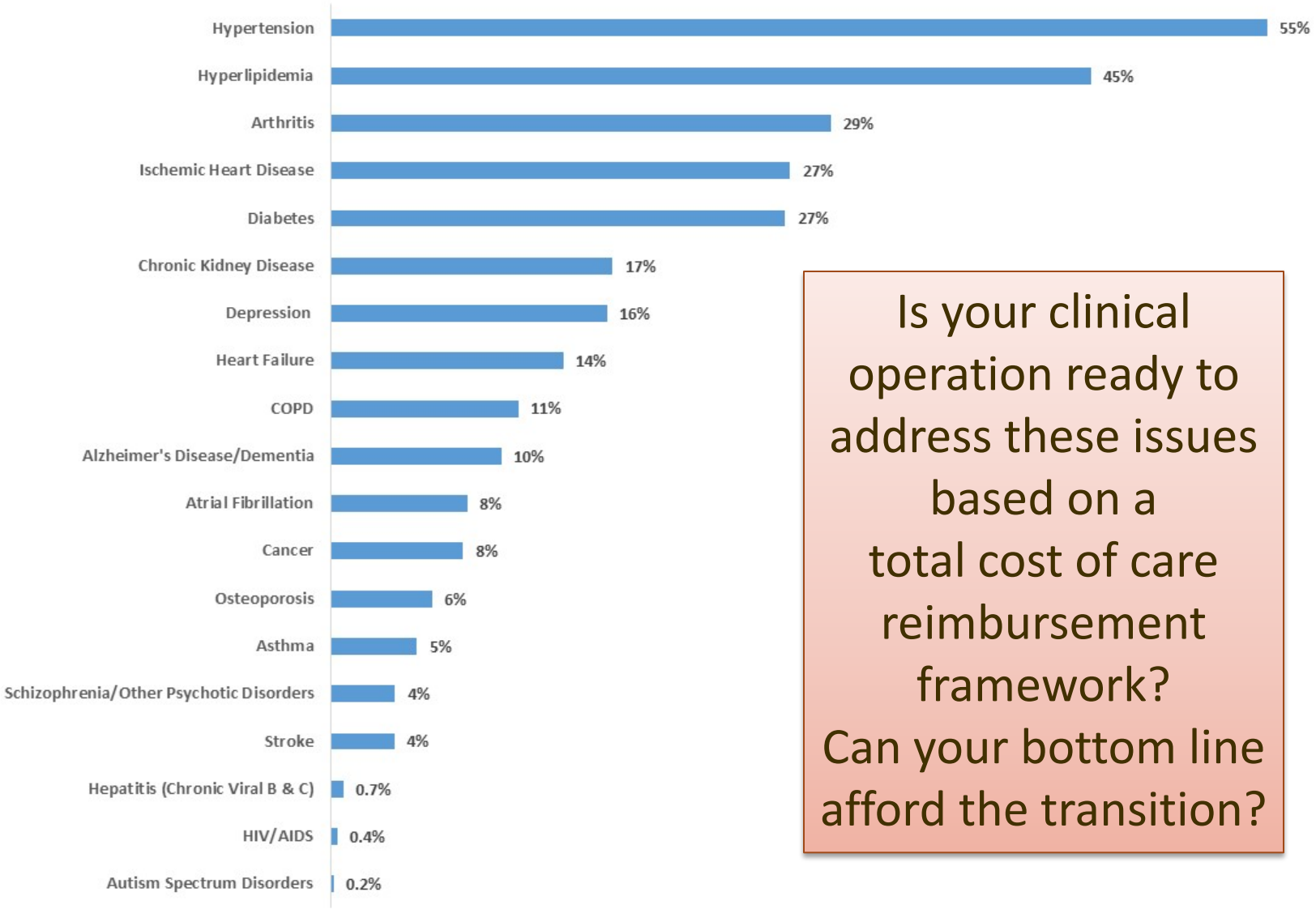
- At the end of this session, you will be able to:
  - Highlight industry trends impacting reimbursement frameworks
  - Provide an overview of team-based care
  - Review the economic impact of population health and team based care models from a global health system finance perspective

Current Trends in Population Health…

Medicine is More Complicated Than Ever

- The US spends more on health care than any country
- Life expectancy in the US lags behind other industrialized nations with much higher costs
- Americans are living longer with more chronic disease
- 90 new drugs released in 2015 compared to 36 in 2012
- 45% of adults have two or more chronic conditions
- 46% of physicians report burnout in 2015. Up 6 points from 2013 survey

Figure 1: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries: 2014



Is your clinical operation ready to address these issues based on a total cost of care reimbursement framework? Can your bottom line afford the transition?

Clinical Calamity- The Big Three

Hypertension

- 29% of American Adults
- 70 Million People
- 50% do not have HTN under control
- 30% of Americans have pre-HTN

COSTS
- $46B direct medical expenses
- $3.6B lost productivity

Diabetes

- 9.3% of US Population
- 29.1 Million People
- 27.8% of patients are undiagnosed – 8.1M People

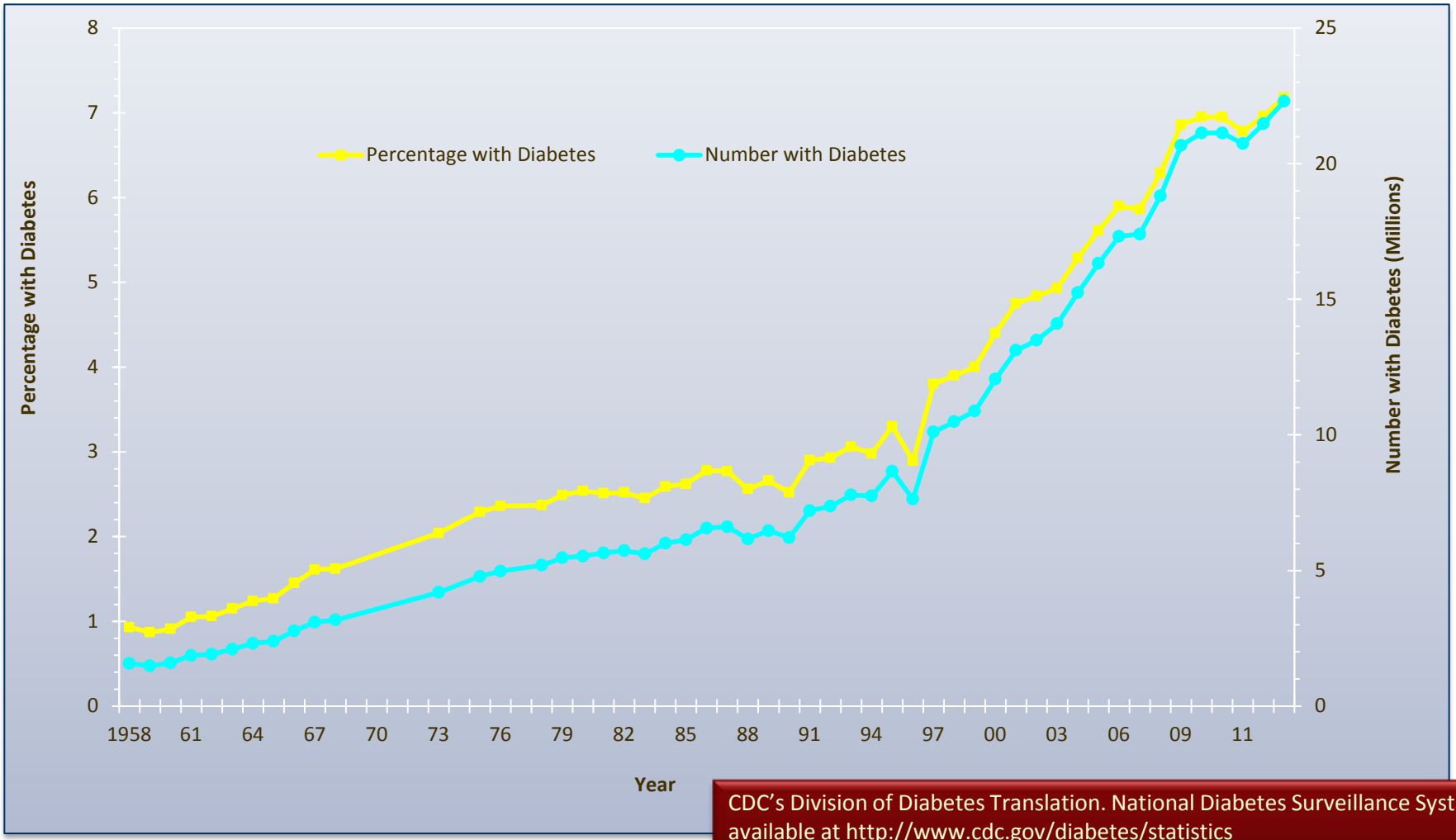
COSTS
- $176B direct medical expenses
- $69B lost productivity, indirect costs

Obesity

- 35% Obese
- 34% Overweight
- 31% Healthy BMI

COSTS
- $190B obesity related illnesses
- $4.3B obesity related absenteeism
- 36% Higher – Medical costs attributed to obese and overweight adults

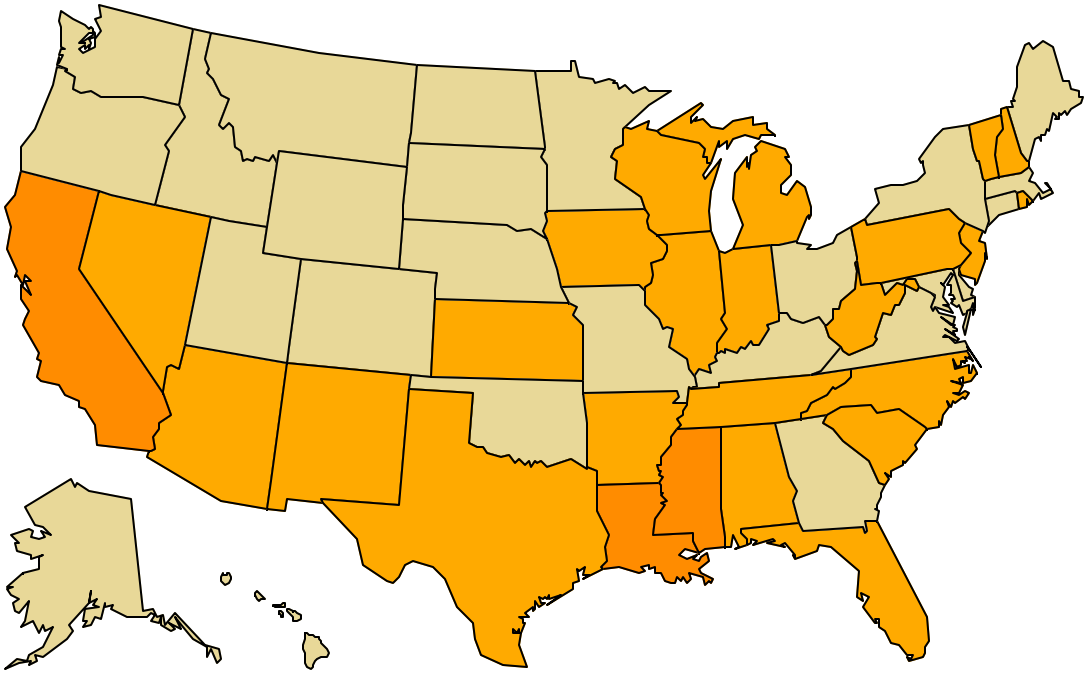
Number and Percentage of U.S. Population with Diagnosed Diabetes, 1958-2013



CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at http://www.cdc.gov/diabetes/statistics

Diagnosed Diabetes Prevalence

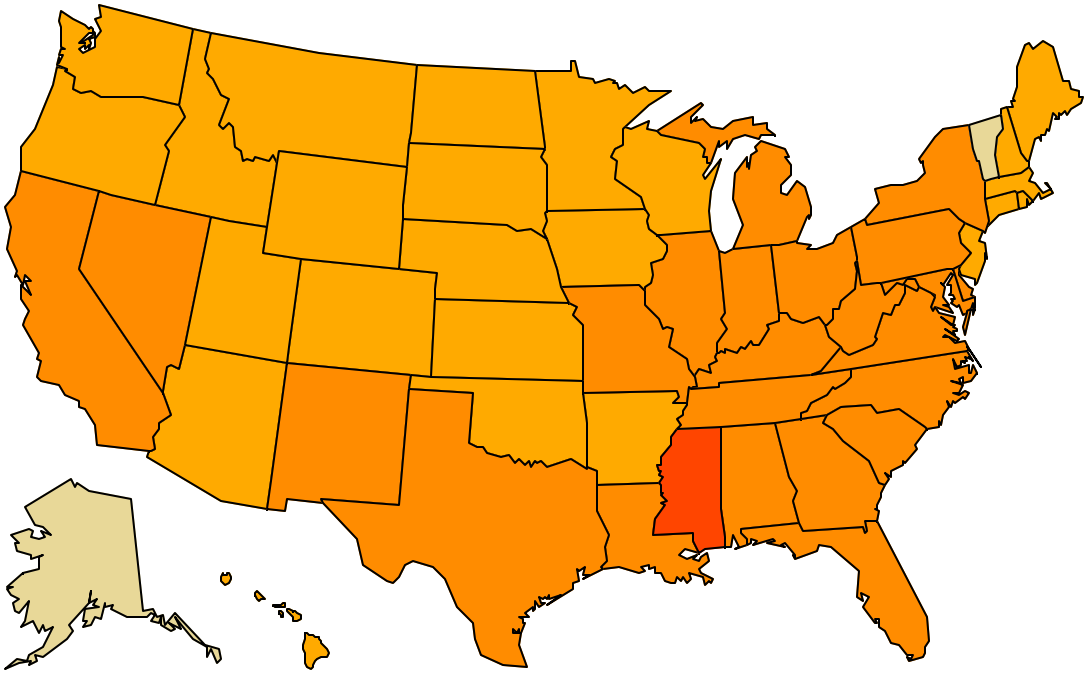
1995



Source: CDC

Diagnosed Diabetes Prevalence

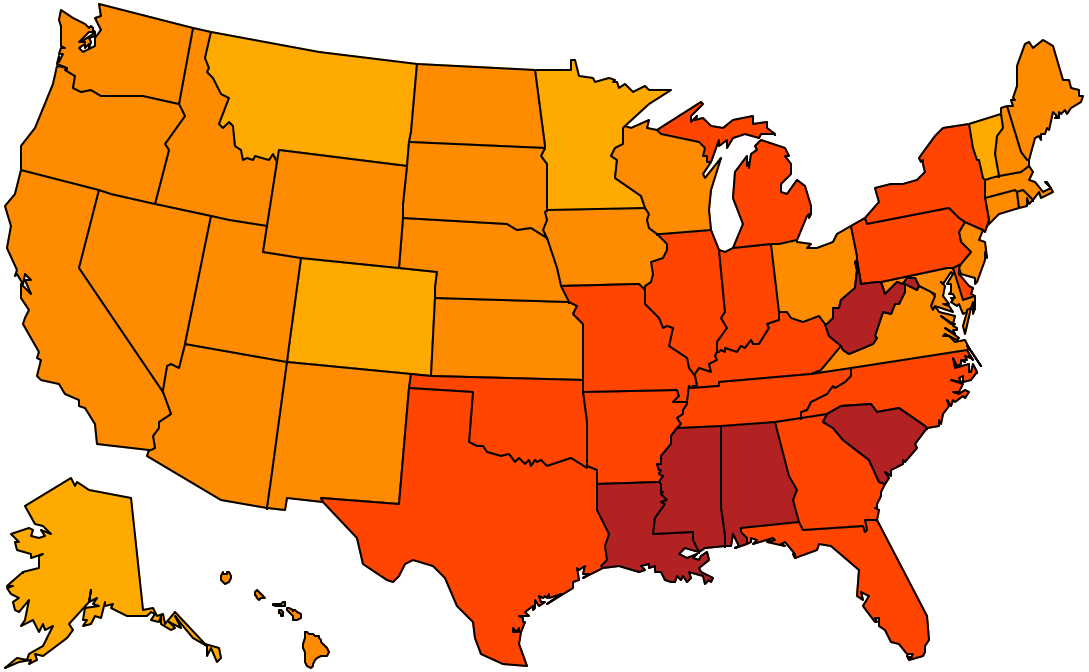
2000



Source: CDC

Diagnosed Diabetes Prevalence

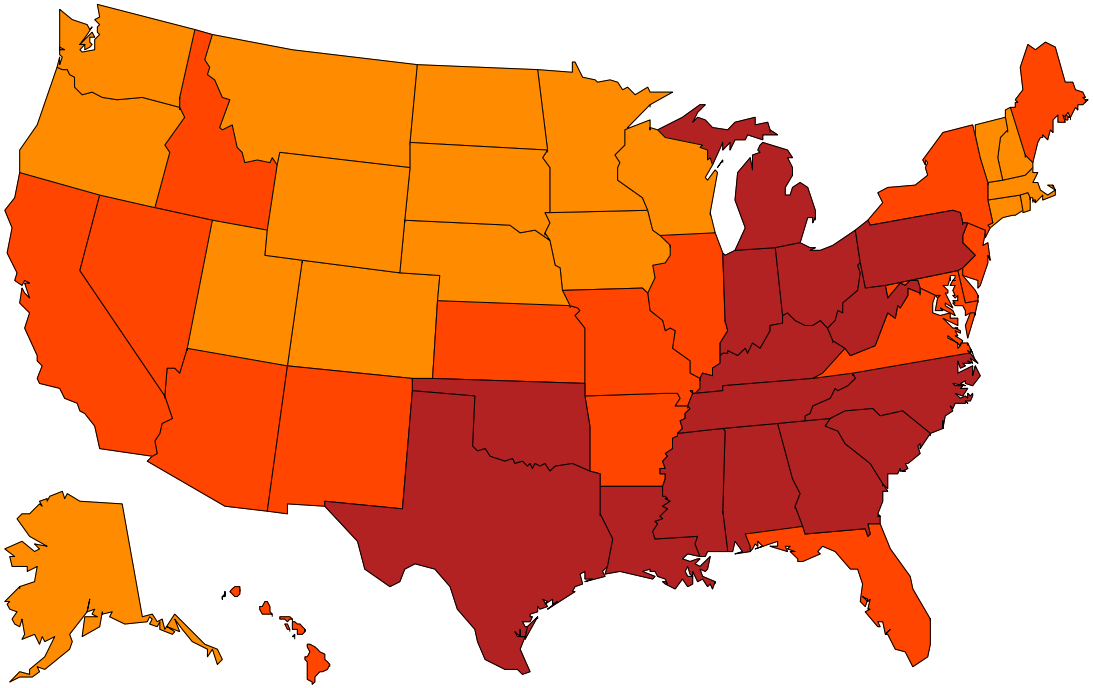
2005



Source: CDC

Diagnosed Diabetes Prevalence

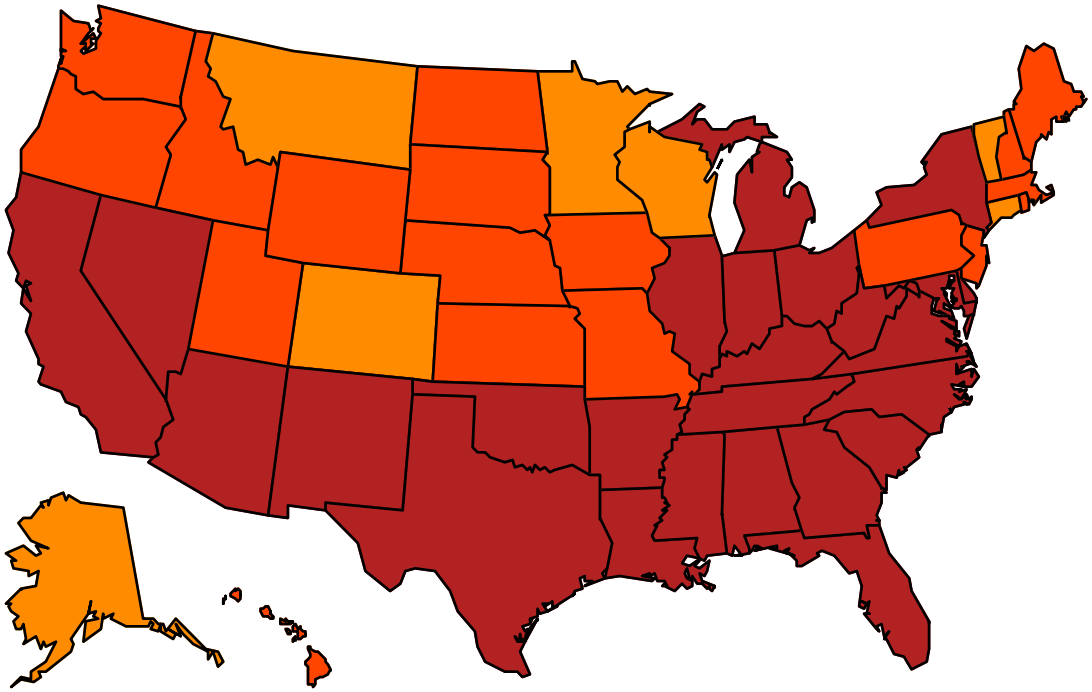
2010



Source: CDC

Diagnosed Diabetes Prevalence

2013



Source: CDC

Prevalence¶ of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2011

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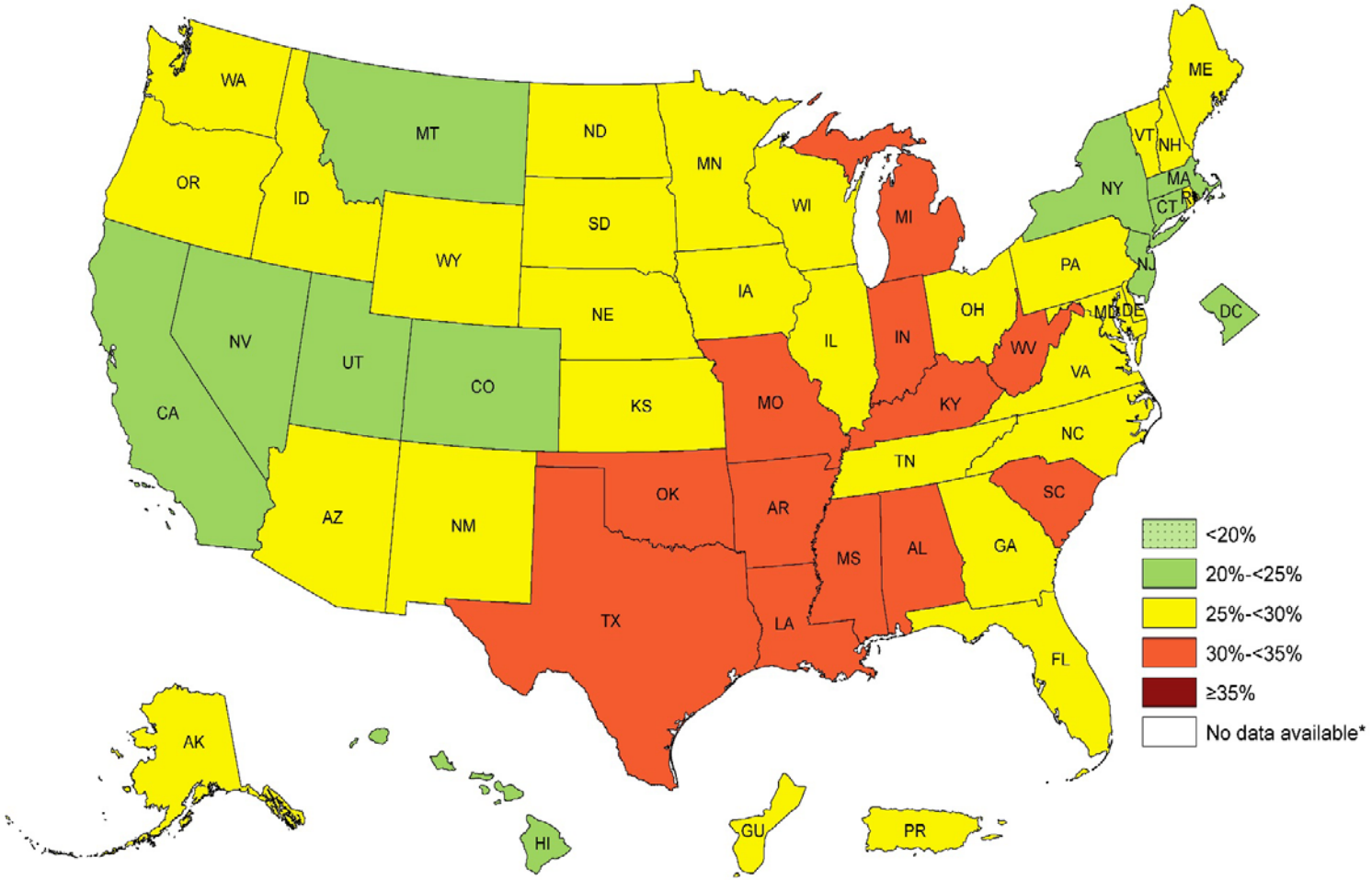

***Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.**

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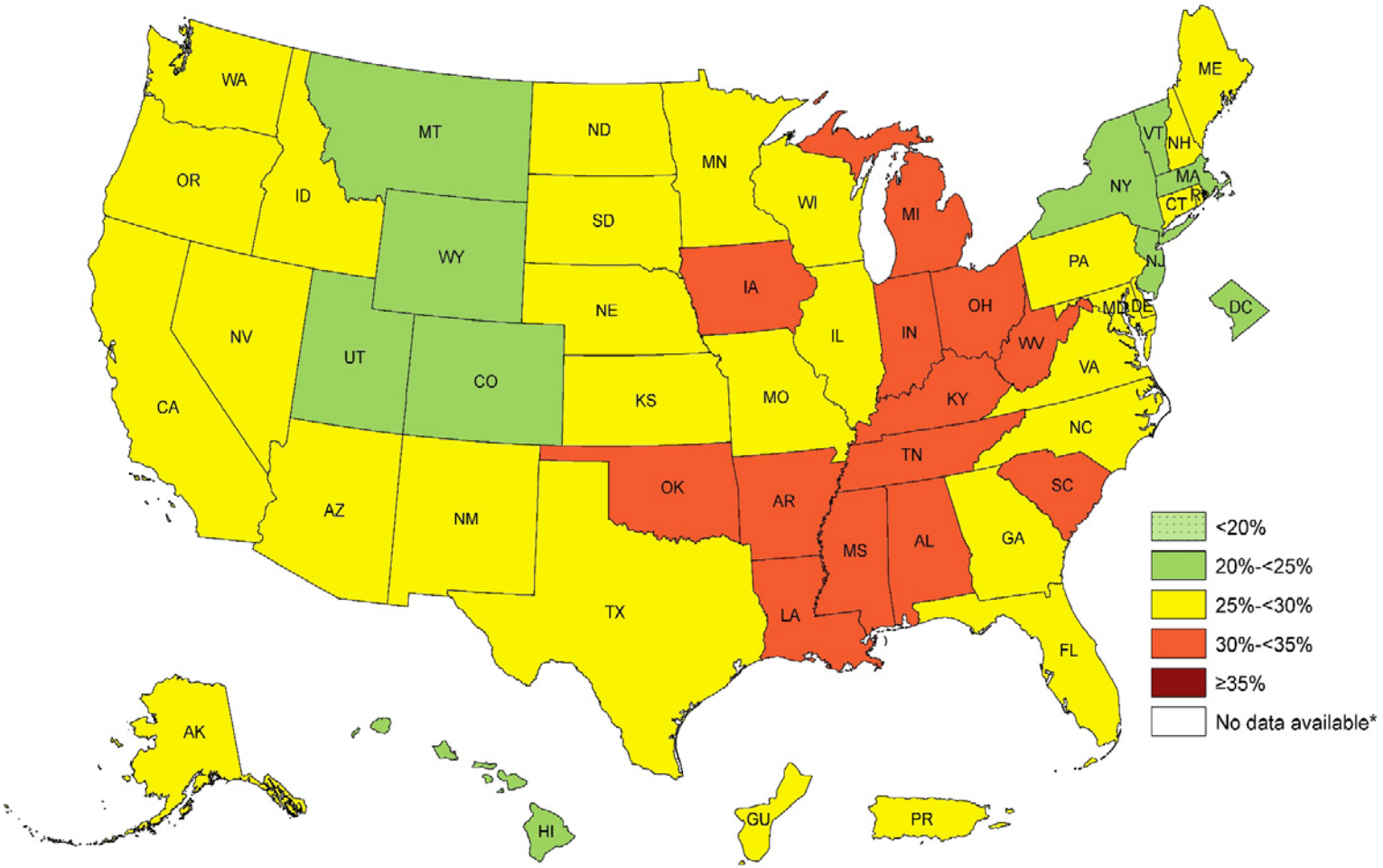

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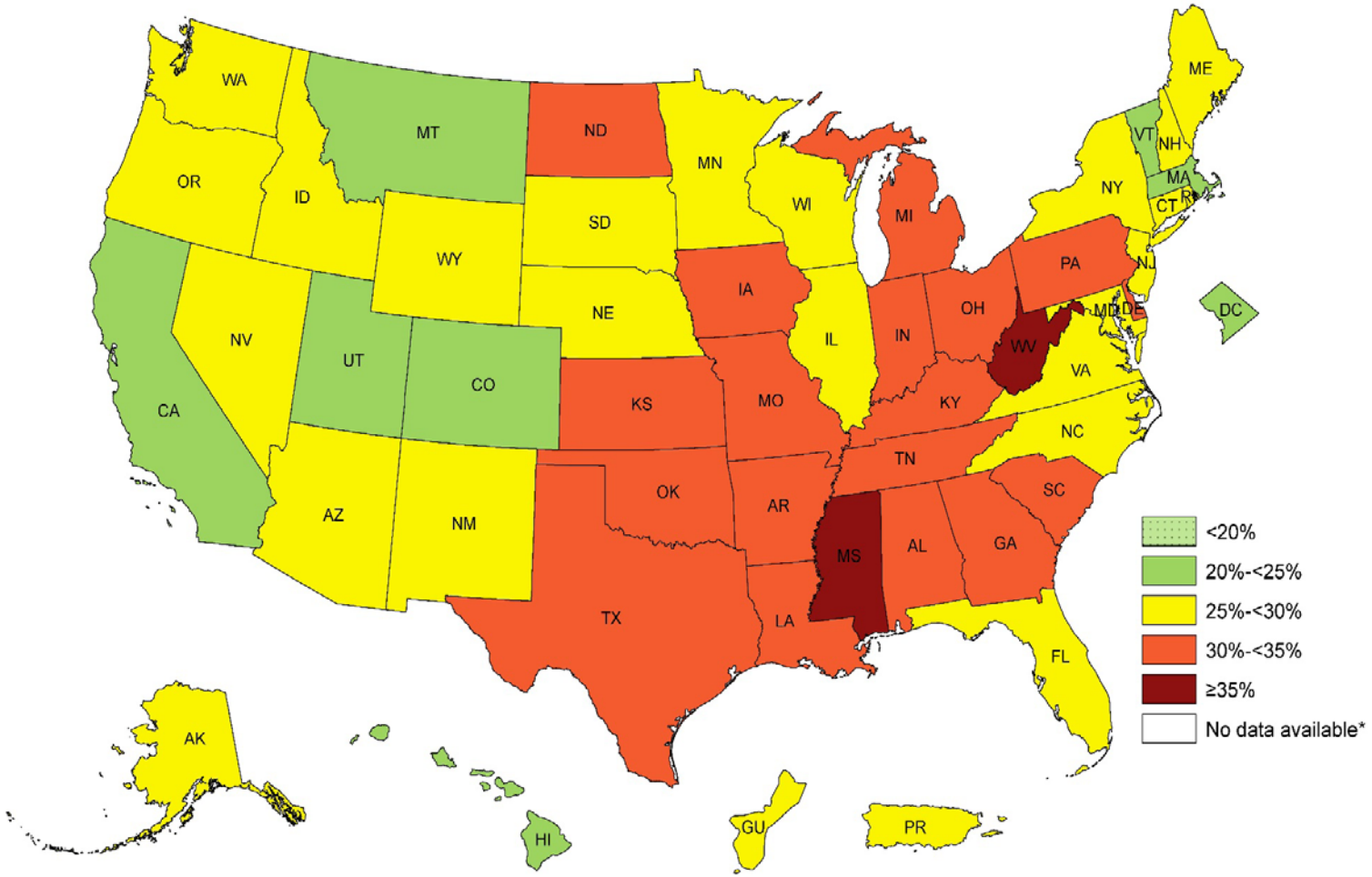

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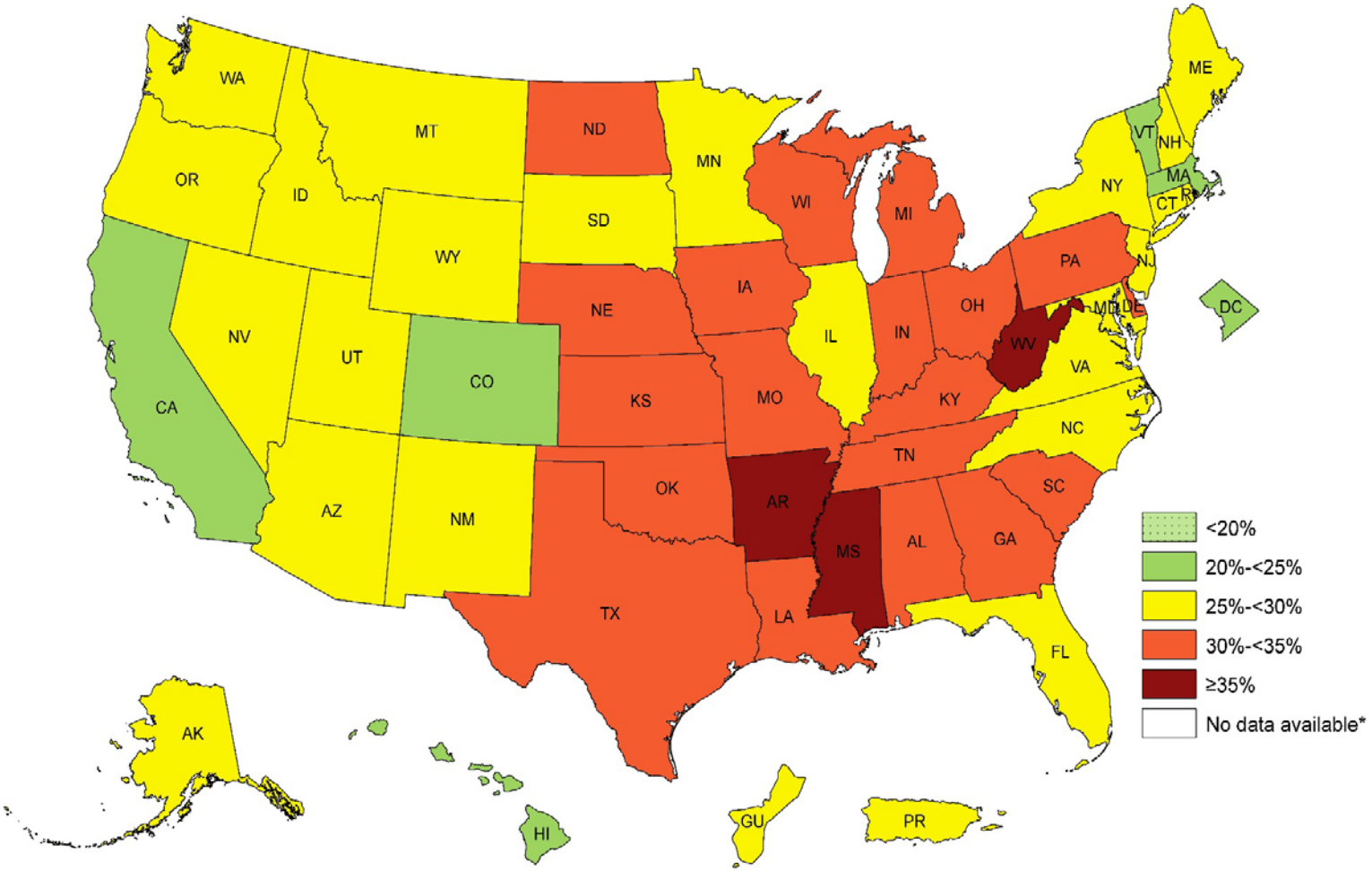

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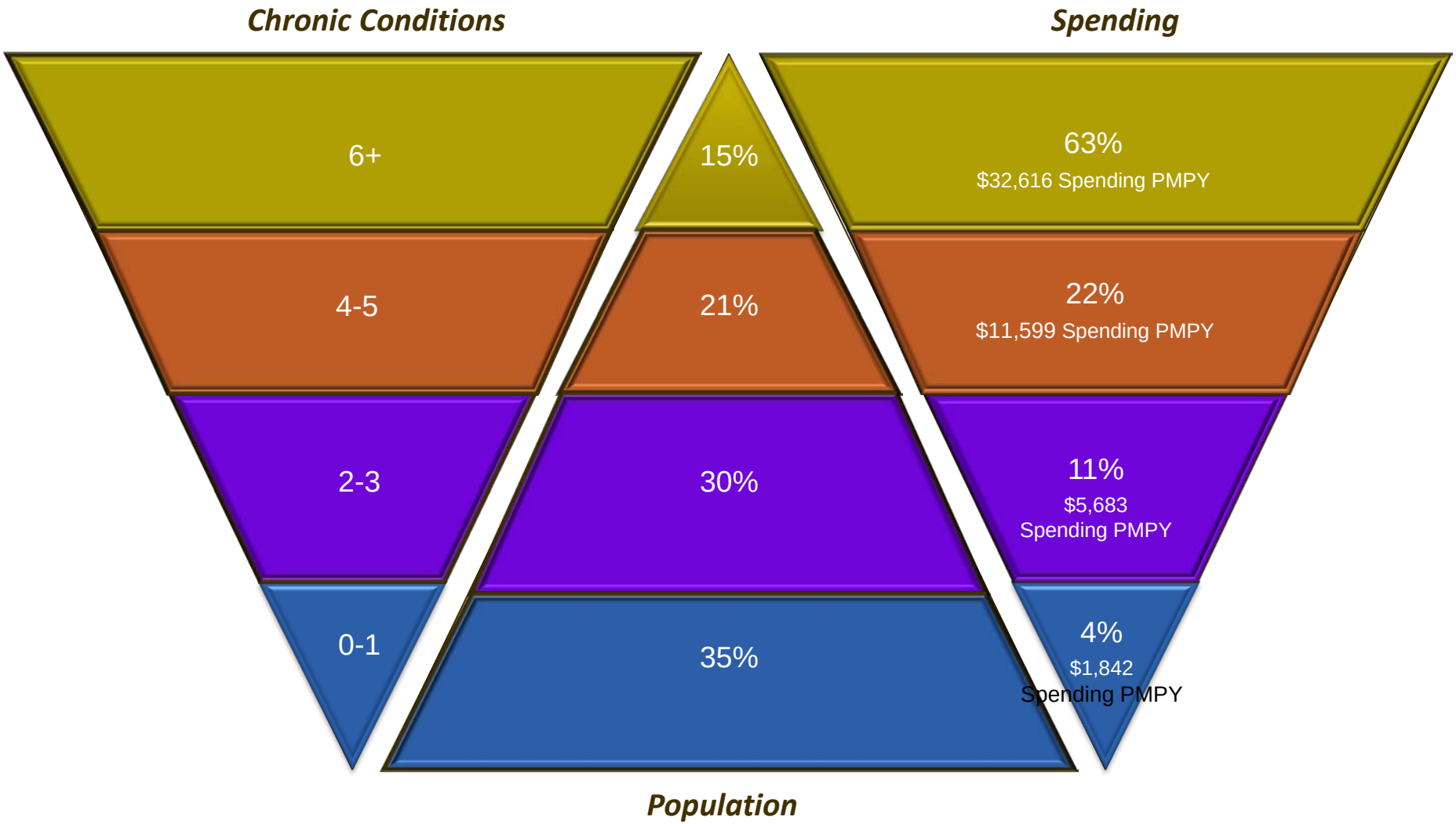
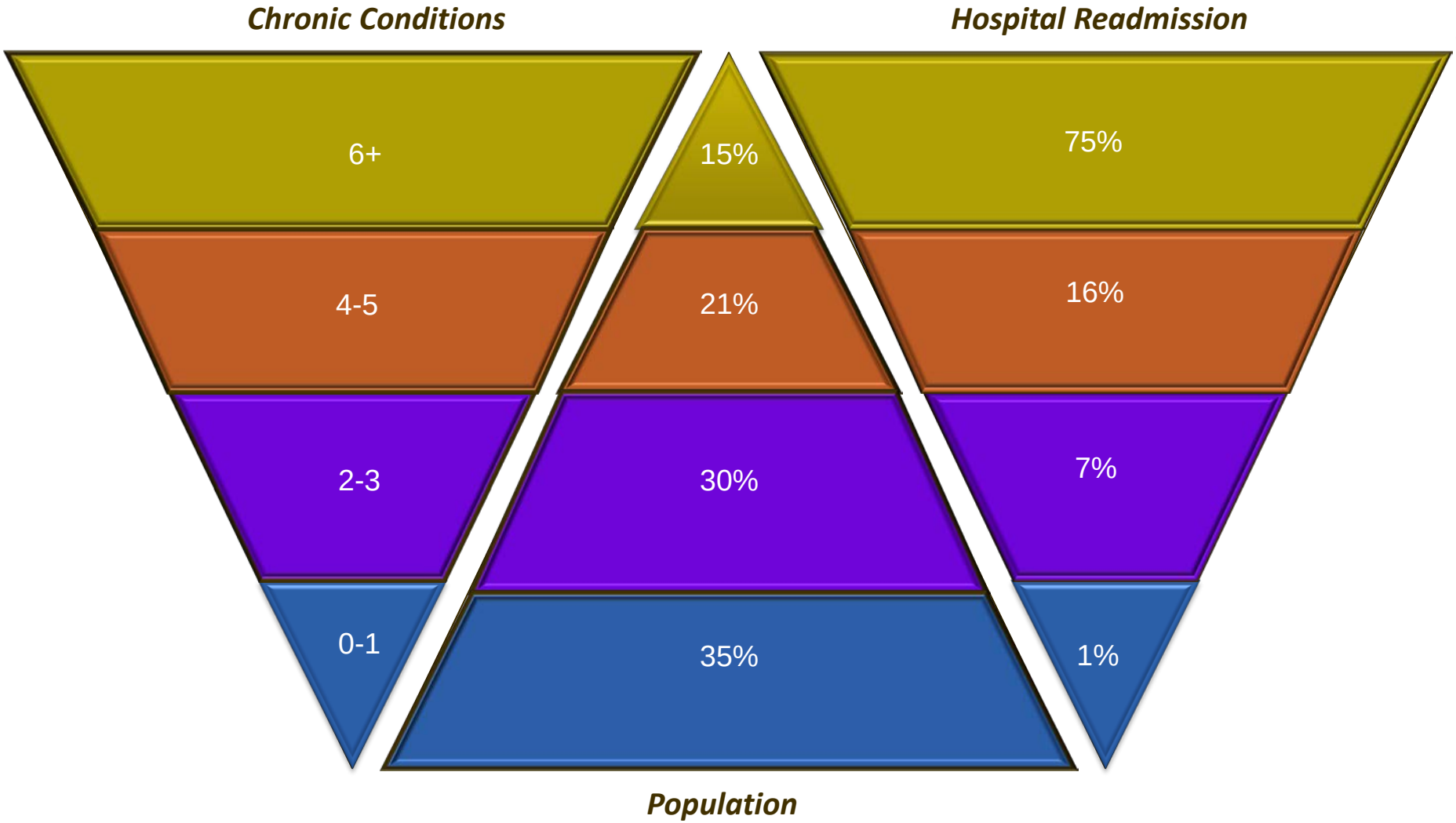
2014 Medicare FFS Population Health Distribution Spending

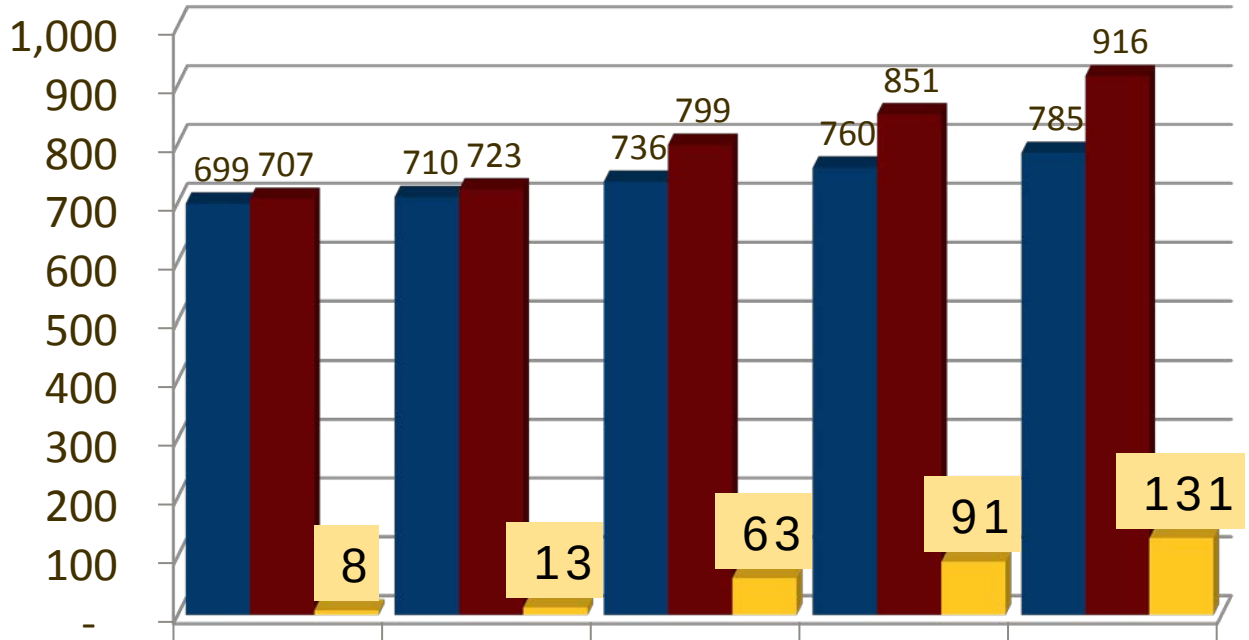


2014 Medicare FFS Population Health Distribution Readmissions



Projected FTE Physician Supply and Demand

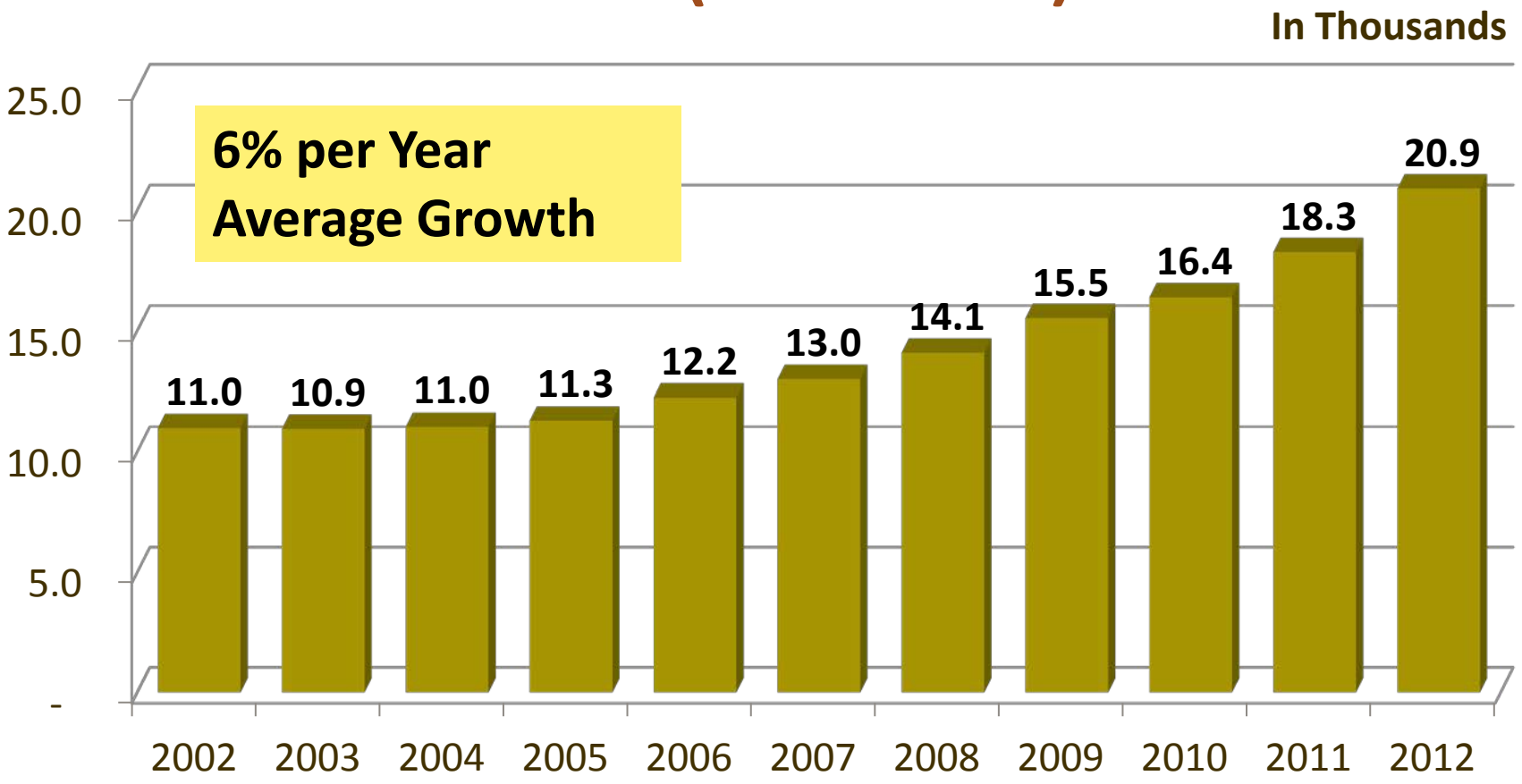
Physician FTEs
In Thousands



	2008	2010	2015	2020	2025
Supply	699	710	736	760	785
Demand	707	723	799	851	916
Shortage - All Specialties	8	13	63	91	131

Source: AAMC Center for Workforce Studies, June 2010 Analysis

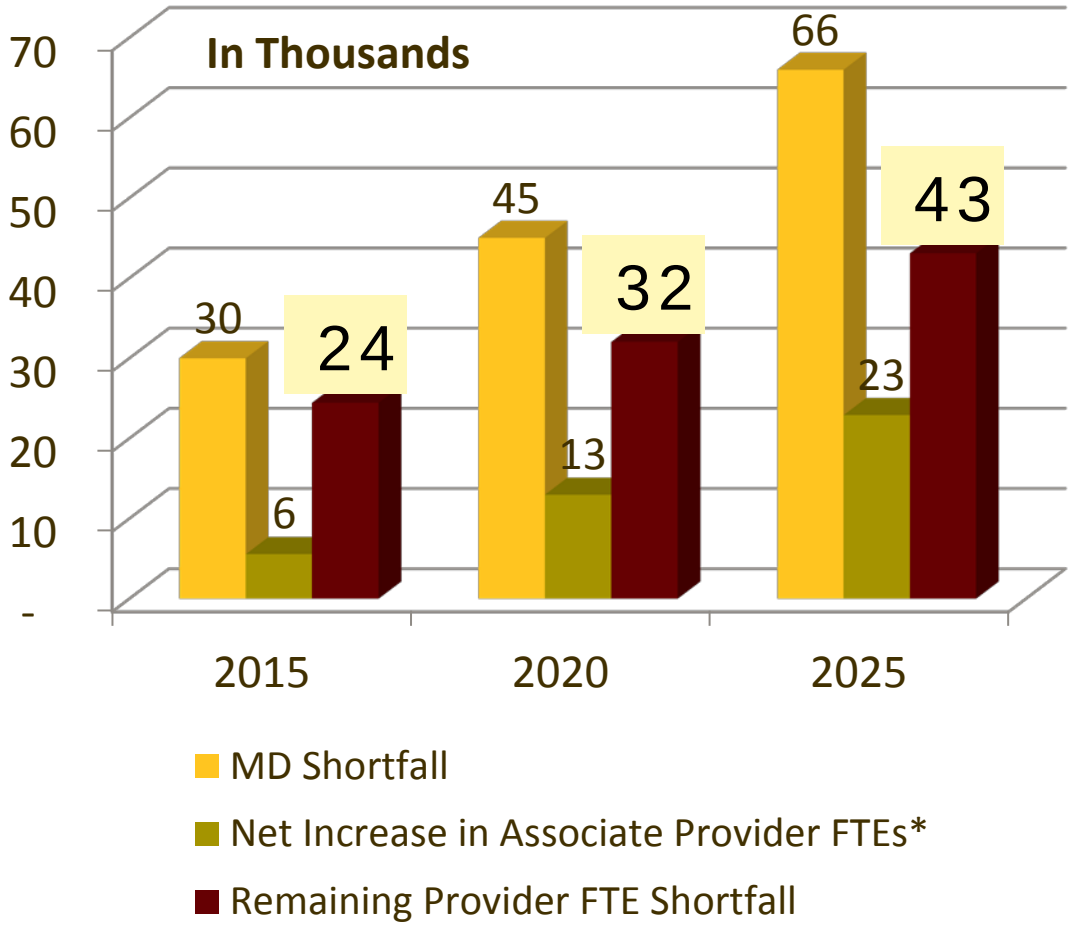
Trends in Annual Numbers of Certified Associate Providers (PA and NP)



Data Source: National Commission on Certification of Physician Assistants (NCCPA), "Certified Physician Assistant Population Trends"; 2012 data from personal communication with NCCPA, January 16, 2013.

Data Source: HRSA compilation of data from the AACN Annual Survey (in collaboration with the National Organization of Nurse Practitioner Faculties for collection of nurse practitioner data). Note: Counts include master's and post-master's degree NP and NP/clinical nurse specialist graduates as well as bachelor's-to-doctorate of nursing practice graduates.

Potential Primary Care Provider Shortfall

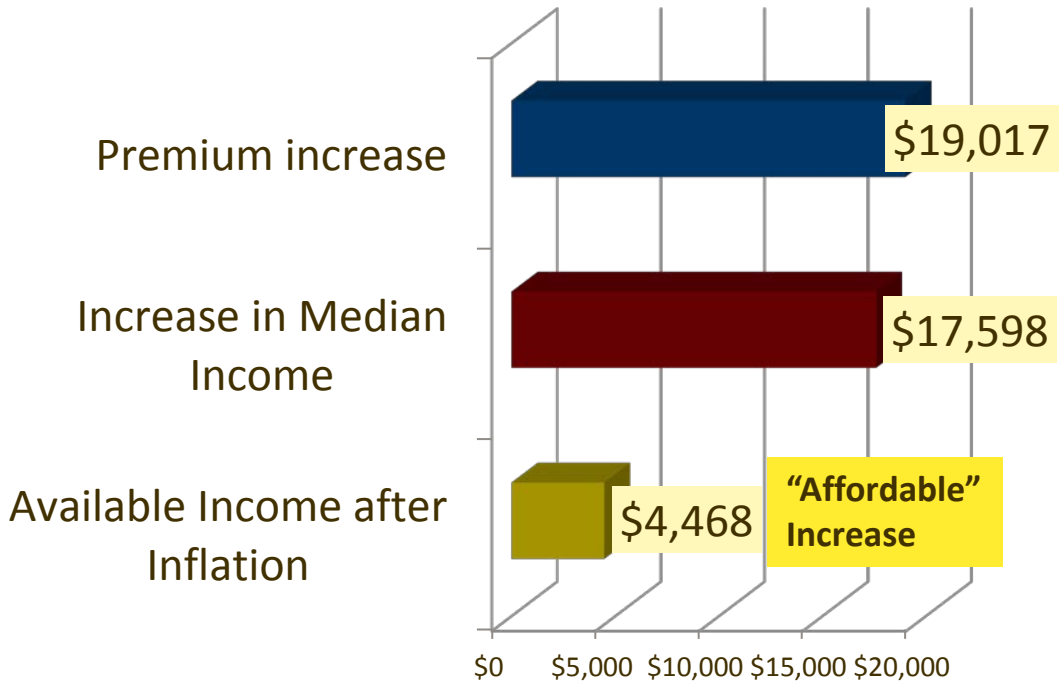


Even with continued growth in associate providers, **primary care provider supply will fall 10% short of demand**

**** At growth rate trends similar to 2002 - 2012***

Are You Prepared for Less Revenue Growth
Unsustainable Increases in Health Care Spending?

Projected Increases by 2022 (vs. 2012) *



Historical Premium Increases **8.2%** Per Year

"Affordable" Premium Increases **2.5%** Per Year

QUESTION

Are you prepared for **75% less revenue growth in the next decade?**

**** At growth rate trends similar to 2002 - 2012***

Base Data Source: Federal Reserve and Kaiser Family Foundation

Current Health Care Delivery Model

- systematically designed to add cost

- Fee for Service Model
  - Volume driven
  - RVU's / charges generated
  - Face to face visit
  - Heads in beds
  - Maximize Procedures
- Provider/Doctor Centric (PCP)
  - MD defines quality
  - Cost not considered
- Growth – focused on volume
- Multiple payers/contracts
- Medical Record "secrets"

And yet…

The health care industry continues to apply old solutions within a framework we know to be ineffective:

- MD Shortage:
  - Recruitment strategy which is better than our competition
- Reduced Admissions:
  - Grow market share
  - Improve facilities to make our campus the “desired” choice

It's a New World

At no time before has a health care organization's revenue been tied to performance until now.

Payment Facts:

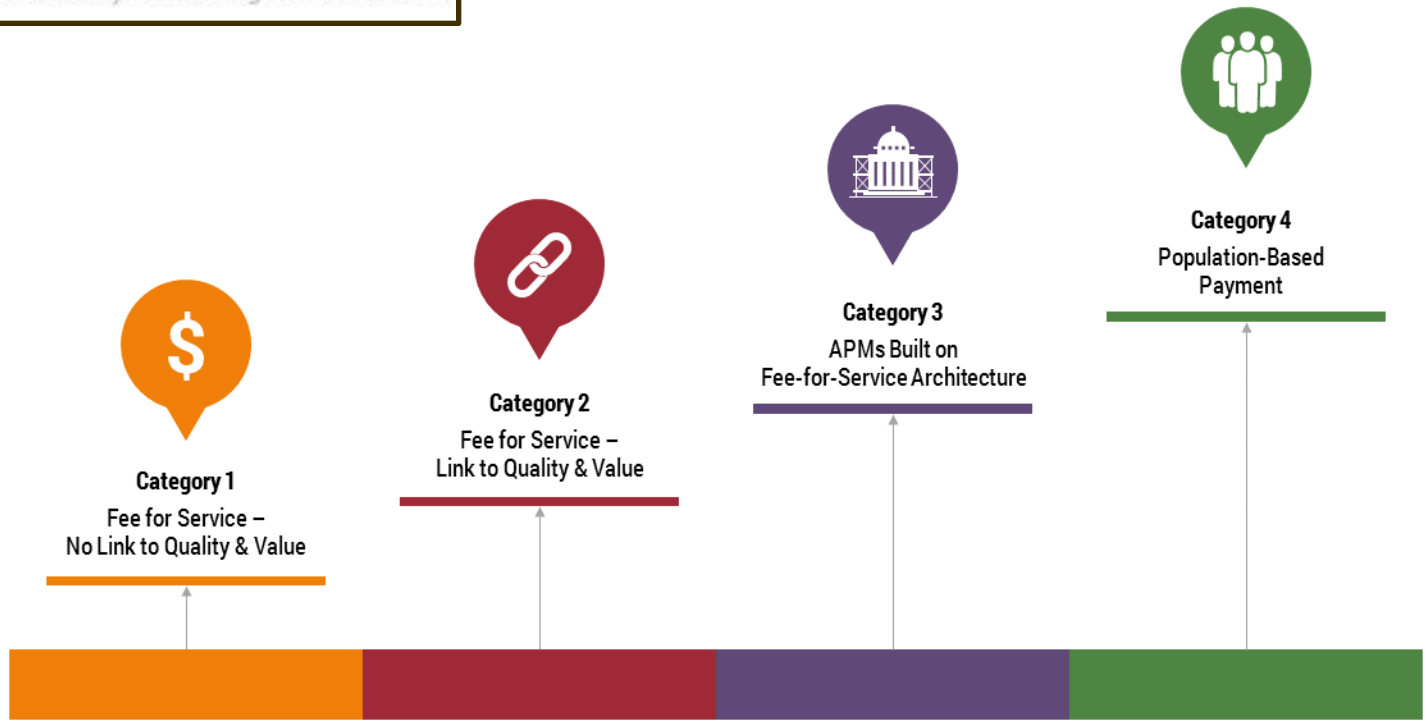
- 90% of the Medicare dollars will be paid based upon providers' value – **cost + quality** performance – by 2018.
  - 50% in alternative payment models
- A group of significant private payers have a goal to pay 75% of their contracts with providers based on performance by 2020
- Site neutral payments

Triple Aim Goals

- Better Care
- Better Population Health
- Lower Cost

Transitioning Reimbursement: HHS Framework

HCP LAN
Health Care Payment Learning & Action Network



HCP LAN
Health Care Payment Learning & Action Network

Category 1

Fee for Service –
No Link to Quality & Value

Category 2

Fee for Service –
Link to Quality & Value

Category 3

APMs Built on
Fee-for-Service Architecture

Category 4

Population-Based
Payment

Fee-for-Service	A Foundational Payments for Infrastructure & Operations	B Pay for Reporting	C Rewards for Performance	D Rewards and Penalties for Performance	A APMs with Upside Gainsharing	B APMs with Upside Gainsharing/ Downside Risk	A Condition-Specific Population-Based Payment	B Comprehensive Population-Based Payment
Traditional FFS	Foundational payments to improve care delivery, such as care coordination fees, and payments for investments in HIT	Bonus payments for quality reporting	Bonus payments for quality performance	Bonus payments and penalties for quality performance	Bundled payment with upside risk only	Bundled payment with up- and downside risk	Population-based payments for condition-specific care (e.g., via an ACO, PCMH, or COE)	Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)
DRGs Not linked To Quality		DRGs with rewards for quality reporting	DRGs with rewards for quality performance	DRGs with rewards and penalties for quality performance	Episode-based payments for procedure-based clinical episodes with shared savings only	Episode-based payments for procedure-based clinical episodes with shared savings and losses		
		FFS with rewards for quality reporting	FFS with rewards for quality performance	FFS with rewards and penalties for quality performance	Primary care PCMHs with shared savings only	Primary care PCMHs with shared savings and losses	Partial population-based payments for primary care	Integrated, comprehensive payment and delivery system
					Oncology COEs with shared savings only	Oncology COEs with shared savings and losses	Episode-based, population payments for clinical conditions, such as diabetes	Population-based payment for comprehensive pediatric or geriatric care
					3N Risk-based payments NOT linked to quality		4N Capitated payments NOT linked to quality	

= example payment models will not count toward APM goal.

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

Stein's Law

If something cannot go on forever, it will stop

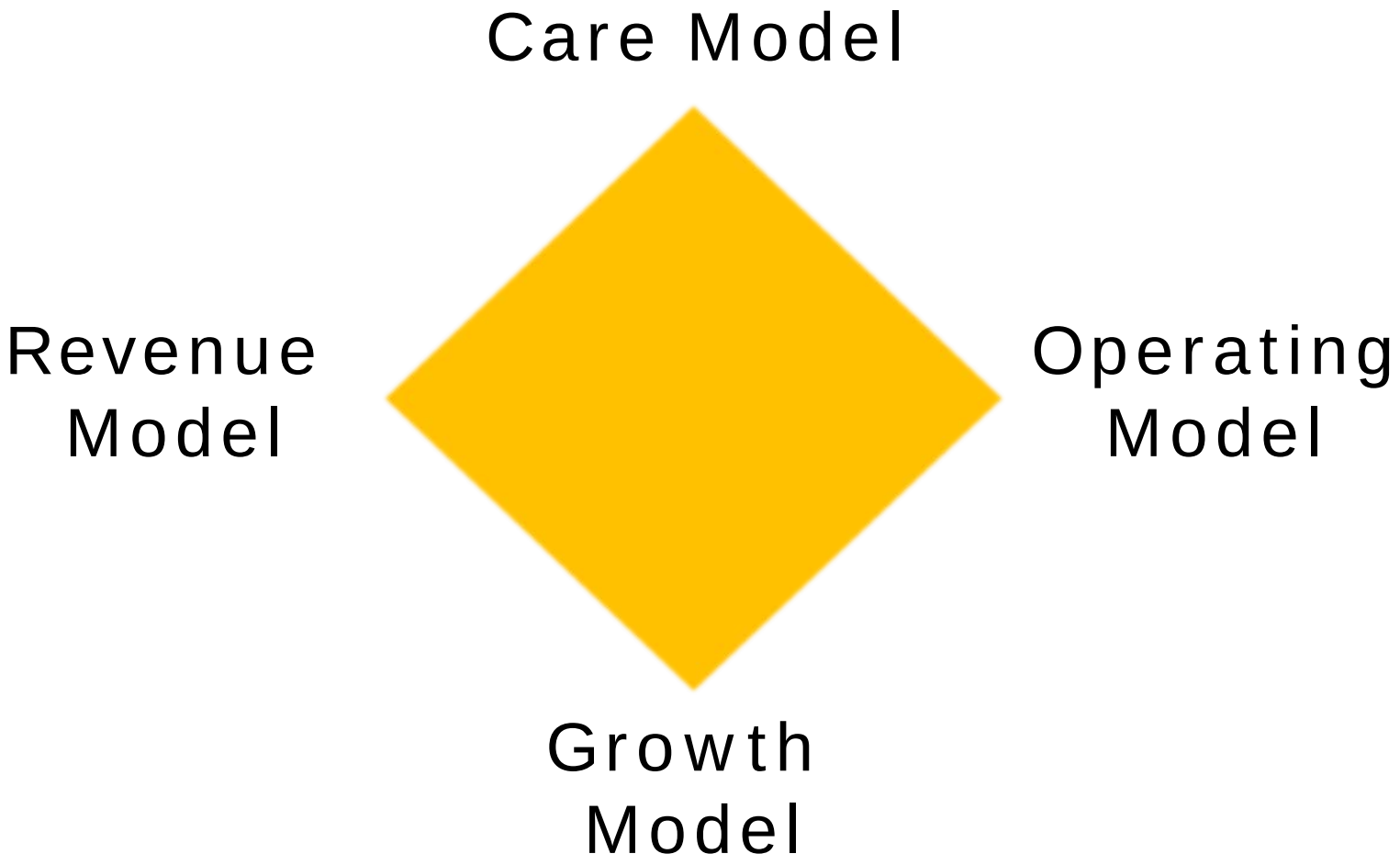
More Current Language….

Trends that can't continue, won't!

Some Observations

- The problem is cost → the **Total Cost of Care** is too high!
- Provider (Delivery System) revenue is **COST**
- **The problem is that Providers have too much revenue??!!!!!**

Modeling Financial Performance: Key Performance Drivers



Value Driven Enterprise

- Financial, clinical, cultural transformation
- Reimagine a health care delivery platform
- Reimagine revenue models
- Intentional partnerships and integration across the entire care continuum
- Understand populations served
- Intentional and proactive engagement of patients in lowest acuity setting possible

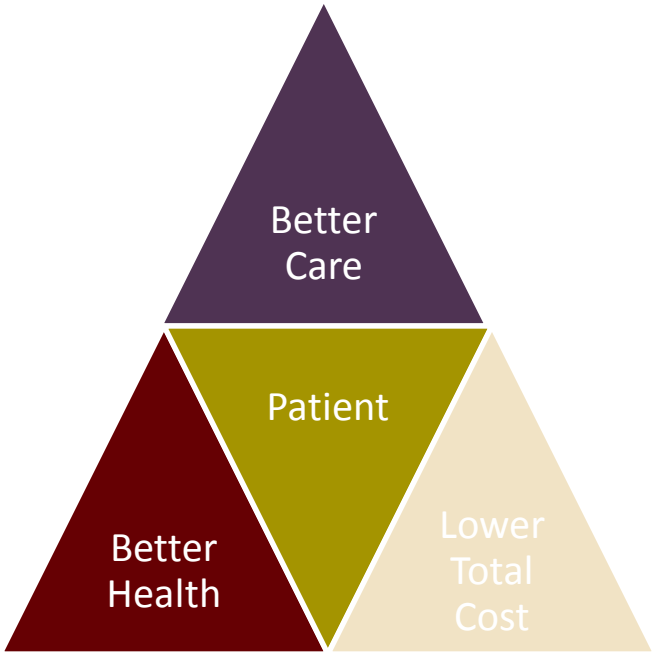
Volume to Value Revolution

- Physician centered
- Transactional, episodic
- Sick – care
- Inaccessible
- Patient turn, volume
- Unwarranted variation
- Bricks & mortar, office hrs.
- Paid to do more

- Patient focused
- Care team managed
- Health and well-being
- Convenient and 24/7
- Patient health value
- Evidenced based standards
- Virtual, mobile, anytime
- Paid to do less
- Change management
- Redeployment of resources

How Hospitals, Systems, and ACOs Define Population Health

- Disciplined management of clinical and financial risk designed to:
  - Stabilize the chronically ill
  - Reduce variation of care delivery
  - Keep healthy people fit and well
- Ultimate Goal:
  - Lower total cost of care (revenue)
  - Better outcomes
  - Satisfied (loyal) patients



Systematic redesign of a better health care delivery platform
Focused on Value – NOT Volume

Population Health Pyramid

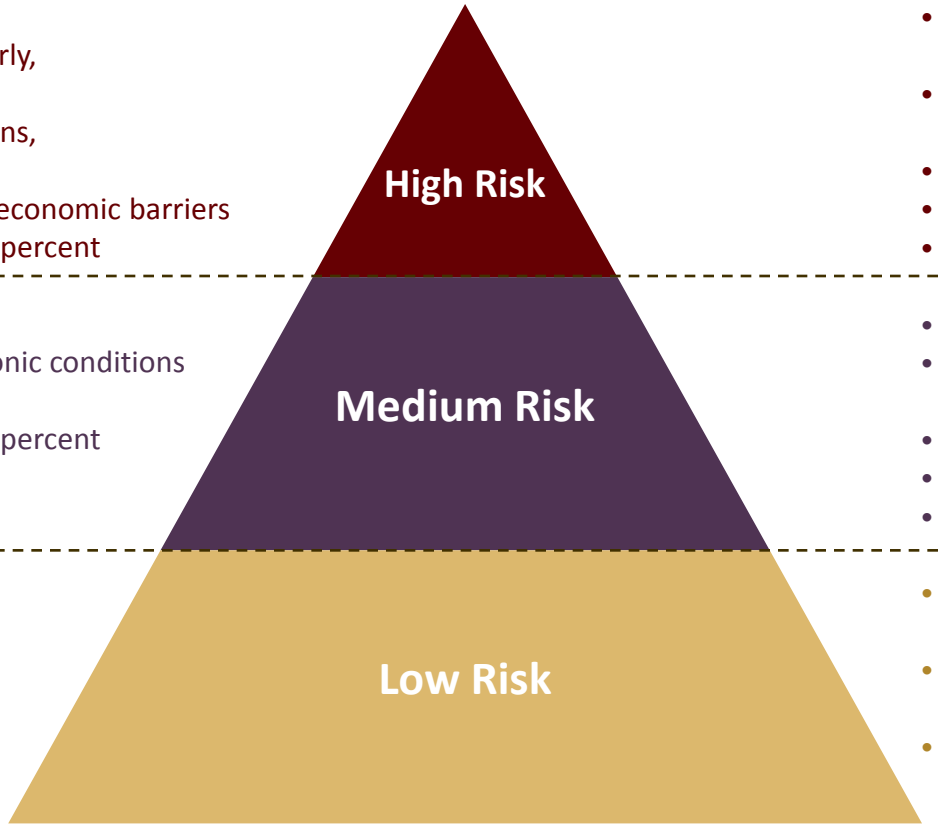
Team Based Care

Characteristics

High Risk
- Super-utilizers
- Poly-chronic, frail, elderly, urban poor
- Frequent hospitalizations, emergency visits
- Psychosocial and socioeconomic barriers
- Costs make up 45 – 50 percent

Medium Risk
- Limited and stable chronic conditions
- At risk for procedures
- Costs make up 30 – 40 percent

Low Risk
- Healthy
- Minor health issues
- Costs make up 10 – 20 percent



High-Impact Care Priorities

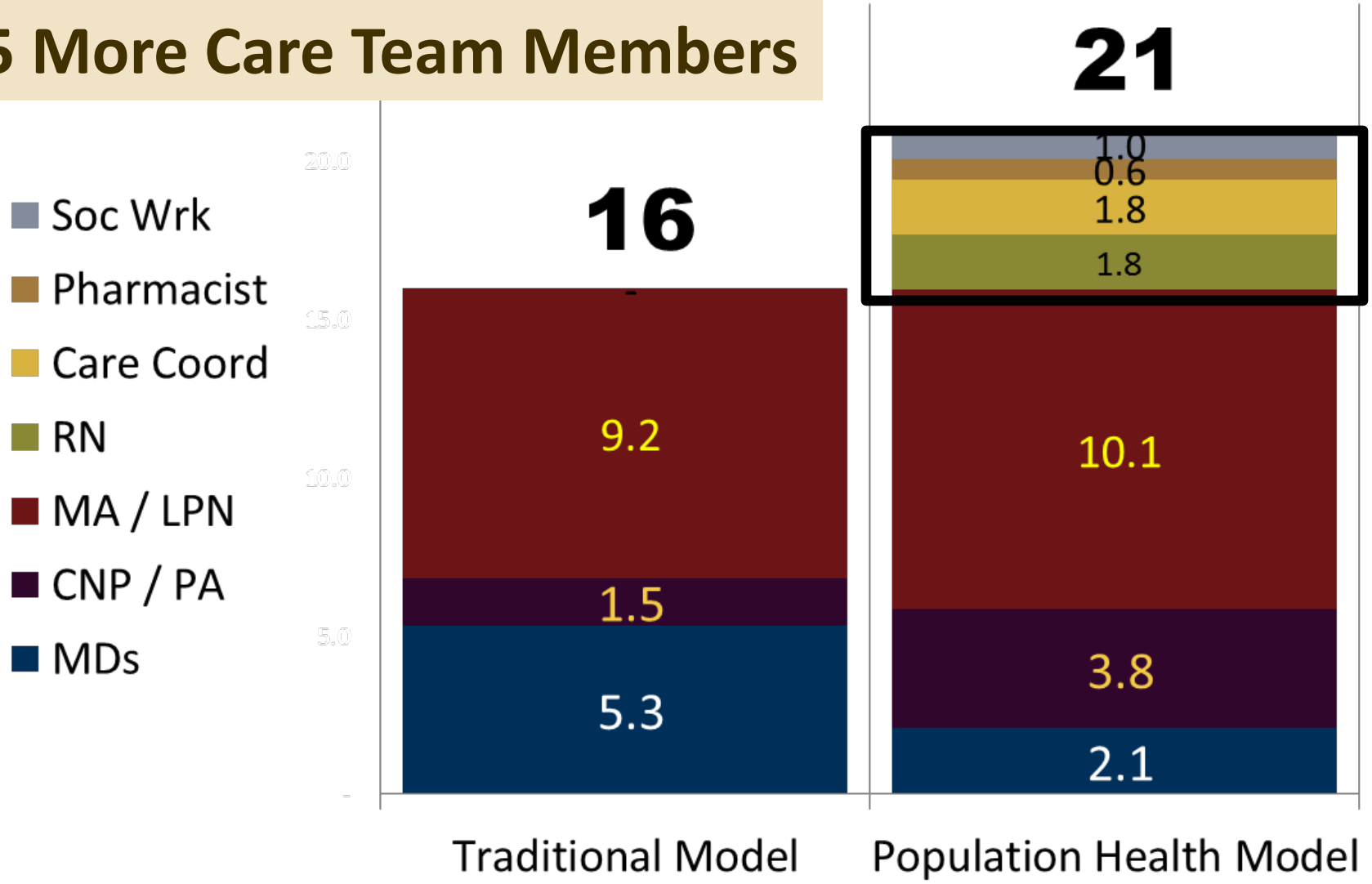
High Risk
- Care coordinators (RNs or social workers)
- Address psychosocial and non-clinical barriers
- Community resources navigation
- Intensive transition planning
- Frequent one-on-one interaction

Medium Risk
- Reduce practice variation
- Systematic care and evidence-base medicine
- Coordinated care
- Scalable care team
- Practice at top of license

Low Risk
- Focused coordination and prevention
- Movement toward virtual, mobile, anytime access
- Convenience

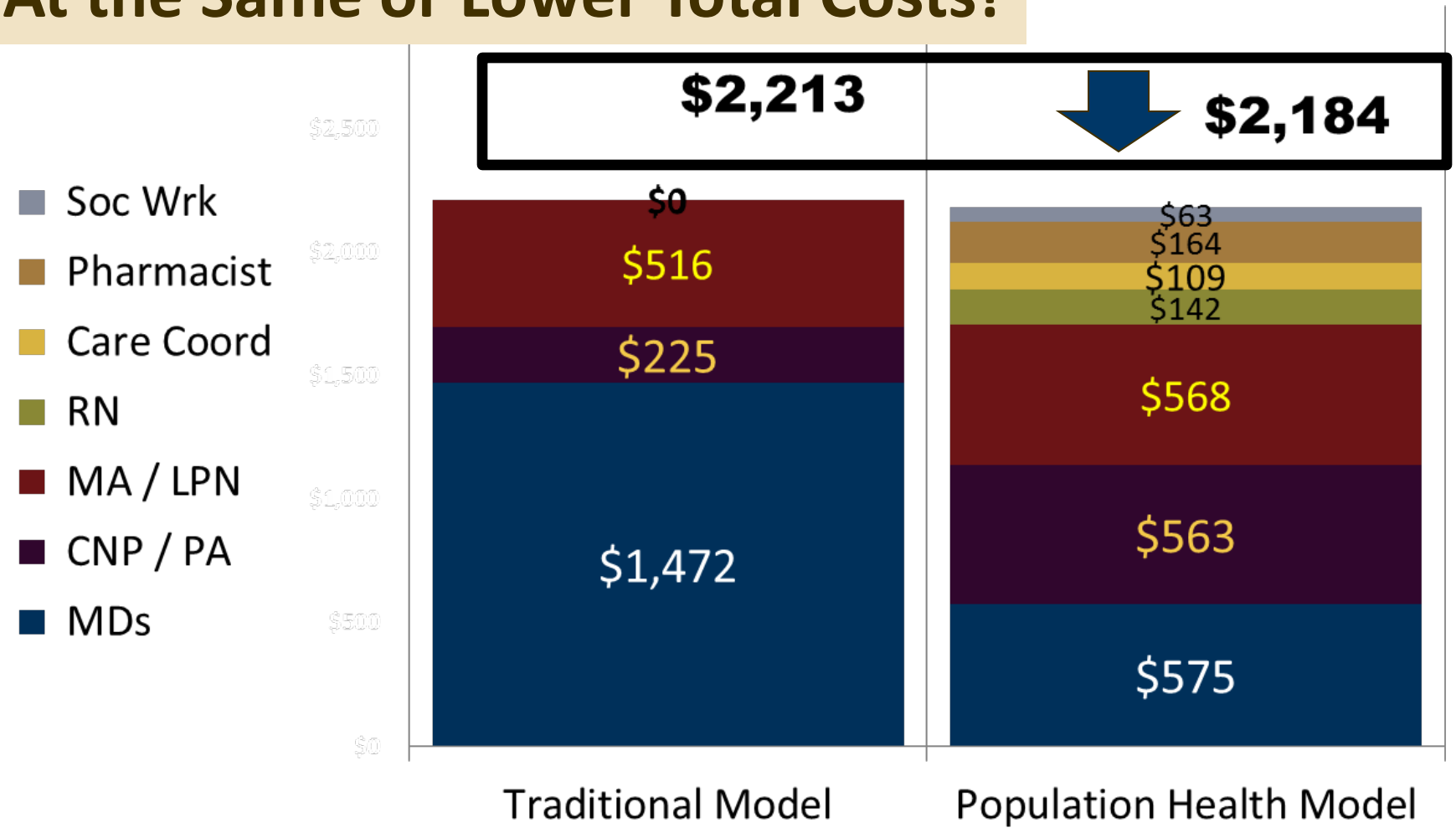
Care Teams
Traditional vs. Population Health

5 More Care Team Members

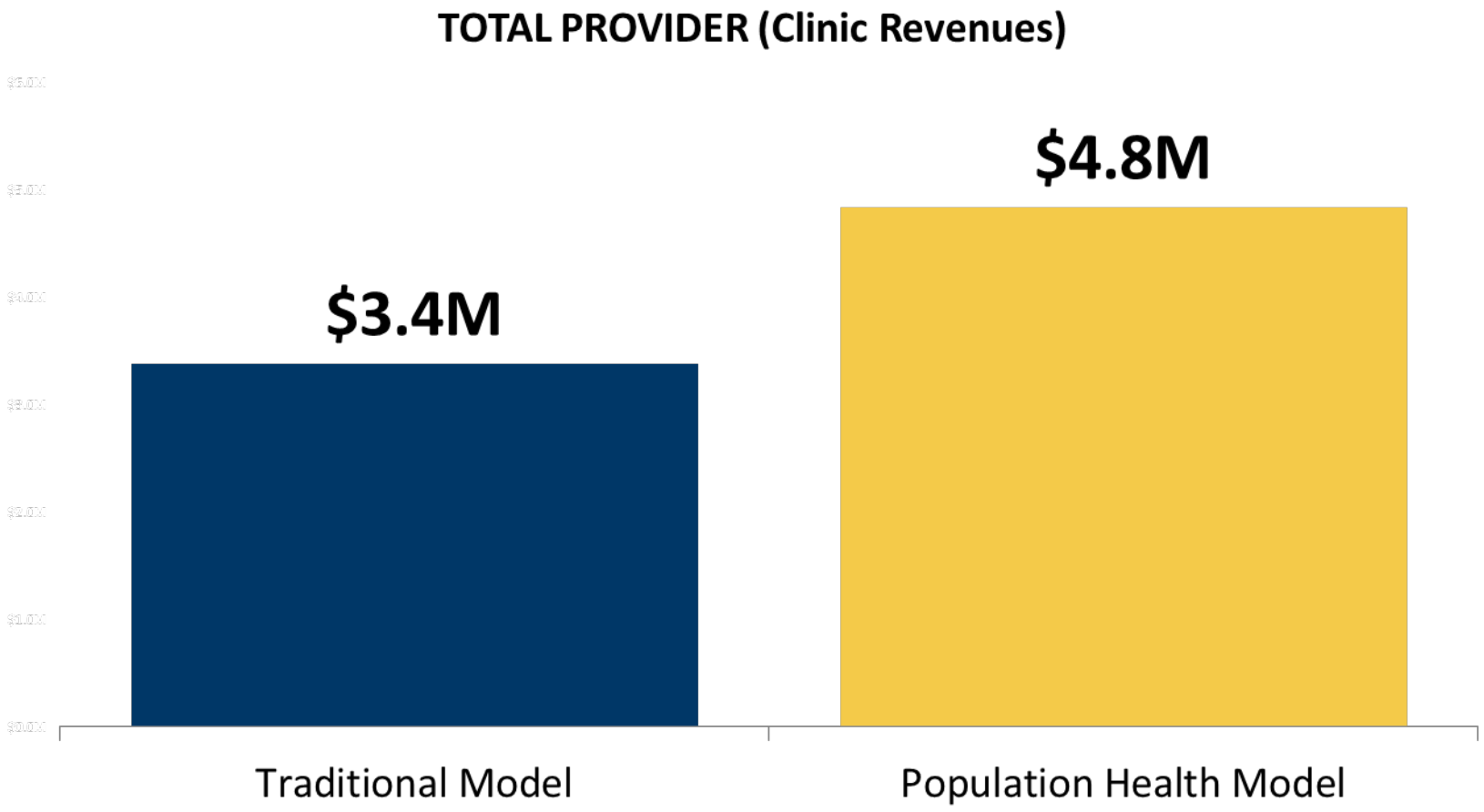


Care Teams
Traditional vs. Population Health

At the Same or Lower Total Costs!



Care Teams
Traditional vs. Population Health
Potential Provider (Clinic) Revenue



New Revenue Opportunities Emerging

Chronic Care Management – CPT 99490

Unique Patient Panel Size	2,000
Medicare Percentage	35%
Unique Medicare Patients	700
Est. Percent with Multiple Chronic Conditions	33%
Medicare Patients Potentially Eligible for CCM Reimbursement	231
Medicare Patients Potentially Eligible for CCM Reimbursement	231
CCM PFS Reimbursement Rate	$ 42.60
Est. Monthly Reimbursement	$ 9,841
Est. Annual Reimbursement	$118,092
Est. Hours/Month to Meet CCM Requirements	77

Care Teams Traditional vs. Population Health

The "Team-Based Care Model" requires a <u>NEW REVENUE MODEL</u>

PROVIDER (Clinic) REVENUES

	Current Model	Population Health Model	Population Health vs. Current
Production Based	3,047,439	2,842,603	(204,837)
Mid Level Reduction	(30,103)	(124,891)	(94,788)
Chronic Care Management	-	1,186,305	1,186,305
Gain Sharing - TCOC Models *	368,556	940,749	572,194
TOTAL PROVIDER (Clinic Revenues)	**3,385,892**	**4,844,766**	**1,458,874**

PLAN IMPACTS

	Current Model	Population Health Model	Population Health vs. Current
Overall TCOC Savings **	2,857,772	8,573,315	5,715,543
Less:			
Chronic Care Management	-	(1,186,305)	(1,186,305)
Gain Sharing - TCOC Models *	(368,556)	(940,749)	(572,194)
Total Plan Savings	**2,489,216**	**6,446,261**	**3,957,044**

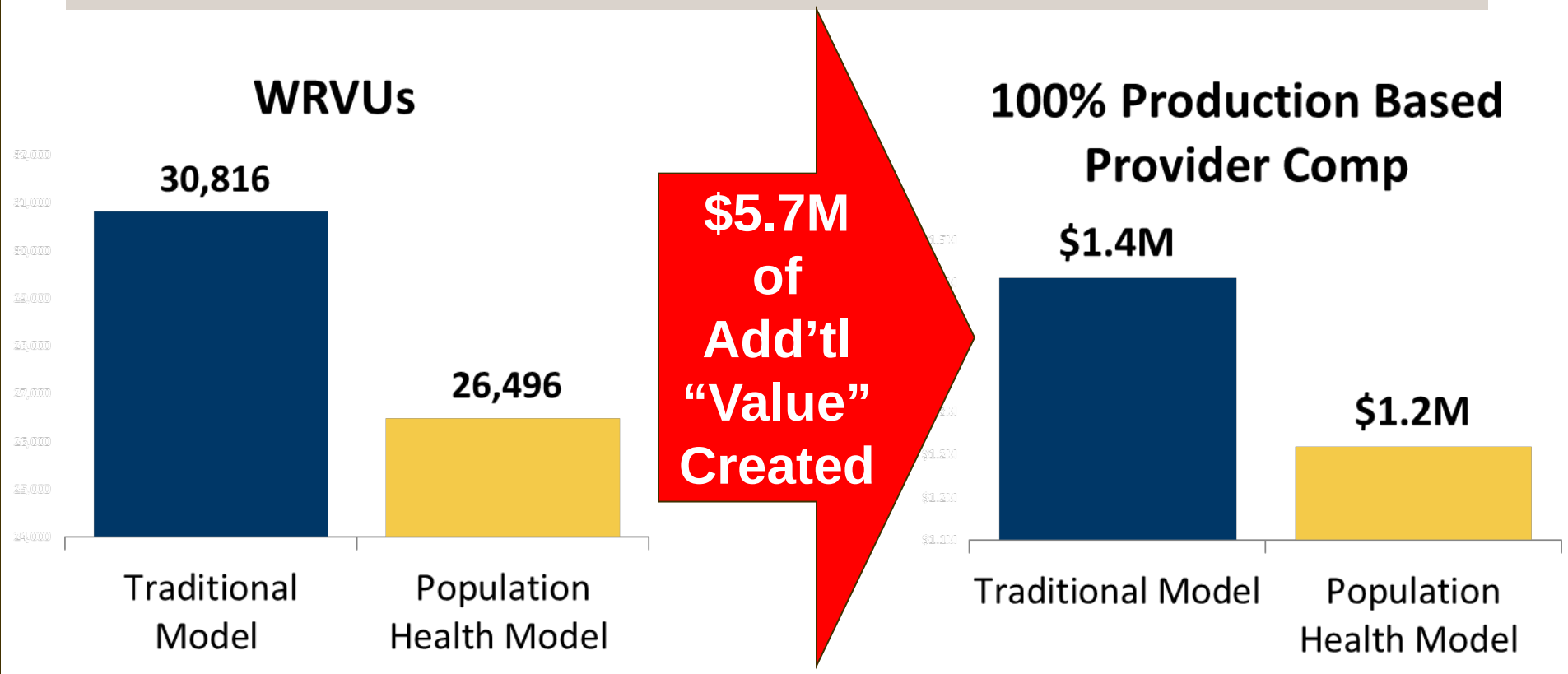
** - Net 15% of allowable gain sharing to Provider (Clinic)*

*** - Assumed Savings in Patients*

With Multiple Chronic Conditions	*-10%*	*-30%*
All Other Patients	*0%*	*0%*

Care Teams
Traditional vs. Population Health
Provider Production (WRVUs) and Compensation Considerations

Is your current production based Provider Comp model ready for this transition?



Care Teams Traditional vs. Population Health Spending and PMPM View

The "Team-Based Care Model" requires a <u>Different understanding of the economics!</u>

		Total Spend ($M)	Total Spend PMPM
Current Baseline		**$54.2M**	**$479.34**
Current Model	5.3		
Providers	MDs	$1.7M	$15.02
Rest of Care Team	6.8	$0.5M	$4.56
Total Care Team	Providers	$2.2M	$19.58
Care Team Model	2.1		
Providers	MDs	$1.1M	$10.07
Rest of Care Team	5.8	$1.0M	$9.26
Total Care Team	Providers	$2.2M	$19.33
Care Model Savings			
Current Model		-$2.9M	($25.29)
Care Team Model		-$8.6M	($75.87)
Pro Forma			
Current Model		$51.3M	$454.05
Care Team Model		$45.6M	$403.47

Schuh's Law

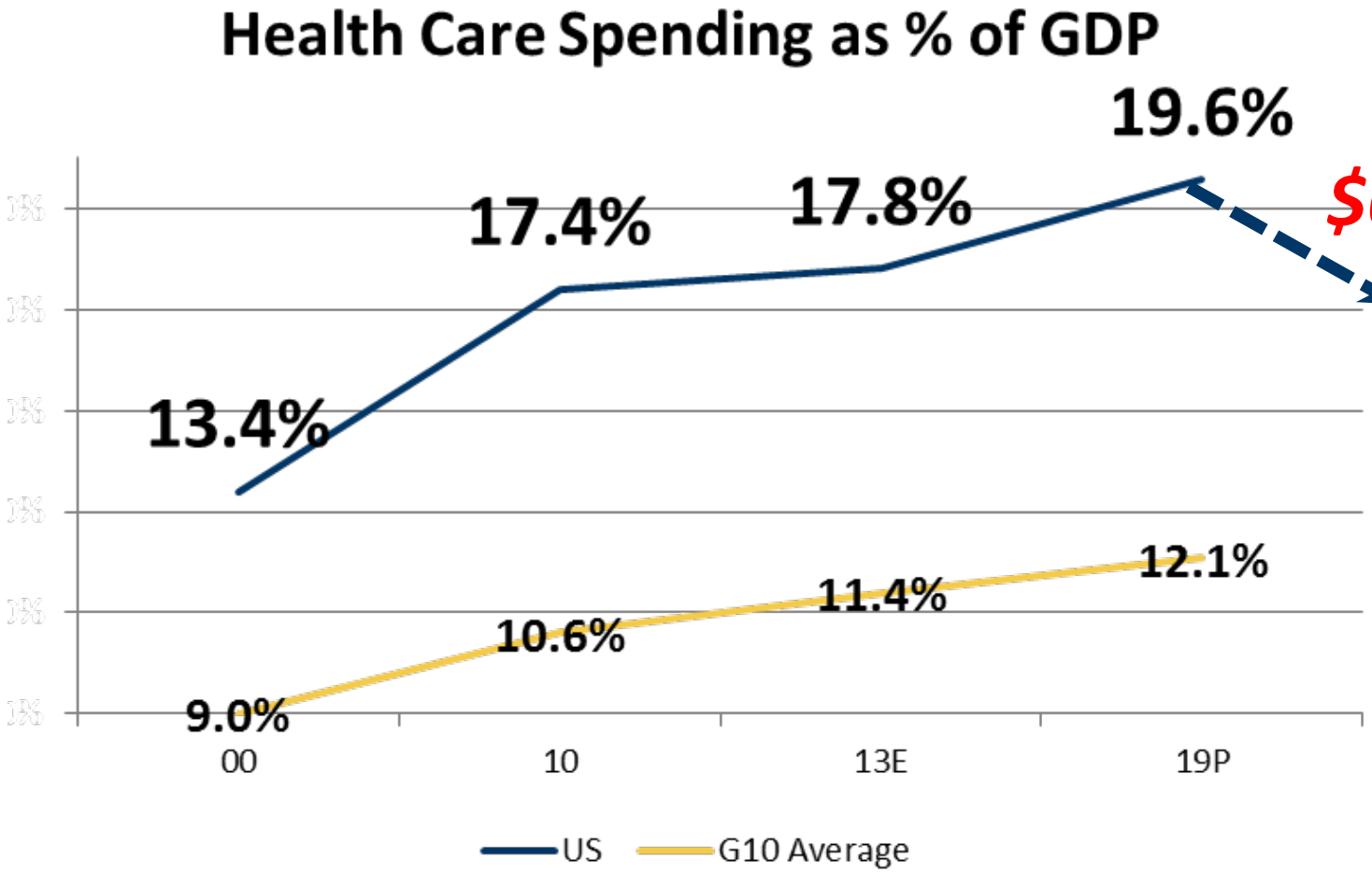
1. Continuing **Status Quo** growth in health care costs in **NOT FINANCIALLY SUSTAINABLE**

2. A properly executed transition to a population health based model is **GOOD BUSINESS**

Is the Status Quo A Better Business Model????

Status Quo (FFV) Model	Population Health Model
No Change in Resource Needs	Less Resources Needed (effectively)
No Changes in Contracts (other than lower rates!)	Significant Changes in Contracts (more/different risks)
A lot less FTEs trying to do the same thing we've always done	FTEs (likely less) doing different work
Volume Centric	Covered Life Centric

Impacting the Future of Health Care



$654 PMPM

17.0%

Our BHAG

$580 PMPM

Status Quo Business Model

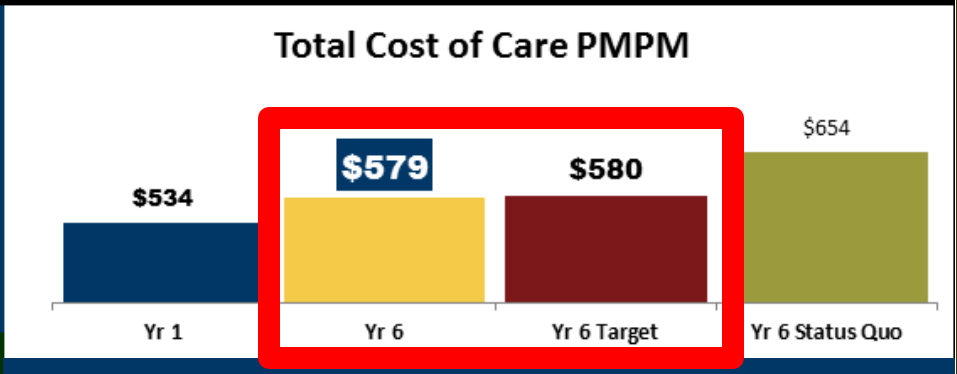
ECONOMICS OF TRANSITIONING TO POPULATION HEALTH ORGANIZATION CLA intuition®

KEY PERFORMANCE DRIVERS

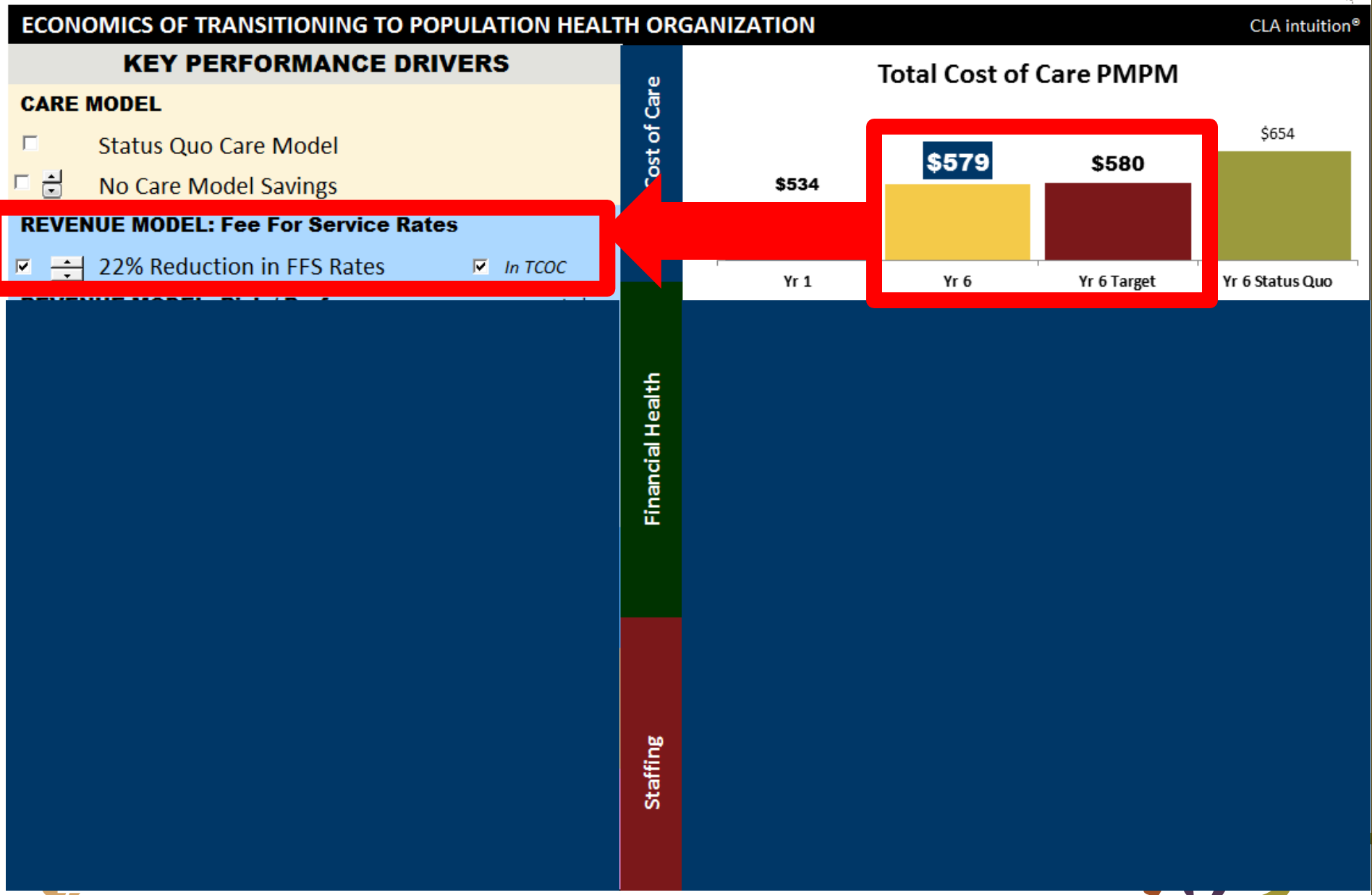
Tottal Cost of Care

Financial Health

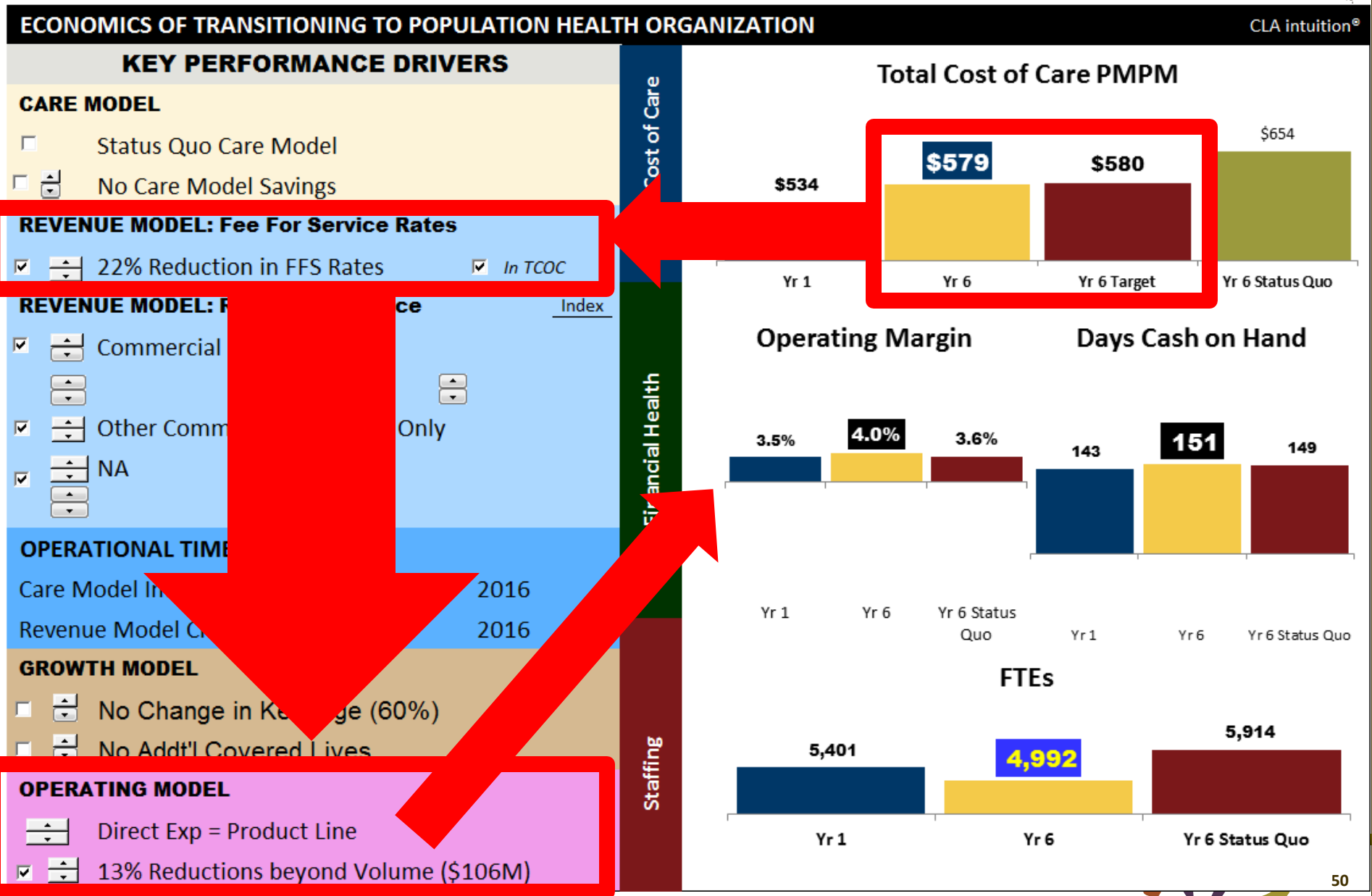
Staffing



Status Quo Business Model



Status Quo Business Model



Population Health Business Model

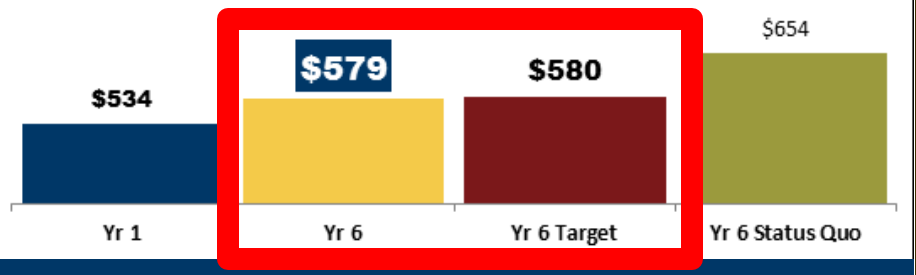
ECONOMICS OF TRANSITIONING TO POPULATION HEALTH ORGANIZATION CLA intuition®

KEY PERFORMANCE DRIVERS

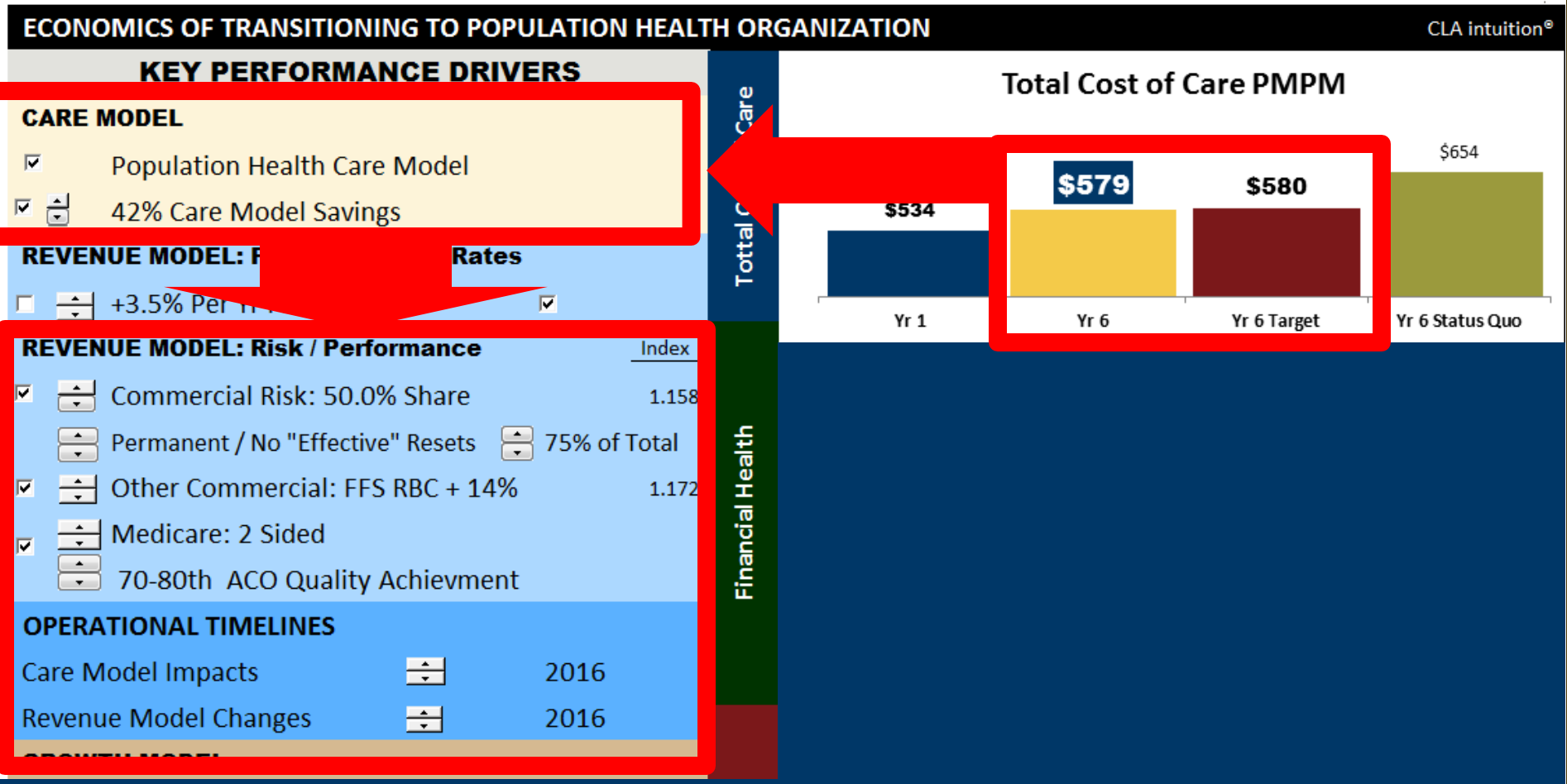
Tottal Cost of Care

Financial Health

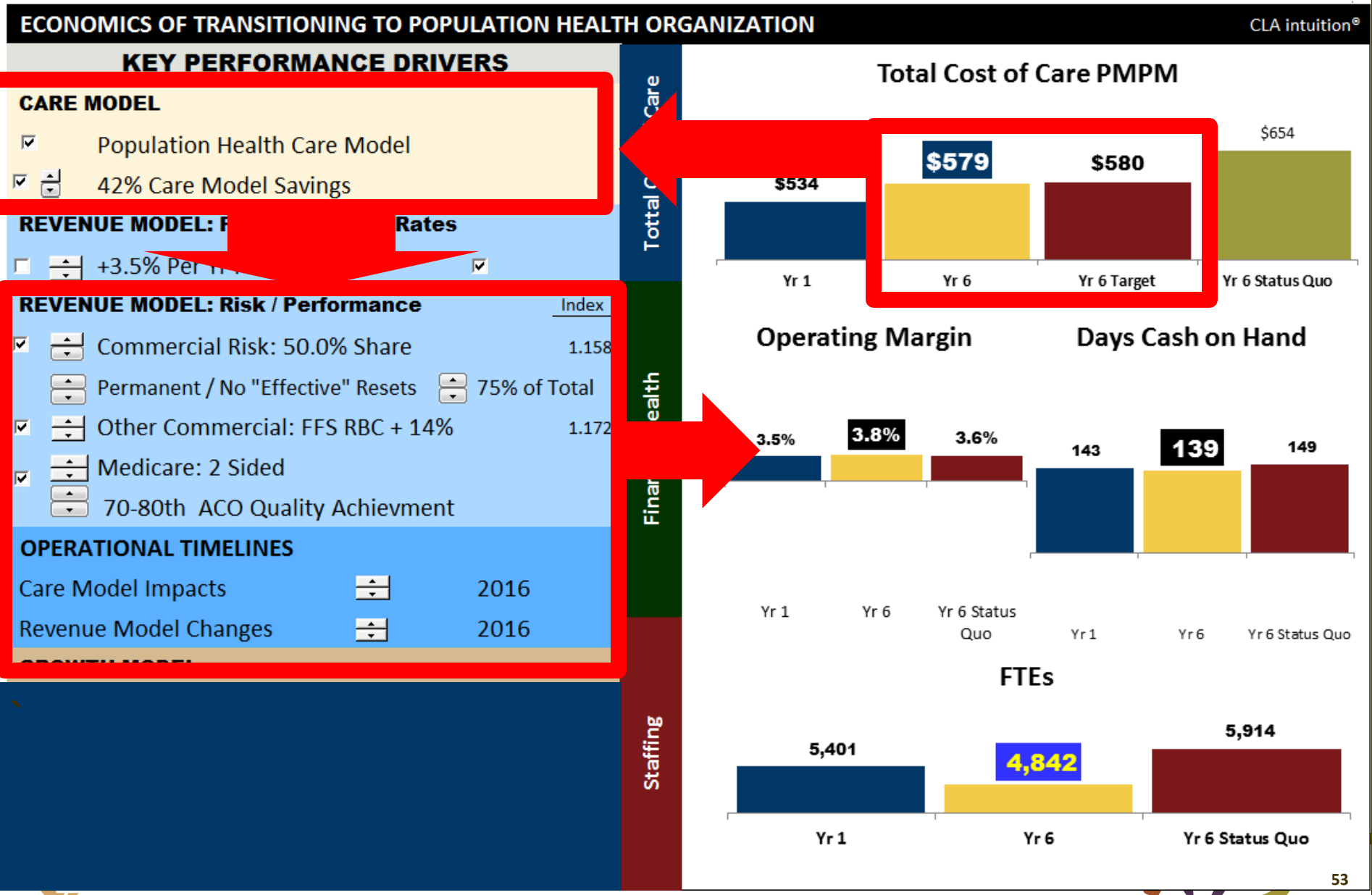
Staffing



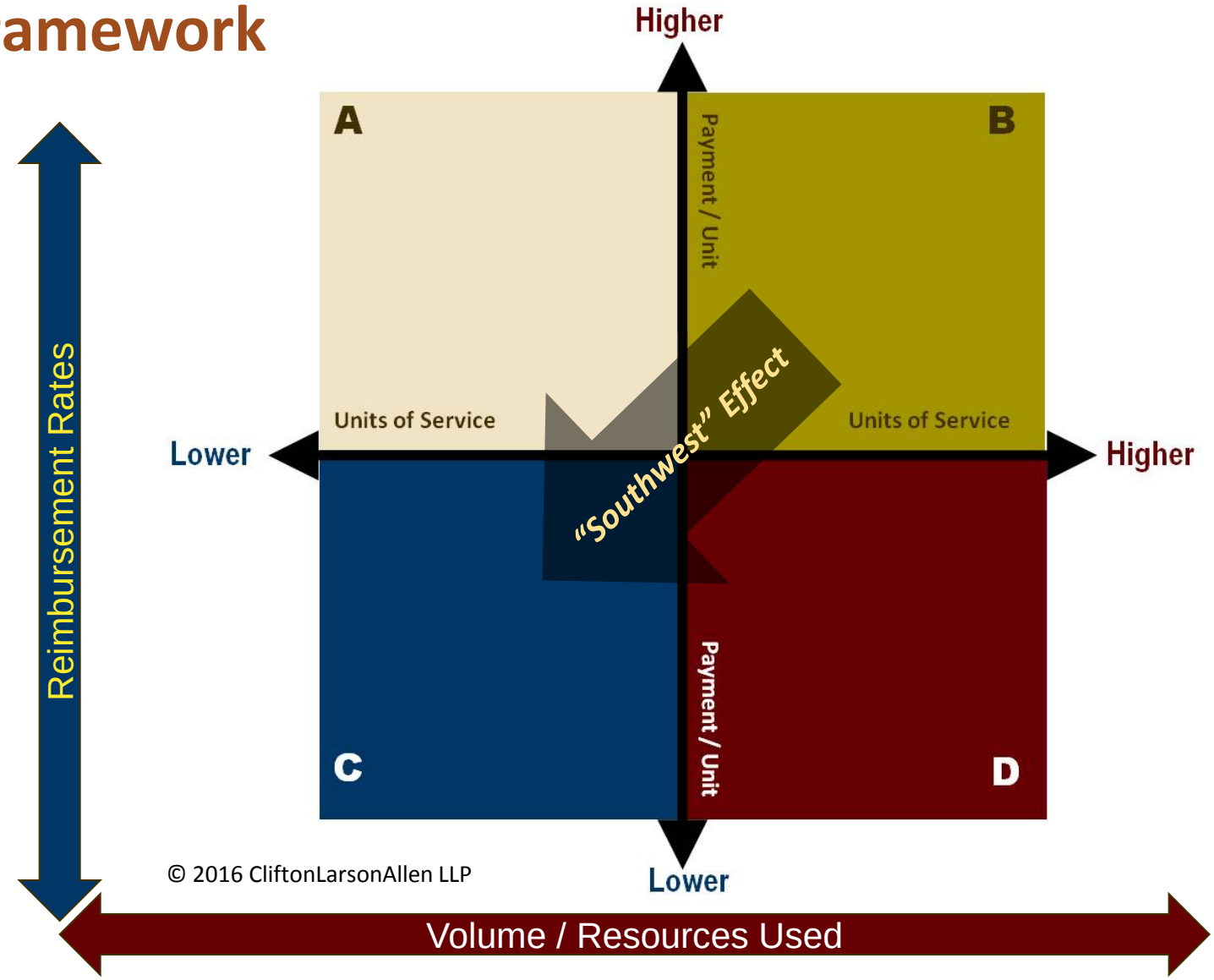
Population Health Business Model



Population Health Business Model



New Strategic Paradigm: Creating an Operating Framework

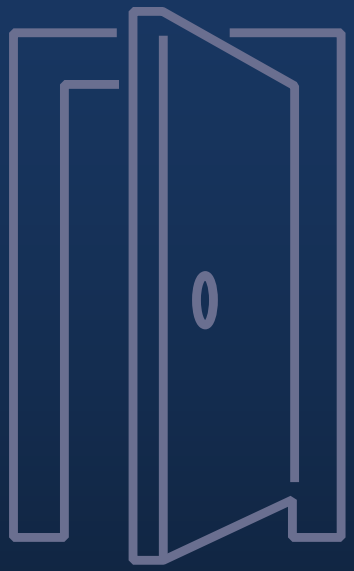


Major barriers to implementing Team-Based Models of Care

- MD population mismatched
  - Primary Care vs. Specialist
  - Urban vs. Rural
- Lacking true IT infrastructure and interoperability
  - Proprietary EMR, designed for episodic care, high cost
- Conflicting incentives and strategies as long as providers work simultaneously in FFS and Value-Based payment worlds
- Provider resistance

Questions / Discussion

Thank you



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