BRIDGING HEALTHCARE AND COMMUNITY

The Evolving Payment, Policy & Public Health Pathways to Value

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NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

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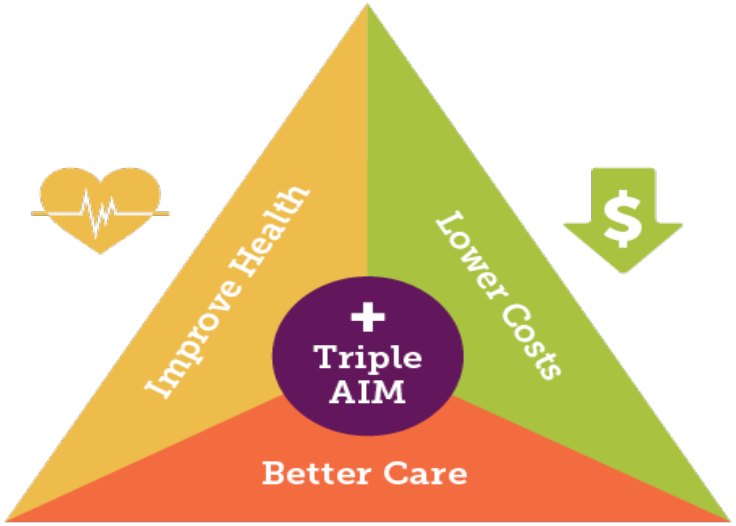
Overview

- Why a Community-Clinical Linkage Model is Critical
- What's Advancing this Model? The Intersection of Payment and Policy
- How is the Community-Clinical Linkage Model Working?

Key Terms

- Triple Aim



- Community-Clinical Linkages
- Community Sector
- Clinical Sector

Why a Community-Clinical Linkage Model is Critical

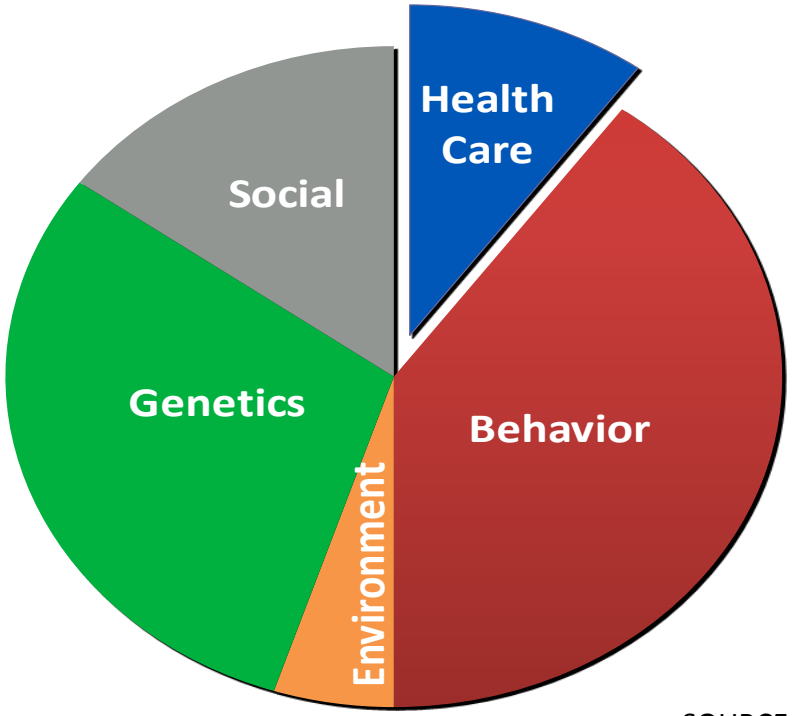
- Epidemiological trends
- Financial trends
- Cultural trends
- Payment and Policy trends

Epidemiological Trends

- Determinants of Health
- Social Determinants of Health
- Burden of Chronic Diseases
- Health Disparity Gaps
- Aging Baby Boomers

Epidemiological Trends

Determinants of Health



SOURCE: Adapted from McGinnis, 2002

Epidemiological Trends

Social Determinants of Health

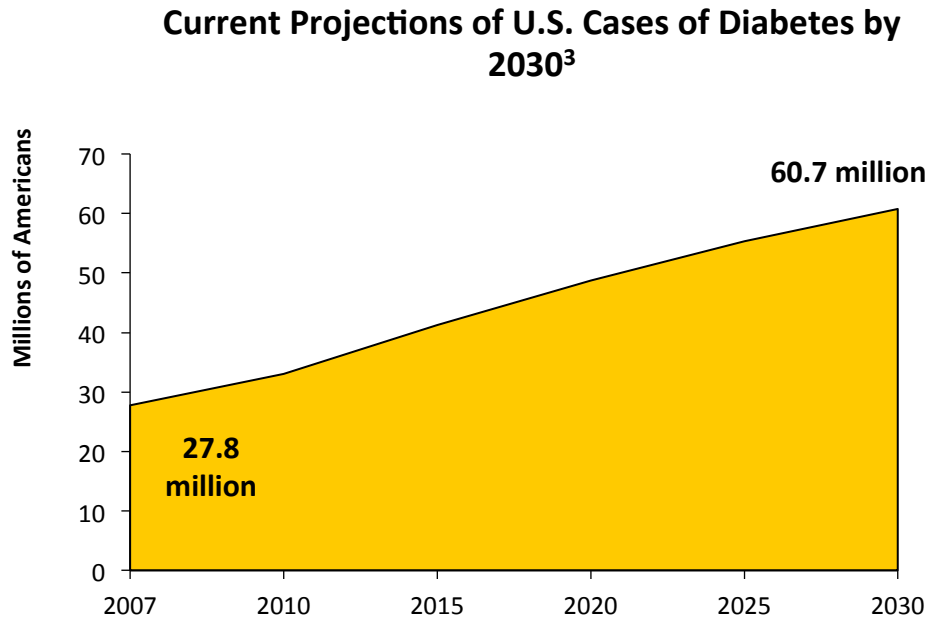
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

The Henry J. Kaiser Family Foundation

Epidemiological Trends

The Burden of Chronic Diseases

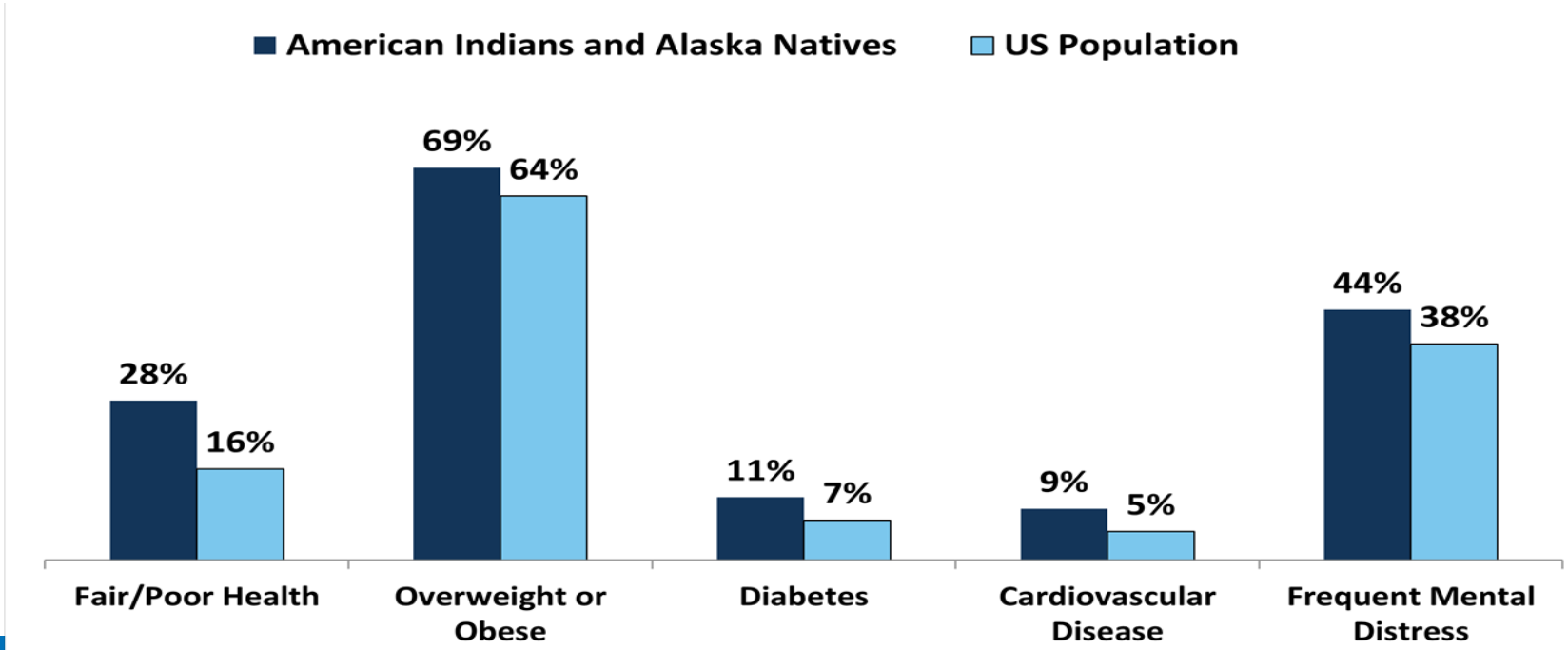


Epidemiological Trends

- *30 million Americans have diabetes*
- *84 million Americans have prediabetes*
- *9 out of 10 adults with prediabetes don't know they have it*

Epidemiological Trends

Health Disparity Gaps Persist

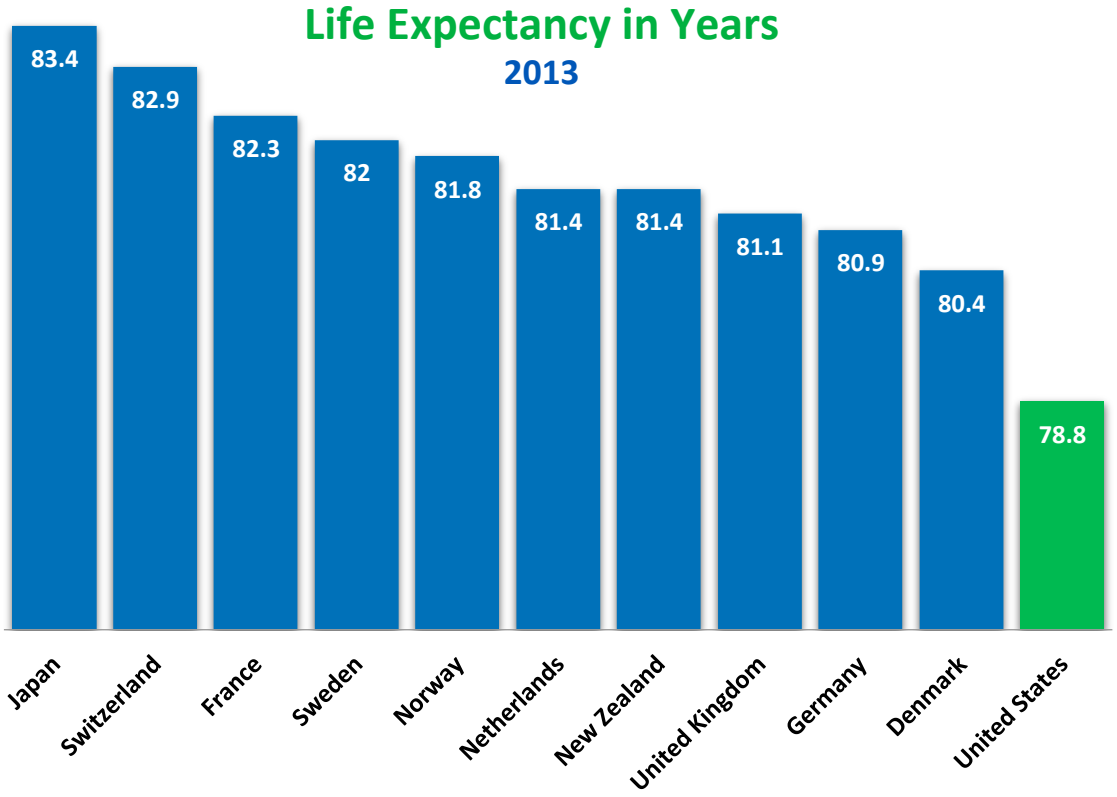


American Indian and Alaska Native includes people of Hispanic origin. Includes nonelderly adults 18-64. All measures for AIANs significantly different from the U.S. population at p<.05.
SOURCE: Kaiser Family Foundation Analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011.

THE HENRY J. KAISER FAMILY FOUNDATION

Epidemiological Trends

Health Disparity Gaps



Epidemiological Trends

The Silver Tsunami

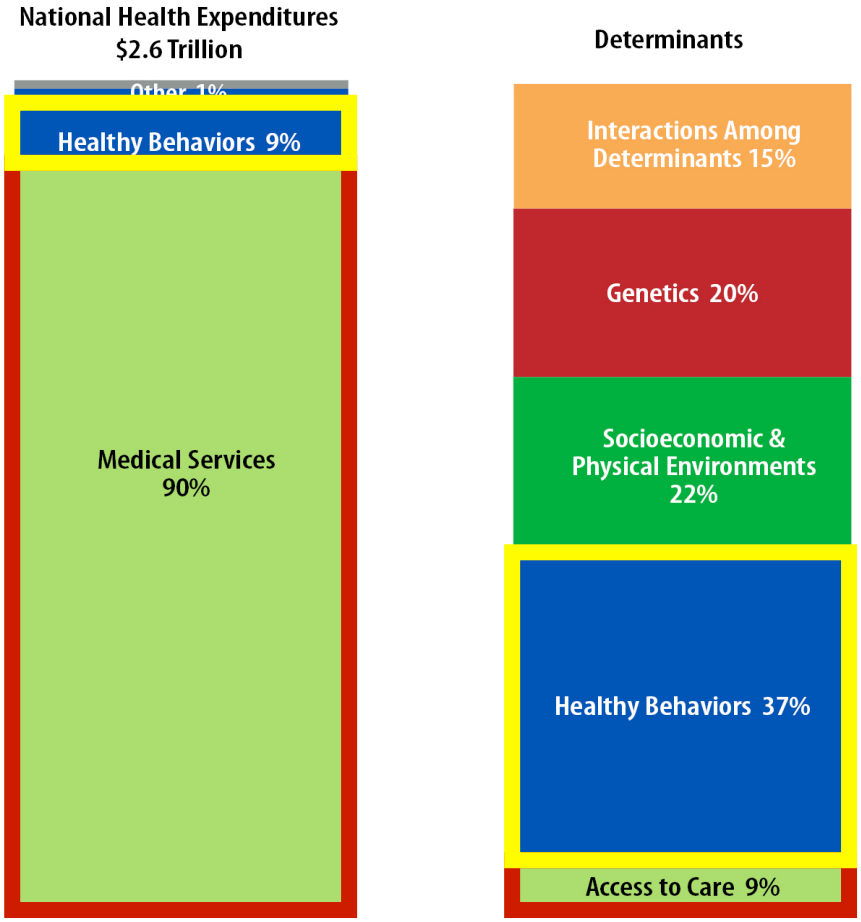
By 2050 America's senior population will nearly double to 83.7 million

Financial Trends

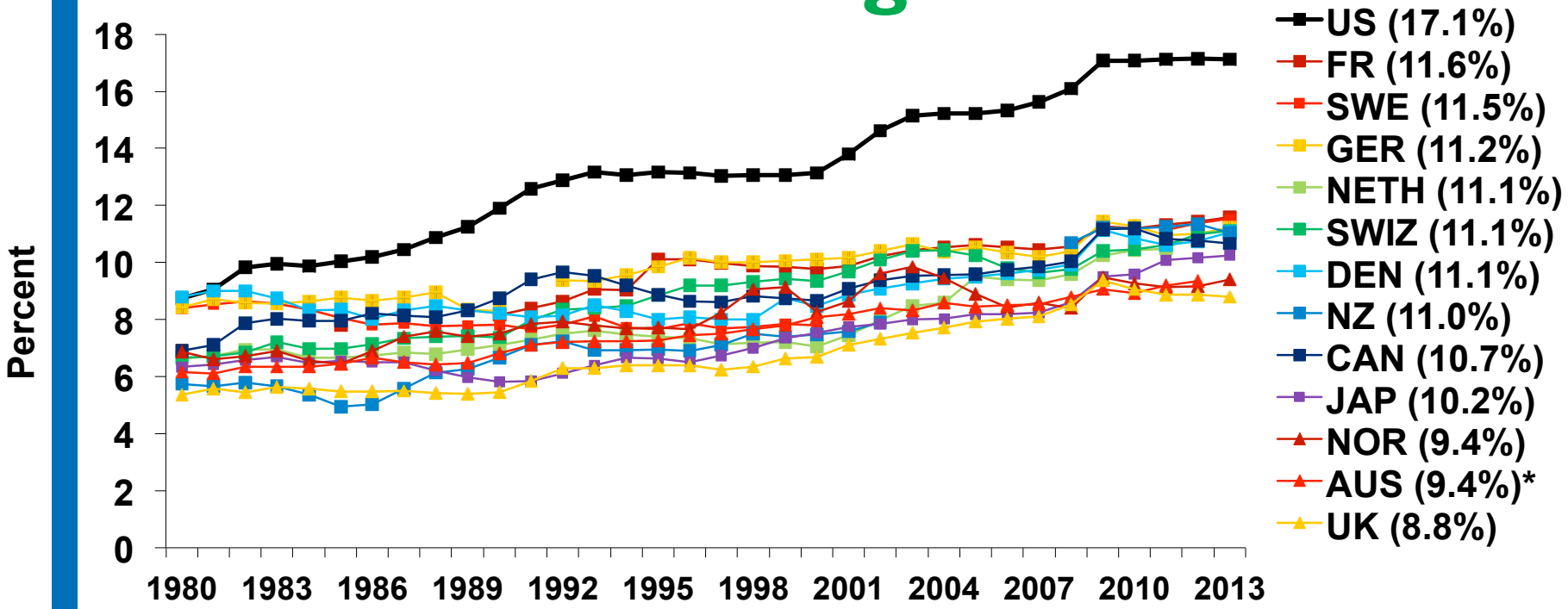
- Cost of health care and chronic disease is not sustainable
- Mismatch between the drivers of health and health care spending
- The US is the highest spender on health care

Cost of Chronic Diseases

The Spending Mismatch



Health Care Spending as a Percentage of GDP



Cultural Trends

- Health and wellness continue to be a priority where Americans live, work, play and pray
- Social networking innovations in health
- Mobile/wireless technology

The Intersection of Payment and Policy

Alternative Payment Model (APM) Framework

Category	Description
Category 1	FFS with no link of payment to quality: payments based on volume
Category 2 VBM	FFS with a link of payment to quality: a portion of payment varies based on established quality or efficiency criteria
Category 3 APM	APM built on FFS architecture: delivery of service remains payment trigger but includes risk components
Category 4 APM	Population-based payment: clinicians/organizations are paid and held accountable for care of an individual for defined period of time (e.g. 12 months)

Quality Payment Program (MACRA Legislation)

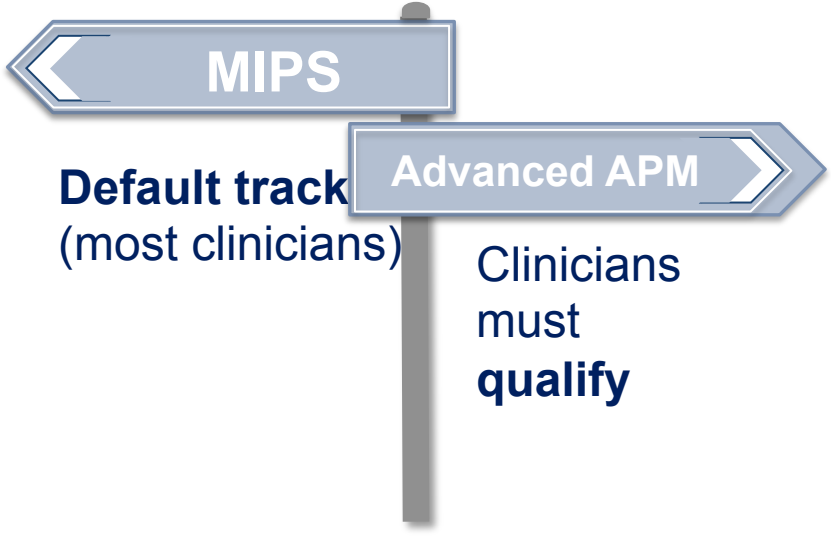
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan legislation signed into law on April 16, 2015.

Affects Physicians, NPs, PAs, and CNAs

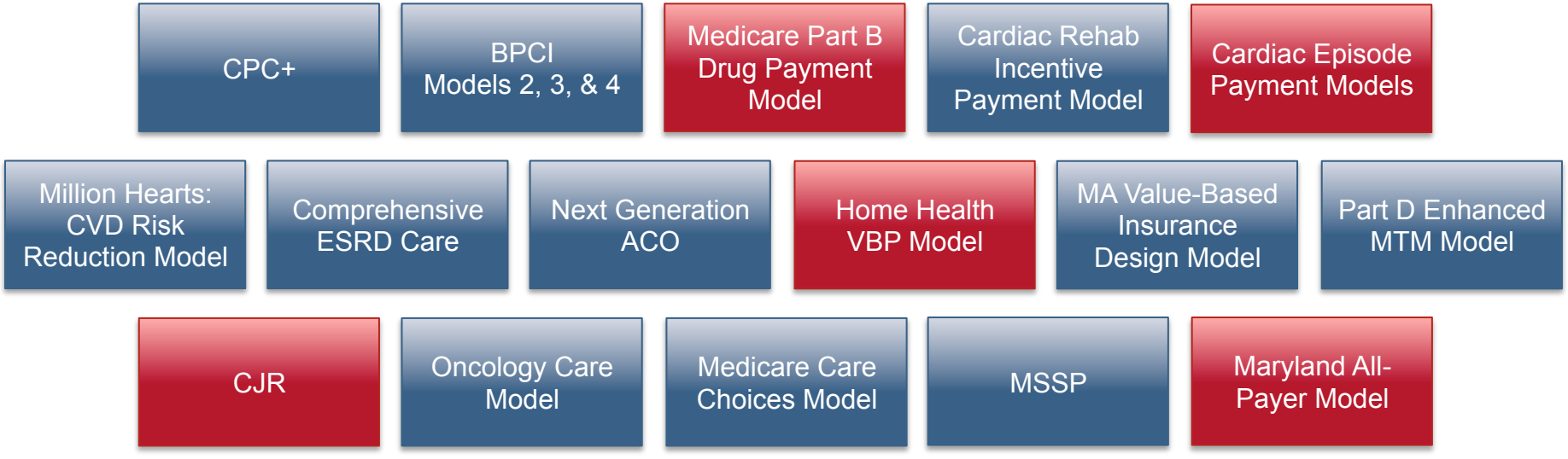
What does QPP do?

- Replaces the Sustainable Growth Rate (SGR) Formula
- Streamlines multiple physician quality incentive programs
- Alters Medicare physician reimbursement to reward value, rather than volume

2019: MIPS vs APM?



Policy Foundation For Value

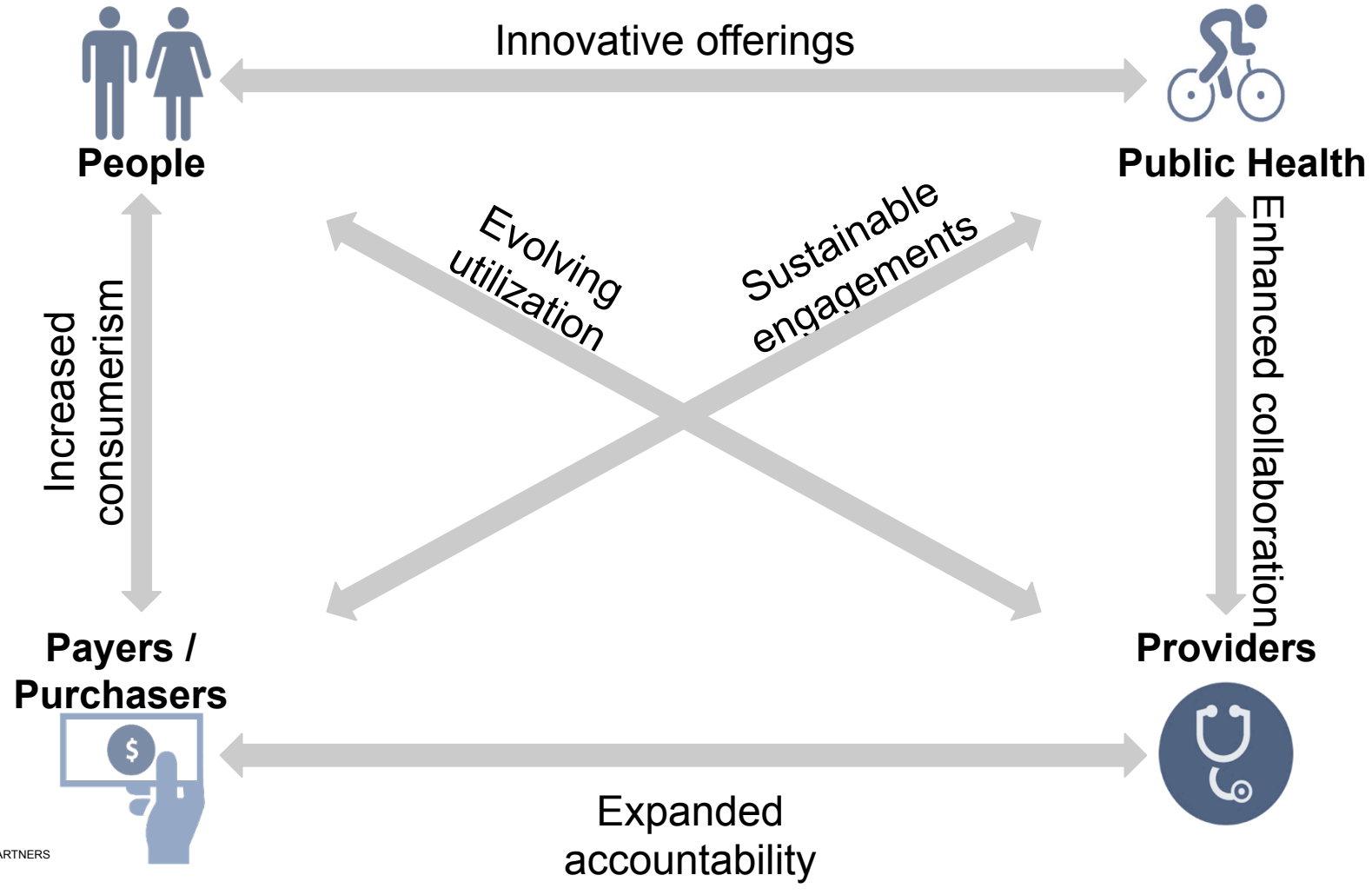


South Dakota Value-based Innovation

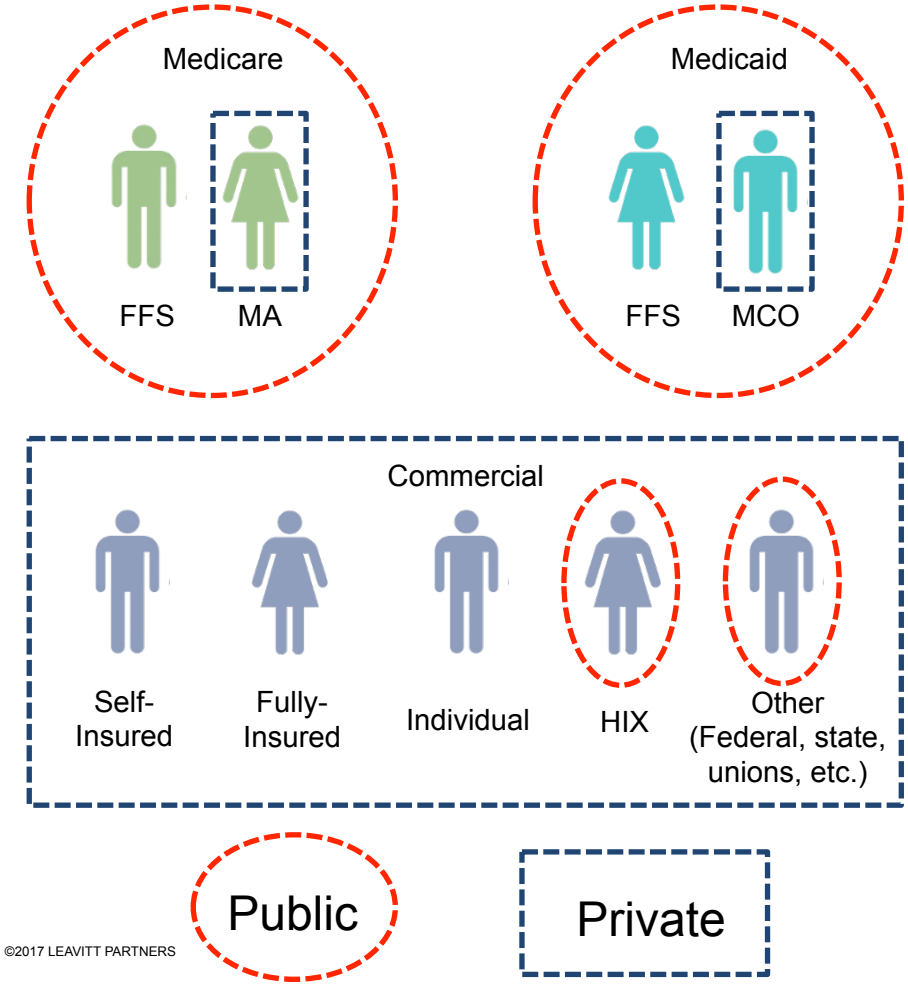
- Health Care Innovation Awards
- Transforming Clinical Practices Initiative
- Acute Myocardial Infarction Model (AMI)
- BPCI Initiative 2 & 3
- Coronary Artery Bypass Graft (CABG) Model
- FQHC Advanced Primary Care Practice Demonstration
- Medicare Care Choices Model
- Selected for AMI-CABG Model

Source: CMS Innovation Center, 2017

Evolving Relationships



Types of Insurance



Medicare

FFS: Hospital and Medical coverage administered directly through the federal government

MA: Medicare Advantage plans sold by private insurance companies that provide Medicare benefits

Medicaid

FFS: Insurance coverage administered jointly through federal and state governments to low-income individuals/families

MCO: Managed Care Organizations provide delivery of Medicaid health benefits via contracts with a state Medicaid agency

Commercial

Self-Insured: Employers accept financial risk and administers its own health insurance plan (82% of employers with 500+ employees self-insure*)

Fully-Insured: Employers pay an insurance company who assumes financial risk for their employees

Individual: Consumers purchase individual/family plans from private insurance companies and pay full premiums out of pocket

HIX: Consumers purchase individual/family plans from the state- or federally-based insurance exchange; federal subsidies are available based on income to reduce monthly premiums

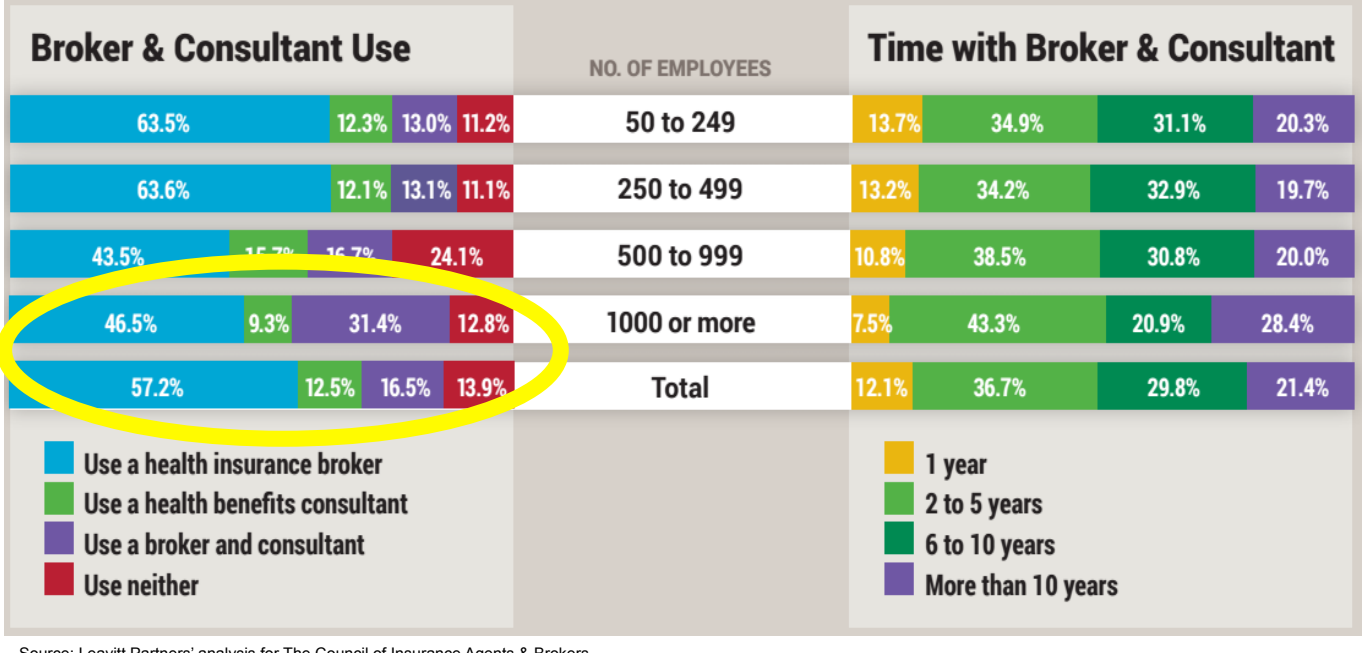
Other: Group coverage obtained through an option not associated with an employer, HIX, or individual plan; i.e., federal, state, or union plans, etc.

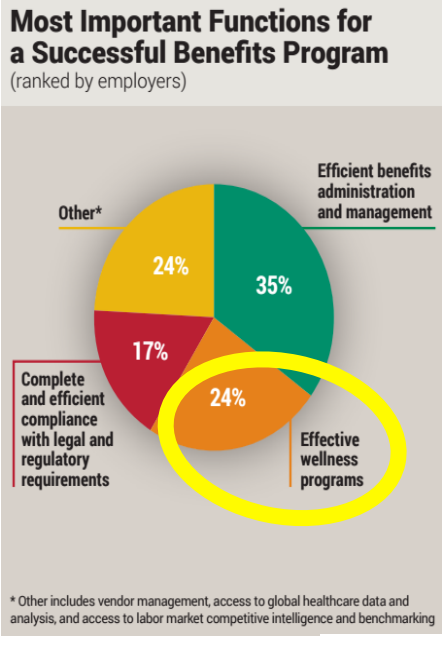
*Source: Department of Health and Human Services, 2015

Brokers / Benefits Consultants

An individual or firm that advises an employer or plan sponsor in matters relating to group insurance or employee benefits.

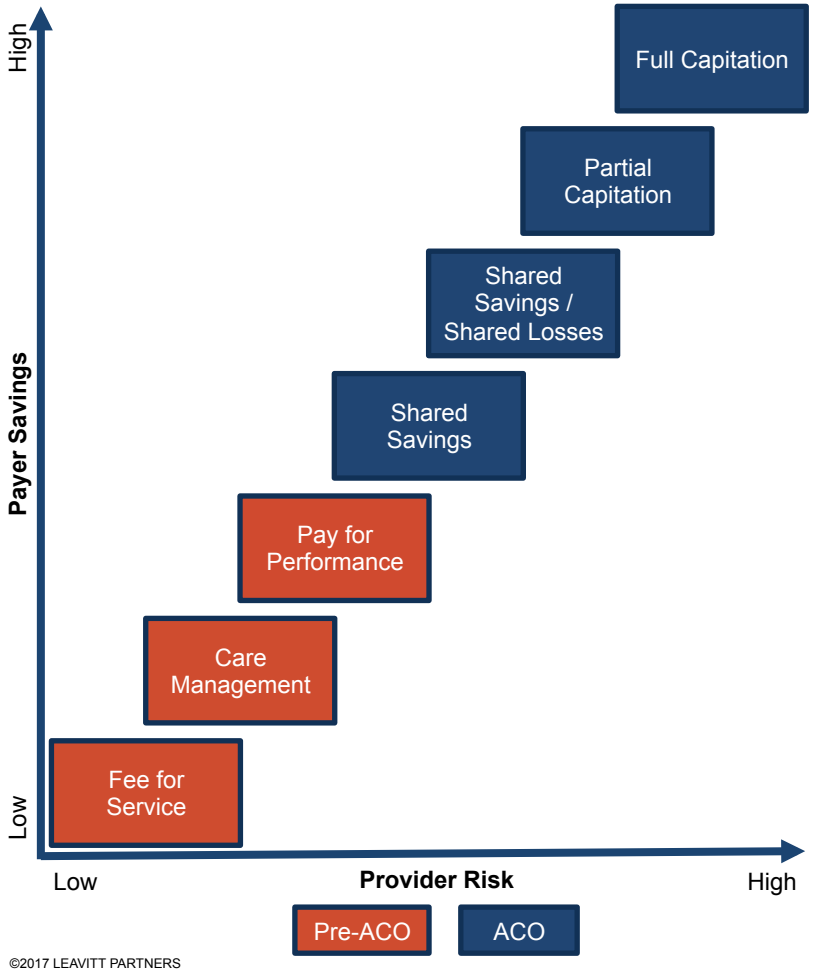
Benefit Consultants advise employers on an array of employee benefits – insurances, investing, legal, health/wellness, etc. **Brokers** match employers' needs (i.e. health insurance) to the right seller (i.e. payer) at the optimal price. Remember, self-insured employers bear financial risk for employee health, but still contract with a third-party payer for administrative capabilities. Fully-insured employers shift the financial risk and administration to a payer.





Source: Leavitt Partners' analysis for The Council of Insurance Agents & Brokers

The Accountable Care Movement



Pre-ACO

Fee for Service: A "traditional" payment system in which provider organizations receive separate payments for each individual service provided to patients

Care Management: A payment to provider organizations for certain non-face-to-face care coordination services furnished to patients with multiple chronic conditions

Pay for Performance: A payment approach in which provider organizations are rewarded or penalized based on adherence to predetermined quality metrics, such as meaningful use, patient quality, or value-based purchasing

ACO

Shared Savings: A payment approach whereby a provider organization shares in the savings (but not in the losses) that accrue to a payer when actual spending for a defined population is less than a target amount

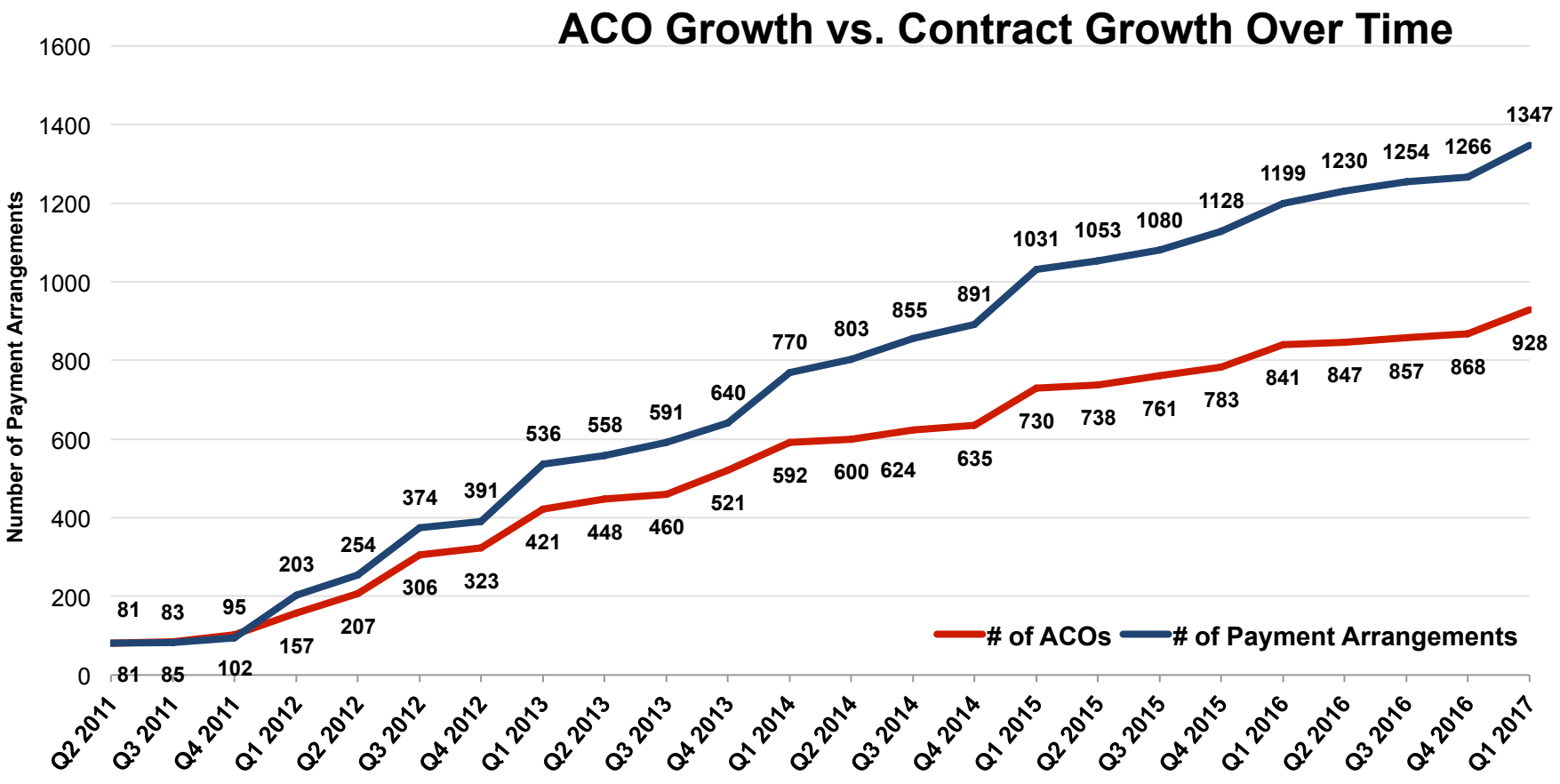
Shared Savings / Shared Losses: A payment approach whereby a provider organization shares in the savings and losses that accrue to a payer when actual spending for a defined population is less or more than a target amount

Partial Capitation: A payment approach in which only certain types or categories of services are paid on a capitated basis; typical examples of this include capitation for primary care services, specialty care or other services such as mental health

Full Capitation: A single payment made to a provider organization to cover the cost of a predefined set of services delivered to a patient

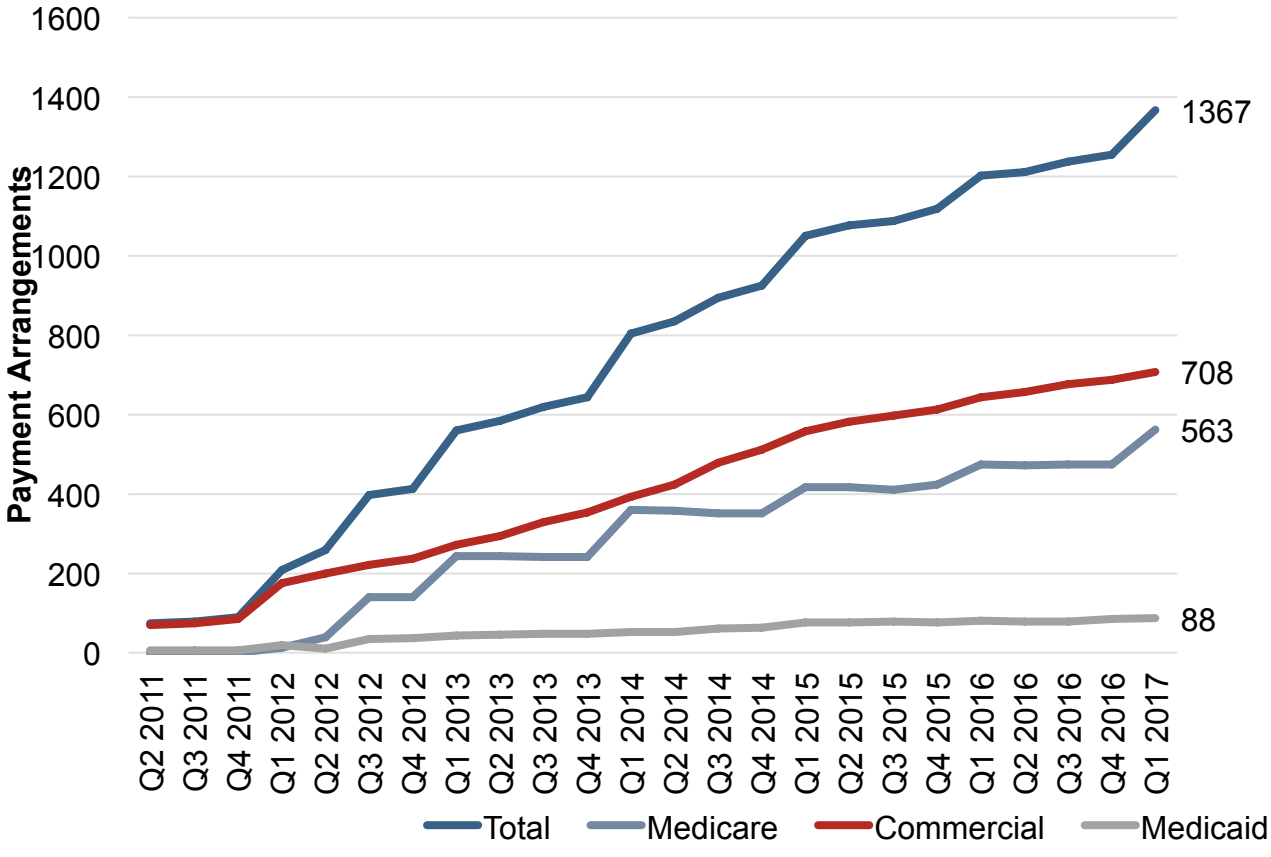
ACO Growth

Total ACOs: 928
Total Contracts: 1,347

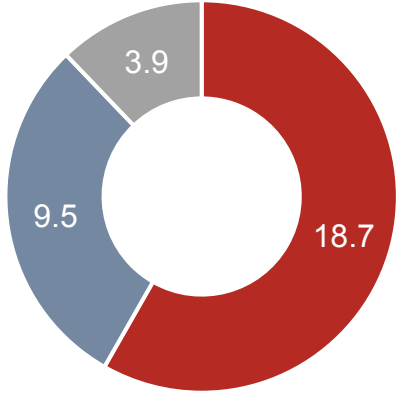


Source: *Leavitt Partners Center for Accountable Care Intelligence*

ACO Growth By Payer



ACO Lives Per Payer (in Millions)



Source: Leavitt Partners Center for Accountable Care Intelligence

Community-Clinical Linkages

How they work in the real world?

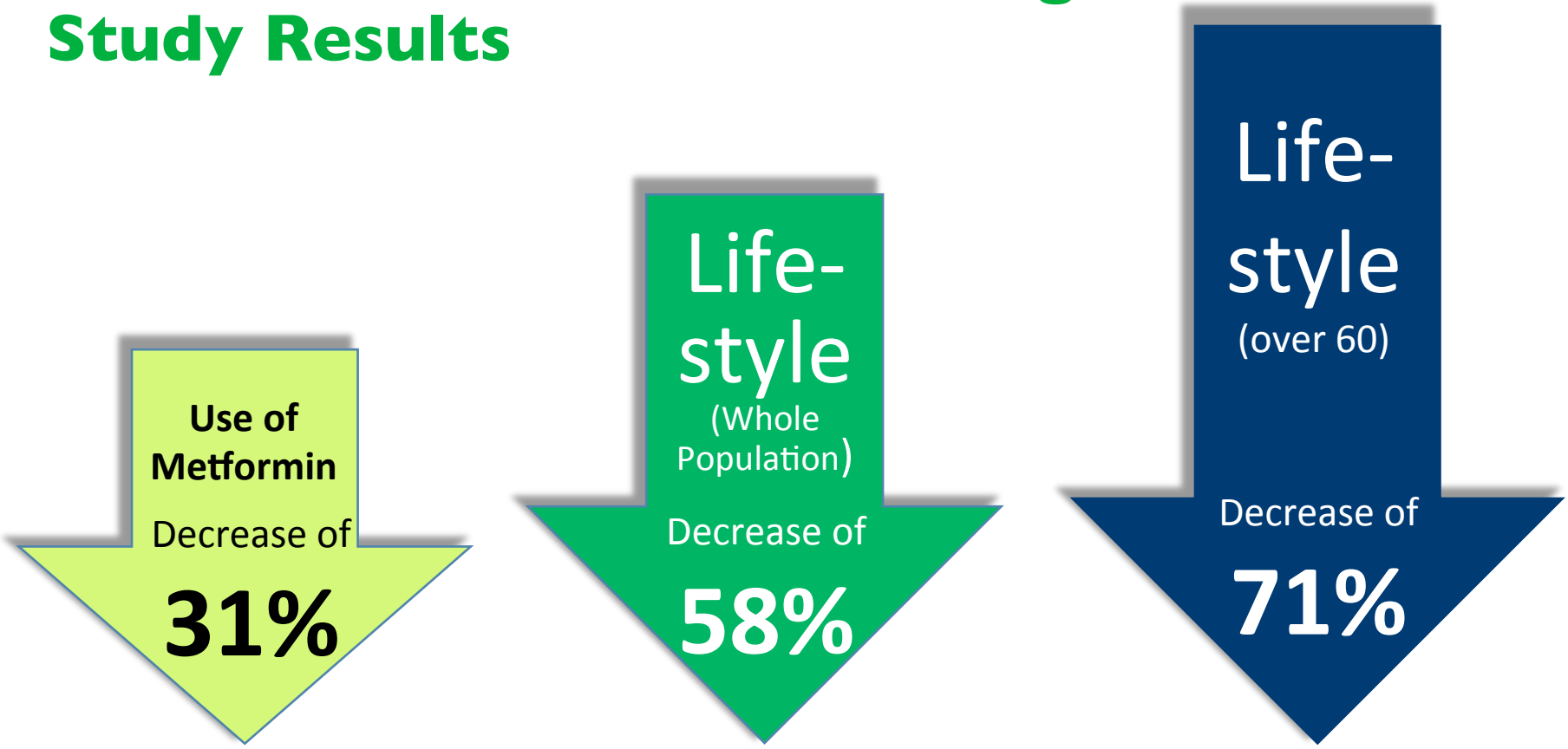

NATIONAL
Diabetes
PREVENTION
PROGRAM

30 million Americans have diabetes

84 million Americans have prediabetes

9 out of 10 adults with prediabetes don't know they have it

The Diabetes Prevention Program Study Results



Core Elements of the DPP Lifestyle Change Program

A TRAINED
LIFESTYLE COACH

CDC-APPROVED
CURRICULUM

GROUP SUPPORT
OVER THE COURSE
OF A YEAR

What Are Communities Doing?

1,400 Organizations

- **CBOs**
- **YMCA**
- **Cooperative Extension**
- **Worksites**
- **Faith-Based Organizations**

What is the Clinical Sector doing?

1. Create awareness
2. Identify patients with prediabetes
3. Educate at-risk patients
4. Refer patients with prediabetes to an evidence-based diabetes prevention program
5. And, follow up on patient progress with feedback loops from community providers

What is the Payer/Employer Sector Doing?

- National Payers
- Public and Private Payers
- Large Employers

National Payers

$2,640 per Medicare Participant saved in the first five quarters[1]

CMS Coverage of the National DPP

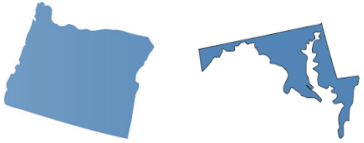
- CMS expanded coverage of the NDPP to all Medicare Part B beneficiaries beginning January 1, 2018.
- The National DPP is the first CMS CMMI project to be certified for expansion to all Medicare Beneficiaries.
- The CMS Office of the Actuary certified that an expansion of the program to Medicare beneficiaries would not increase net-Medicare spending.
- The Institute for Clinical and Economic Review (ICER) stated "*Providing the National DPP in a group setting appears to be cost-saving over time.*"

Public and Private Payers

11 States cover the NDPP for state employees

Over **60** commercial plans provide some coverage for the NDPP

Minnesota and **Montana** cover the NDPP for Medicaid Beneficiaries.



Oregon and **Massachusetts** cover the NDPP for some Medicaid Beneficiaries.

Large Employers

Employers across the nation are making the decision to cover the National DPP lifestyle change program.

Participating Employers

- Costco
- General Dynamics Bath Iron Works
- Latham & Watkins
- University of Michigan
- New York City
- University of Utah Health

National DPP Coverage Toolkit

About National DPP

Resources and information on the National DPP

Learn More

Medicaid Agencies

Resources and information for state Medicaid agencies

Learn More

Medicaid MCOs

Resources and information for Medicaid MCOs

Learn More

Medicare Advantage

Resources and information for Medicare Advantage Plans

Learn More

Commercial Plans

Resources and information for commercial health plans

Learn More

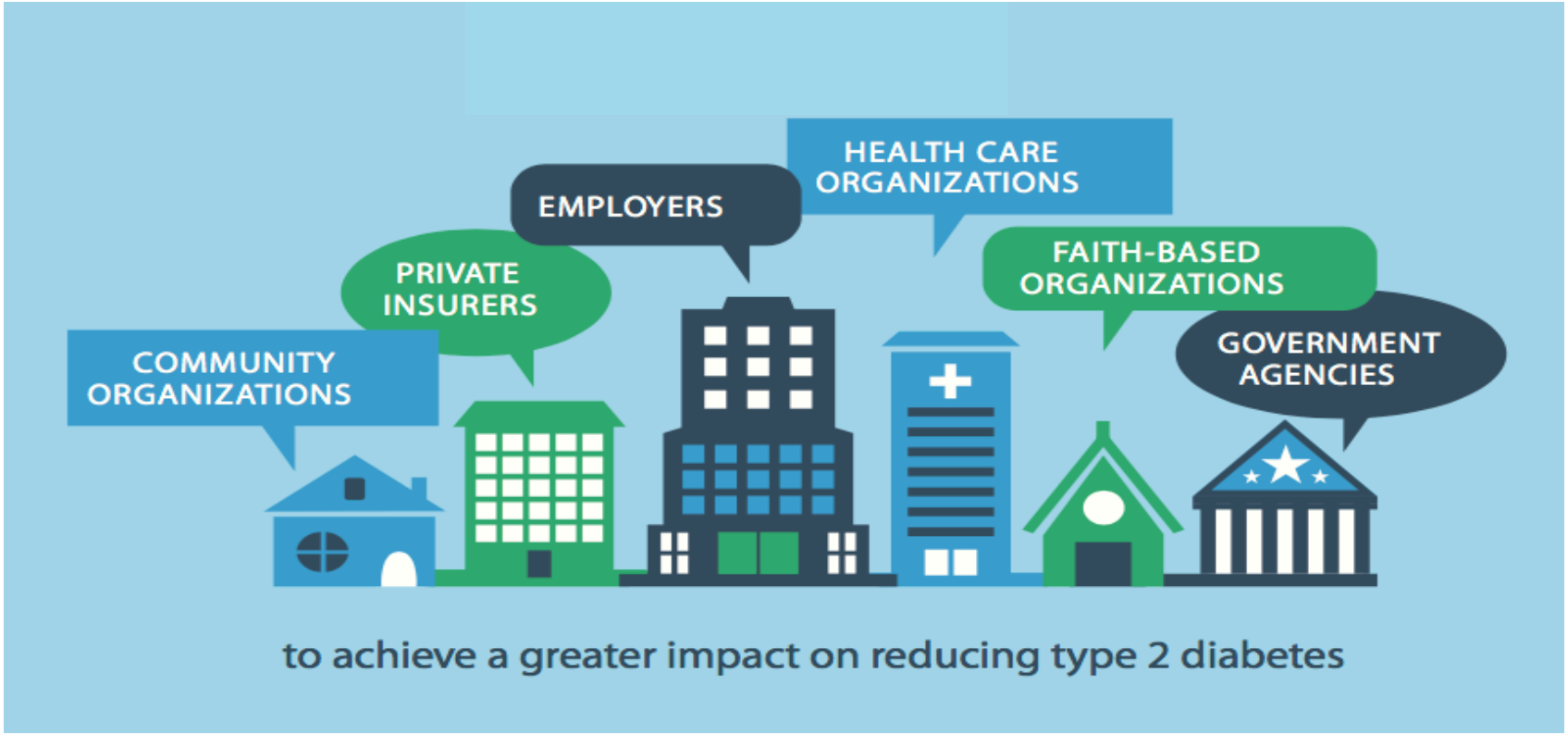
Becoming a CDC Recognized Organization

Clinical Studies

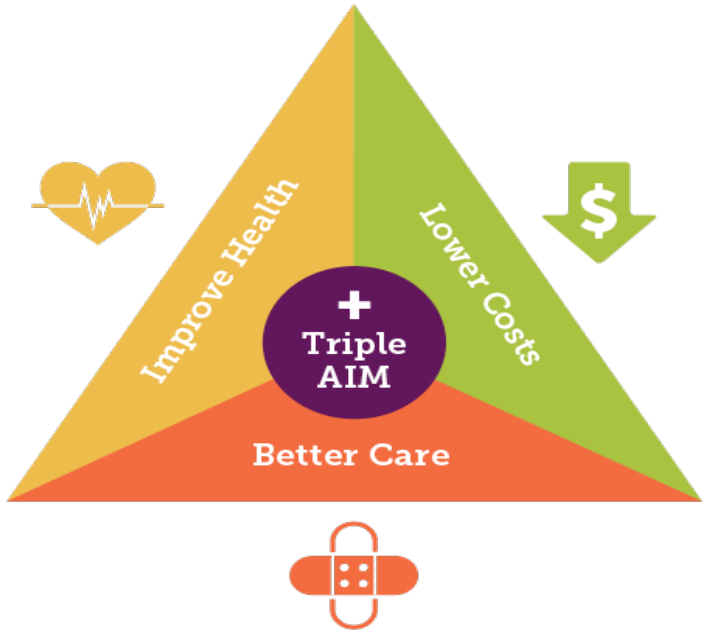
Economic Impact

Market Players

Bringing it all together



The National DPP: Addressing the Triple Aim through Community-Clinical Linkages

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DIABETES

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Sources

SLIDE 7: SOURCE: Adapted from McGinnis, 2002. Priorities from a National Academy of Medicine Initiative - Vital Directions for Health and Health Care – March 21, 2017 https://nam.edu/wp-content/uploads/2017/03/Vital-Directions-for-Health-Health-Care-Priorities-from-a-National-Academy-of-Medicine-Initiative.pdf

SLIDE 8: The Henry J. Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity (by Harry Heiman and Samantha Ariga), Nov. 2015

SLIDE 9: Centers for Disease Control and Prevention. National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014. Atlanta, GA; US Department of Health and Human Services, Centers for Disease Control and Prevention, 2014

SLIDE 10: Centers for Disease Control and Prevention. National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014. Atlanta, GA; US Department of Health and Human Services, Centers for Disease Control and Prevention, 2014; 2: https://www.cdc.gov/diabetes/prevention/prediabetes-type2/index.html; 3: Zhang X, Gregg EW, Williamson DF, et al. A1C level and future risk of diabetes: a systematic review. Diabetes Care 2010;33(7):1665–73.

SLIDE 11: Kaiser Family Foundation Analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011 http://www.commonwealthfund.org/usr_doc/Mead_racialethnicdisparities_chartbook_1111.pdf

SLIDE 12: https://nam.edu/wp-content/uploads/2017/03/Vital-Directions-for-Health-Health-Care-Priorities-from-a-National-Academy-of-Medicine-Initiative.pdf

SLIDE 13: U.S. CENSUS BUREAU May 2014 https://www.census.gov/prod/2014pubs/p25-1140.pdf

SLIDE 15: http://www.cdc.gov/chronicdisease/overview/ , http://www.cdc.gov/chronicdisease/overview/#sec3, http://www.cdc.gov/chronicdisease/resources/calculator/

SLIDE 16: Data from Network of Excellence in Health Innovation (NEHI) 2013 http://www.tbf.org/tbf/56/hphe/Health-Crisis

SLIDE 17: Source: OECD Health Data 2015. Australia data is 2012.
http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/oct/pdf_squires_us_hlt_care_global_perspective_oecd_exhibits.pdf
Exhibit 1

SLIDE 29: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf

SLIDE 30 & 31: http://www.nationaldppcoveragetoolkit.org/participating-payers/