Where We’re Heading in Health Care

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Founder & Strategist
CHESS

(BlueCross BlueShield of Tennessee Inc., an Independent Licensee of the BlueCross BlueShield Association)
Mission:
To be your medical home

Vision:
To be the model for physician-led health care in America

Values:
As a physician owned and directed company, we are committed to ensuring that patient care is efficient, effective, equitable, patient centered, safe, and timely
Our Mission: 
To empower providers to make the transition to value-based medicine

Our Vision: 
To be the force across the nation that builds healthy communities by enabling coordinated and sustainable care

Our Values: 
Collaboration, Innovation, Fairness, Integrity
All health care talks seem to present the same three concepts:
1. The health care system is doomed!

![Graph showing national health expenditures per capita from 1960-2010](image1)

![Graph showing average annual health insurance premiums and worker contributions for family coverage from 2000-2010](image2)

![Graph showing national health spending per capita now equals 30% of median income](image3)
2. Doctors Are cats!
3. We should all play hockey like Wayne Gretzky!
But I don’t believe any of that…
The health care delivery system is going to get much better over the next ten years.
Doctors are going to help lead the transformation of health care.
As far as Gretzky goes… there are a lot of people playing hockey and trying to figure out where to skate…
That’s ok, but I’m not the least interested in where the puck is going to be…
Because we’re playing an entirely different game now.
The U.S. health care system is too expensive, wildly variable, with lower than desired quality and outcomes.
The unsustainability of the US health care system naturally leads to policy change because it represents one sixth of the entire US economy.
The New Alphabet Soup:

- ACO
- APM
- ARRA
- CIN
- HI-TECH
- MACRA
- MIPS
- MSSP
- MU
- PCMH
- PPACA
- PQRS
- SGR
January 26, 2015:

HHS Secretary Sylvia Burwell announced goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018.

April 16, 2015:

Obama signed SGR repeal with overwhelming bipartisan support that accelerated payment reform.
MACRA replaced the sustainable growth rate formula with physician payments tied to quality.

Source: http://leavittpartners.com/
MACRA may ultimately have a larger impact on how providers deliver care than the Affordable Care Act.

Source: http://leavittpartners.com/
All physicians will be paid based upon meeting new performance requirements.

Source: http://leavittpartners.com/
Merit-based incentive payment system will impact physicians who do not participate in Alternative Payment Models.
Participation in alternative payment models exempts physicians from MIPS.

<table>
<thead>
<tr>
<th></th>
<th><strong>MEDICARE-ONLY OPTION</strong></th>
<th><strong>ALL-PAYER OPTION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% OF PAYMENTS IN AN</td>
<td>% OF PAYMENTS IN AN</td>
</tr>
<tr>
<td></td>
<td>ELIGIBLE APM</td>
<td>ELIGIBLE APM</td>
</tr>
<tr>
<td>2019-2020*</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td>2021-2022*</td>
<td>50%</td>
<td>25% Medicare &amp; 50% All-payer</td>
</tr>
<tr>
<td>2023-2024*</td>
<td>75%</td>
<td>25% Medicare &amp; 75% All-payer</td>
</tr>
<tr>
<td>2025 onward</td>
<td>75%</td>
<td>25% Medicare &amp; 75% All-payer</td>
</tr>
</tbody>
</table>

* Under both options, providers receive a 5% bonus from 2019 until 2025.

Source: http://leavittpartners.com/
The approximate regulatory timeline for MACRA payment implementation is quite rapid from a policy point-of-view.

Source: http://leavittpartners.com/
Proposed Medicare Payment Model Change
2015 – 2018

Quality Based Payment Programs
• Hospital value-based purchasing
• Hospital readmission reduction
• Hospital-acquired condition reduction
• End-stage renal disease (ESRD)
• Quality incentives
• Value-based modifier

Alternative Payment Programs
• Pioneer ACO
• MSSP
• Bundled Payments for Care Improvement
• Comprehensive Primary Care Initiative
• PCMH
• Comprehensive end stage renal disease
• Medicare/Medicaid financial alignment

- All Medicare Payments
- Percentage of payments linked to quality programs
- Percentage of payments linked to alternative programs

Revised from Robert Nesse, MD; AMGA 2016
## Medicare Bonus & Penalties SRP to MIPS 2016 – 2020

<table>
<thead>
<tr>
<th>Bonus &amp; Penalties</th>
<th>2016</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>-2%</td>
<td>-4% to +4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS*</td>
<td>-2%</td>
<td>-2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value Modifier**</td>
<td>-2% to +2%</td>
<td>-4% to +4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIPs***</td>
<td></td>
<td>-4% to +4%</td>
<td>-5% to +5%</td>
<td>-9% to +9%</td>
<td></td>
</tr>
<tr>
<td>Alternate Payment Model 2019-2024</td>
<td></td>
<td></td>
<td>5% based on prior year CMS expenditure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Physician Quality Reporting System – CMS quality and safety measures  
** Value Based Modifier Measures – CMS resource use and efficiency measures  
*** Medicare Incentive Payment System – Planned consolidation of meaningful use, PQRS, and VBM measures  

(Exceptional performance bonus of +10% proposed)

Revised from Robert Nesse, MD; AMGA 2016
Value-based payment models operate on a continuum of provider accountability and integration.

Modular set of payment models align with a care providers’ risk readiness

- Fee-for-Service
- Primary Care Incentives
- Performance-Based Contracts
- Bundled/Episode Payments
- Performance-Based Programs
- Shared Savings
- Shared Risk
- Capitation + PBC

Degree of provider integration and accountability
Innovation changes how services are delivered.
All businesses have the same strategic choices:

- Status Quo
- Sell
- Collaborate
- Innovate
- Transform
We should aspire to achieve the Triple Aim.

- Improve the patient experience
- Reduce the cost of care
- Improve population health
Transformation requires comprehensive changes to our business models.

<table>
<thead>
<tr>
<th>Reimbursement</th>
<th>Volume Based</th>
<th>Value Based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• FFS/DRGs</td>
<td>• Outcomes &amp; Quality Based</td>
</tr>
<tr>
<td></td>
<td>• No payment for readmits, never events, etc.</td>
<td>• Global Payments</td>
</tr>
<tr>
<td>Organizational Model</td>
<td>• Departmental</td>
<td>• Populations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Focused Factories</td>
</tr>
<tr>
<td>Value Drivers</td>
<td>• Volume</td>
<td>• Quality and Low Variability</td>
</tr>
<tr>
<td></td>
<td>• Efficiency (on a procedure level)</td>
<td>• Efficiency (on a population level)</td>
</tr>
<tr>
<td>Profit Pools</td>
<td>• Visits</td>
<td>• Wellness and Prevention</td>
</tr>
<tr>
<td></td>
<td>• Surgery/Procedures</td>
<td>• Population Management</td>
</tr>
<tr>
<td></td>
<td>• Outpatient Ancillary</td>
<td>• Chronic Condition Management</td>
</tr>
<tr>
<td>Investments</td>
<td>• Capacity</td>
<td>• Health IT</td>
</tr>
<tr>
<td></td>
<td>• Revenue-Producing Assets</td>
<td>• Clinical Integration</td>
</tr>
<tr>
<td></td>
<td>• Patient Referrals</td>
<td>• Commercialization</td>
</tr>
</tbody>
</table>
Opportunities for cost reduction and quality improvement require realignment of the health care ecosystem into a new value chain.
A new ecosystem of disruptive business models will arise.
One disruptive business model is the Accountable Care Organization:

And ACO is a group of health care providers who voluntarily come together to provide coordinated high-quality care to populations of patients.
Accountable Care Organizations are transitional business models in the move to Population Health Management.
The number of ACOs by state varies substantially.
January 2015

Source: http://leavittpartners.com/
But the growth of ACOs over time continues to accelerate…

Source: http://leavittpartners.com/
...as does the portion of the US population being cared for in ACOs.

Source: http://leavittpartners.com/
MACRA has increased the predicted rate of growth of ACOs
CMS announced in January 2016:
New hospitals and health care providers join successful, cutting-edge federal initiative that cuts costs and puts patients at the center of their care.
Population health management is a different business.

<table>
<thead>
<tr>
<th></th>
<th>Fee-for-Service Business</th>
<th>Population Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Customer</strong></td>
<td>People who are admitted (or use outpatient services)</td>
<td>Everyone who pays for coverage or is enrolled in a plan/program*</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td>Paid per unit of service</td>
<td>Monthly fixed amount</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td>Primarily labor and facilities</td>
<td>Healthcare services</td>
</tr>
<tr>
<td><strong>Data Systems</strong></td>
<td>Cost accounting and billing</td>
<td>Predictive models and care management</td>
</tr>
<tr>
<td><strong>Key to Success</strong></td>
<td>Keep occupancy high and expenses low</td>
<td>Increase management and monitoring to reduce unnecessary care</td>
</tr>
</tbody>
</table>

*Note: There is a movement to define the population as everyone who lives in a region regardless of payer class. The definition included in this table and for the purposes of this white paper is relevant for current population health management.
New competencies are required to support the population health management business.

- Care Coordination
- Clinical Performance Management
- Effectiveness Analysis
- Financial and Clinical Risk Management
- Patient Engagement
- Patient Safety
- Physician Development and Training
- Smart Care Teams
- Value-Based Contracting
Interventions work…but it may take time.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expected Impact</th>
<th>Time to Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transitions of care management</strong></td>
<td>Reduce readmissions</td>
<td>3 months</td>
</tr>
<tr>
<td><strong>Case management for high-risk patients with targeted conditions:</strong></td>
<td>Reduce primary admissions and ED</td>
<td>3–6 months</td>
</tr>
<tr>
<td>diabetes, heart failure, COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case management for other high-risk patients</strong></td>
<td>Reduce primary admissions and ED</td>
<td>6–12 months</td>
</tr>
<tr>
<td><strong>Pharmacy management</strong></td>
<td>Increase generic use</td>
<td>6–12 months</td>
</tr>
<tr>
<td><strong>Nursing home management</strong></td>
<td>Reduce readmissions/primary admissions</td>
<td>12–18 months</td>
</tr>
<tr>
<td><strong>More efficient specialists and ancillary providers</strong></td>
<td>Decrease cost per episode of care</td>
<td>12–18 months</td>
</tr>
<tr>
<td><strong>High-end imaging</strong></td>
<td>Reduce unnecessary testing</td>
<td>12–18 months</td>
</tr>
<tr>
<td><strong>Interventions for low-risk chronic disease patients:</strong></td>
<td>Improved control; avoid complications</td>
<td>2–5 years</td>
</tr>
<tr>
<td>disease registries, chronic disease care optimization</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care; screening; lifestyle change; wellness</strong></td>
<td>Earlier identification and treatment; decrease incidence of chronic diseases</td>
<td>2–5+ years</td>
</tr>
</tbody>
</table>

*Source: Geisinger*
Models of care must be designed around the patient’s needs, not the tyranny of the 15 minutes office visit.

<table>
<thead>
<tr>
<th>Healthy and Independent</th>
<th>Health Risk Factors</th>
<th>Early Stage Chronic Disease</th>
<th>Complex Conditions</th>
<th>Late-stage or poly-chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>No chronic conditions and free of key risk factors</td>
<td>No major conditions with one or more risk factors</td>
<td>Chronic condition that is well-controlled and now substantially progressed</td>
<td>Systematic or otherwise complex condition</td>
<td>One or more chronic conditions that are uncontrolled or advanced</td>
</tr>
<tr>
<td>Normal weight Non-smoker</td>
<td>High cholesterol High blood pressure Smoker</td>
<td>Diabetes Asthma Coronary artery disease</td>
<td>Cancer Multiple sclerosis Cystic fibrosis</td>
<td>Congestive heart failure End-stage renal disease</td>
</tr>
</tbody>
</table>
Team based care model redesign is crucial...

...and it requires reorganization of the health care work force into SMART CARE TEAMS.
Smart care teams are integrated across the continuum of care.

- Community Workers
- Dieticians/Nutritionists
- Extensivists
- Faith-based community
- Health Coaches
- Health Navigators
- Licensed Social Workers
- Patient Care Advocates
- Pharmacists
- Primary Care Providers
- Psychologists
- Specialists
Next generation PHMs will thrive on complex adaptive systems that are highly-tailored to particular segments of the population.

**Severe behavioral**
- Dedicated psychiatric NPs/MDs
- Bio-monitoring of Rx adherence
- Dedicated social worker and PCP
- Etc.

**Chronic with social needs**
- Case worker embedded in care team
- Dedicated coach focused on nutritional and mental health needs
- Etc.

**Generally healthy**
- Affordable acute care options
- Rewards and incentives
- Social/mobile health tracking tools
- Etc.

**End of life**
- Palliative care experts
- Support for caregivers
- Hospice centers
- Legal/financial advisers for family
- Etc.

**Poly-chronic/complex**
- Dedicated “Extensivists”
- Remote monitoring
- Specialty clinics
- Integrated behavioral health
- Etc.

**Early chronic/at-risk**
- Dedicated health coach focused on fitness, nutrition
- Attention to behavioral health
- Rewards for meeting health goals
- Etc.

Specialized care models will be supported by new population-specific ecosystems.
Cornerstone’s Population Health Journey:

**January**
- Westchester Building built
- Extended and weekend hours now offered

**January**
- Premier Building built
- NCQA Medical Home designations

**December**
- Cornerstone Health Care, PA formed
- CHC on EMR

**January**
- CHC & Oliver Wyman Redesign
- Care Pathway Redesign
- Optum & Teradata Tech partners
- VBR: Negotiating Contracts

**March**
- Personalized Cardiac Care Program launched

**April**
- Personalized Cancer Care w/ embedded Primary Care launched

**June**
- CHC opens its first practice in Hickory

**July**
- MSSP ACO Personalized Primary Care Program launched

**January**
- 13 CHC practices earn 2011 PCMH Recognition
- COPD Model Launched

**March**
- FastMed partnership

**April**
- Cornerstone Convenience Care opened at Westchester building

**July**
- Shareholders approve Cornerstone Compact

**December**
- Gainshares paid out
- Catawba Valley Medical Center signs contract with CHESS
- Received highest quality score in NC & ranked 6th in the nation on quality

**January**
- Value-based compensation formula implemented

**February**
- Care Outreach & Life Care Clinics launched
- Transitions of Care implemented
- Launch of CHESS

**October**
- Shareholders vote to move to PFV

**January**
- Rite Aid Alliance
- Labcorp Partnership
- Strategic Partnership with WFBMC & CHESS

**January**
- CMS NextGen ACO participant

**January**
- CHC goes full-risk
- CHESS MSSP ACO
- CHESS Select
- Lightbeam launch
- Nephrology Medical Home Launched
- Touchcare telemedicine begins

**October**
- AMGA Acclaim Award Winner
Cornerstone MSSP Results
Population health management requires three changes…
...patient care model redesign...
...infrastructure redesign...
...and payment system redesign.
Here’s what we need to do together:

• **Commit to partnership that drives value further faster**
  - Reduce clinical variation
  - Reduce costs for all involved
  - Strong focus on consumerism

• **Build culture**
  - Transparency, team work, trust, solution-focused

• **Evolve economics and associated business models**

• **Learn together**
  - Predictive analytics and micro-segmentation
  - Match clinical models and interventions
But we are just at the starting line...
Three transformational waves are reshaping the health marketplace

**WAVE 1**
**PATIENT-CENTERED CARE**
2010-2016

**FROM**
- Physician-centered
- Transactional, isolating
- Sick-care
- Inaccessible
- Patient turnover-volume
- Unwarranted variation

**TO**
- Patient-focused
- Care team managed
- Convenient and 24/7
- Patient health-value
- Evidence-based standard

**WAVE 2**
**CONSUMER ENGAGEMENT**
2014-2020

**FROM**
- Uninformed
- Limited engagement
- Isolated individual
- Limited consequence
- Bricks, office hours
- Physician opinion

**TO**
- Informed, shared decisions
- Highly engaged/empowered
- Socially connected
- Financial rewards/incentives
- Virtual, mobile, anytime
- Informed shared decisions

**WAVE 3**
**SCIENCE OF PREVENTION**
2018-2025

**FROM**
- Basic health management
- Symptom treatment
- One-size-fits-all
- Limited biomarkers
- Big pharmaceuticals
- Medical competencies

**TO**
- Genome-linked life plan
- Monitoring and prevention
- Personalized therapies
- 100% accurate diagnostics
- Tailored gene/microbiome therapies
- Life, social, and ethics competencies
Questions?