



Health Plan Advisory Council

Facilitating Sustainable Population Health

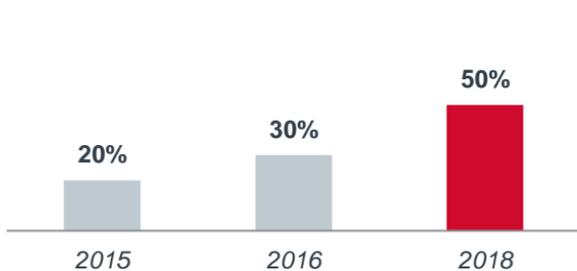
Prepared for Texas Health and Human Services Commission

CMS Lays Down Marker for Value-Based Payment

Historic Payment Targets Demonstrate Commitment to FFS¹ Alternatives

Aggressive Targets for Transition to Risk

Percent of Medicare Payments Tied to Risk Models



Examples of Qualifying Risk Models



Medicare Shared Savings Program



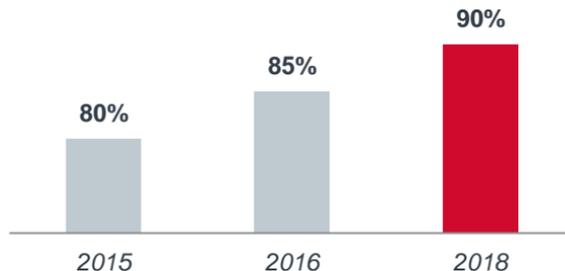
Bundled Payments for Care Improvement Initiative



Patient-Centered Medical Home

FFS Increasingly Tied to Value

Percent of Medicare Payments Tied to Quality



Examples of Quality/ Value Programs



Hospital-Acquired Condition Reduction Program



Hospital Value-Based Purchasing Program



Hospital Readmissions Reduction Program



Merit-Based Incentive Payment System

1) Fee-for-Service.

Key Implications for Providers



Any lingering uncertainty about the transition to risk-based payment is over

The largest payer sent a clear signal for system-wide transformation around a concrete schedule of goals. Providers can now invest in population health and care transformation with more certainty than ever before.



Payment transformation must become a multi-payer effort

Operating under two business models is untenable at best. Providers must motivate private payer, employers, and states to accelerate their transitions to alternative payment models to achieve consistent incentives and fully embrace population health.



Payment transformation must be balanced with care transformation

Providers must transform both payment and care models to adopt a population health business model. Care transformation requires investments in infrastructure, care model redesign, and cultural change.

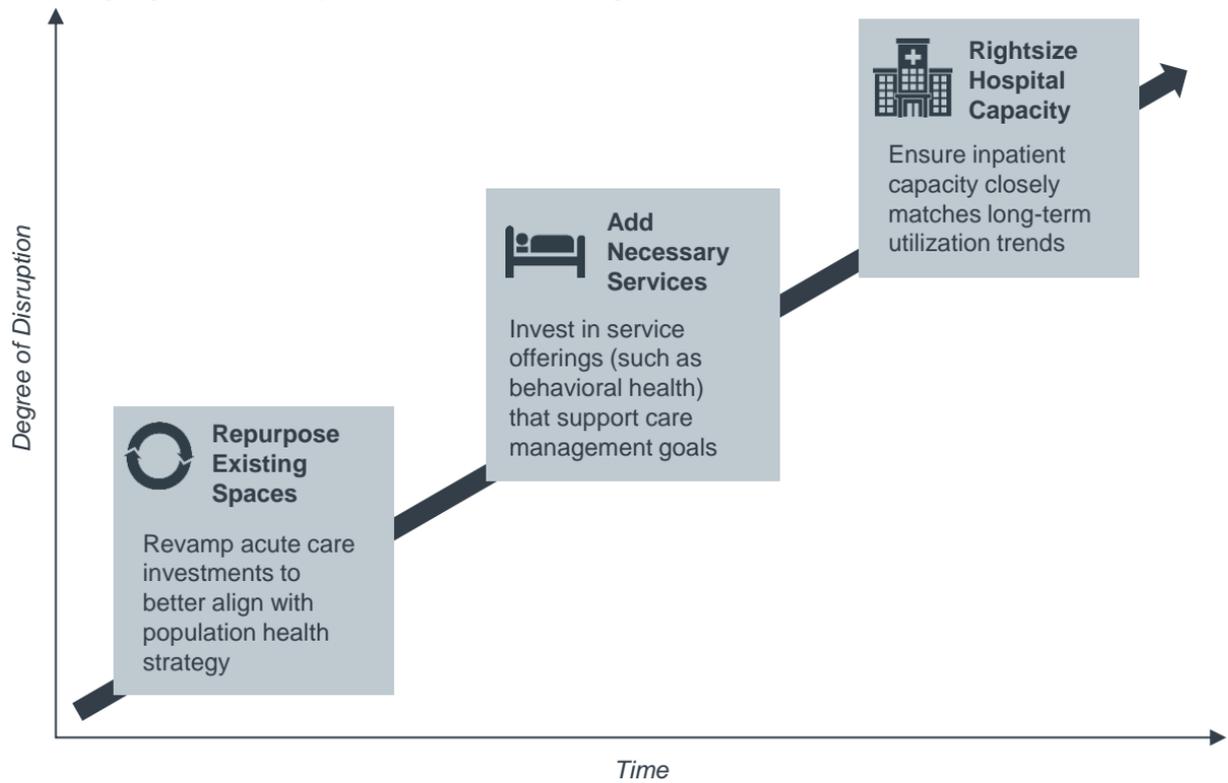
Partnering with Providers on Payment Innovation

Four Guiding Principles for Sustainable Partnerships

- 1 Selectively Finance the Transition to Population Health
- 2 Balance Focused Pilots with Achieving Scale
- 3 Enhance Data Sharing Capabilities
- 4 Right-Size Cost, Quality Targets

Shift Bricks and Mortar Investment Strategy

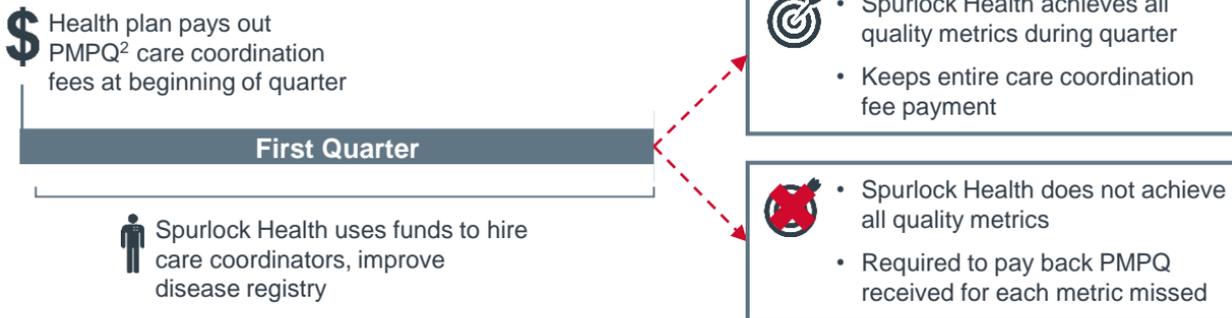
Staging Shift in Physical Asset Planning



Providing Bridge Financing to Get Started

Incenting Success by Placing Support at Risk

Process for Prospective Quality Payments at Spurlock Health¹



Case in Brief: Spurlock Health¹

- Large health system located in the West
- Care coordination fees paid by health plan at beginning of each quarter, receives \$1 PMPQ² for each quality metric included in contract, up to \$8 total PMPQ
- Spurlock must pay back fees received for any metrics missed at end of performance period
- Funds investments necessary for success under population health contracts

1) Pseudonym.

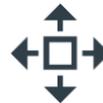
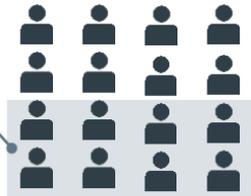
2) Per-member, per quarter.

Stage Expansion Path by Complementary Strengths

Focus on Similar Populations with Similar Management Needs

Population Attributed to Pioneer ACO

Significant number of patients dual-eligible for Medicare, Medicaid



Using infrastructure already in place for existing dually-eligible patients to expand population health management focus to:

- Medicaid managed care
- Medicare Advantage



Case in Brief: Stack Medical Center¹

- Large health system in the Midwest
- Participating in Pioneer ACO program
- Found significant number of patients attributed to ACO under Pioneer program were dual-eligible for Medicare and Medicaid, planning to expand into dual-eligible market

1) Pseudonym.

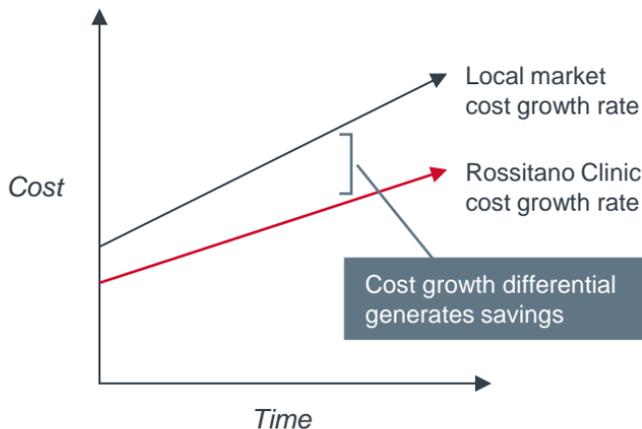
Work With Providers On Advantages



Case in Brief: Rossitano Clinic¹

- Large multi-specialty physician group based in the West
- Found itself to be a low-cost provider in the market
- To earn shared savings through most of its commercial risk contracts, required to beat market average cost growth rate
- Finds this target methodology beneficial because already low-cost

Low-Cost Providers Benefit from Comparison to Local Market Trends

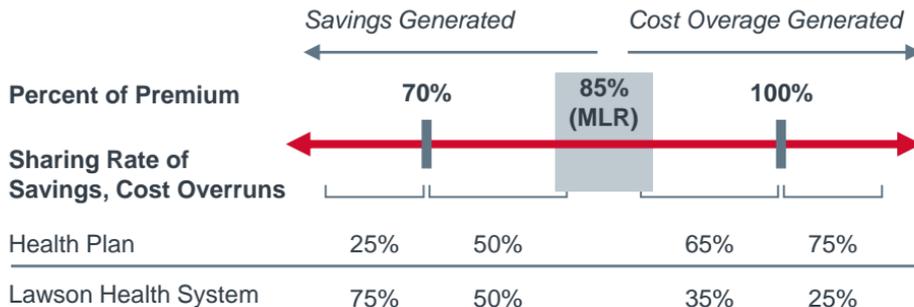


1) Pseudonym.

Mapping to the MLR

“Percent of Premium” Offers Option for Medicare Advantage Populations

Sliding Scale of Opportunity, Risk



?

What is the MLR?

- Created by ACA, requires health plans to spend at least 80-85%² of premiums collected from beneficiaries on medical care
- Used as expenditure target in some MA contracts
- Health plan has already taken risk into account when setting premium, removing need for provider-based risk adjustment



Case in Brief: Lawson Health System¹

- Medium-sized health system based in the South
- Negotiating risk-based contract with local Medicare Advantage plan
- Expenditure target determined by medical loss ratio (MLR), which is set at 85%² of the premium collected by the health plan
- Bonus, overage sharing rate depends on performance against MLR

1) Pseudonym.
 2) 80% for individual, small group markets; 85% for large group markets.
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Source: "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," The Center for Consumer Information & Insurance Oversight: Centers for Medicare and Medicaid Services, December 2, 2011, available at: <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlr/finalrule.html>; Health Care Advisory Board interviews and analysis.



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