

Population-Based Healthcare

Patient-Centered Health Advisory Council

The Patient-Centered Health Advisory Council serves as a key resource for feedback and recommendations to IDPH, the legislature, and other stakeholders on issues related to implementation of health transformation initiatives in Iowa. Additionally, the Patient-Centered Health Advisory Council:

- encourages partnerships and synergy between community healthcare partners in Iowa who are working on new system-level models to provide better healthcare at lower costs by focusing on shifting from volume to value based healthcare.
- convenes stakeholders and leaders from all sectors of the healthcare system in Iowa to build relationships, and streamline efforts.
- educates the public and stakeholders on emerging healthcare transformation initiatives.

Visit the Council's website here: <http://idph.iowa.gov/ohct/advisory-council>

This Issue Brief was developed by the Patient-Centered Health Advisory Council as an educational tool for the public and stakeholders as an emerging healthcare transformation topic.

What is Population-Based Healthcare?

Population-Based Healthcare is focused on the system established to improve the health outcomes of a group of individuals, including distribution of such outcomes within the group. To move toward this type of care, new payment models are emerging that encourages the integration of community services offered outside of the traditional healthcare provider model and allows for the creation of sustainable infrastructures that will hold this expanded healthcare system accountable for both the cost and quality of care.

Healthcare in the U.S. is transitioning away from the traditional fee-for-service model, where healthcare providers are paid for each service they provide, such as an office visit, test, or procedure. New payment models are being used that are designed to reward the healthcare system for improvements in population health status. Population-Based Healthcare payment models create a reimbursement incentive for healthcare providers to think more broadly about health and to establish new partners in providing more integrated and holistic care. This shift toward increased collaboration, outcome-based payment and new benefit design is driving innovation in how healthcare is paid for and delivered. In particular, it establishes a need for healthcare systems to build mechanisms to address patient and family engagement and social determinants of health.

Types of Payment Models

- **Fee-For-Service** payments reward healthcare systems for volume of visits and quantity of services provided and fails to differentiate payment based on quality.
- **Value-Based Purchasing** is designed to shift the basis of reimbursement from volume to value by incorporating financial incentives to improve costs and improve health outcomes. Population-Based Healthcare incentivizes and rewards healthcare systems to keep their patients healthy and out of the doctor's office.

Why Shift to Population-Based Healthcare?

The current U.S. healthcare system was designed to manage illness and disease - not to necessarily promote health and prevent disease. It is widely acknowledged that the current system is overwhelmed by fragmentation, inefficiencies, wide variation in both quality and cost, and primary focus on the treatment of illness rather than population health improvement and management. Additionally, U.S. health expenditures are high, going up, and unsustainable.

Population-Based Healthcare Leads to:

Lower Cost

- Generate savings for potential gain-sharing
- Focus on the clinical need for procedures
- Encourage more evidence-based decisions
- Focus more attention on population health rather than on individual patients
- Focus on prevention

Higher Quality

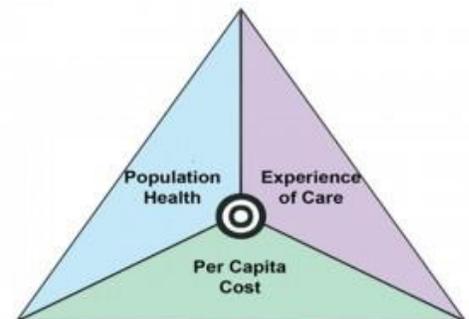
- Provide rewards for good patient outcomes
- Reward providers for adhering to established protocols
- Lower reimbursement for adverse events
- Encourage patient and family engagement
- Mitigate the negative impacts of social determinants of health
- Improves patient experience and level of confidence in managing health

View this [short video](#) explaining in simple terms what value-based payment is and why the U.S. is shifting to this payment model.

The Next Step: Population-Based Healthcare on a Community Level

The movement towards value-based care could potentially have an unintended consequence and discourage providers from caring for sicker patients who may have multiple social needs. Providers could be held accountable for the health impacts caused by these social needs even though they have limited ability to control them.

As the Centers for Disease Control and Prevention (CDC) continues to move towards the [Triple Aim](#), new innovative payment models must shift the emphasis of health from the provider office level to a healthcare system that addresses other influences on health for a larger community. The Triple Aim includes improving the patient experience, improving the health of populations, and reducing the cost of healthcare.



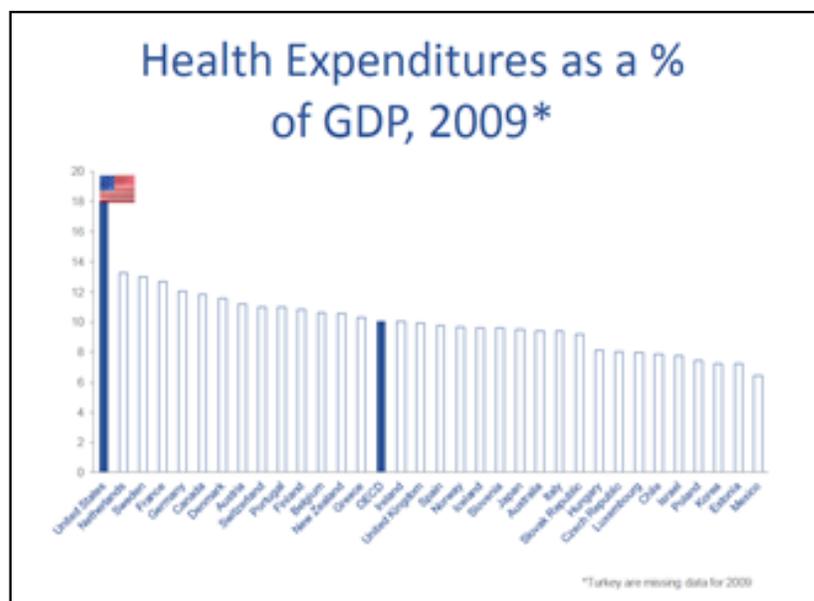
New innovative payment models are taking population-based care to the next level and creating the infrastructure for integration of community-level population health. A provider's target population is no longer being limited to their individual patients but now extends to their larger community and the collective health of that community. This transformation recognizes that most individuals will only be as healthy as the community in which they live. The CDC published a report called "Towards Sustainable Improvements in Population Health" that gives an overview of community integration structures and emerging innovations in financing. The report can be accessed here:

<http://www.cdc.gov/policy/docs/financepaper.pdf>

U.S. Healthcare Expenditures and Healthcare Ranking Compared to Other Countries

According to The Commonwealth Fund report *U.S. Healthcare from a Global Perspective*, the U.S. spent more per person on healthcare than 12 other high-income nations in 2013, while seeing the lowest life expectancy and some of the worst health outcomes. In the U.S., an average of \$9,086 is spent per person annually on healthcare, and life expectancy is 78.8 years. The U.S. is a substantial outlier when it comes to health spending. Healthcare consumed 17.1 percent of the nation's gross domestic product (GDP) in 2013, about 50 percent more than any other country. Access the Commonwealth Fund report here: <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>

According to the Health Affairs report "Variations in Health Outcomes: The Role of Spending on Social Service, Public Health and Healthcare" the ratio of social to health spending at the state level is very much associated with health outcomes. Investment in social services and public health may be key to understanding variations in health outcomes. This study is consistent with the findings from CDC's report "Towards Sustainable Improvements in Population Health". Access the Health Affairs report here: <http://content.healthaffairs.org/content/35/5/760.abstract>



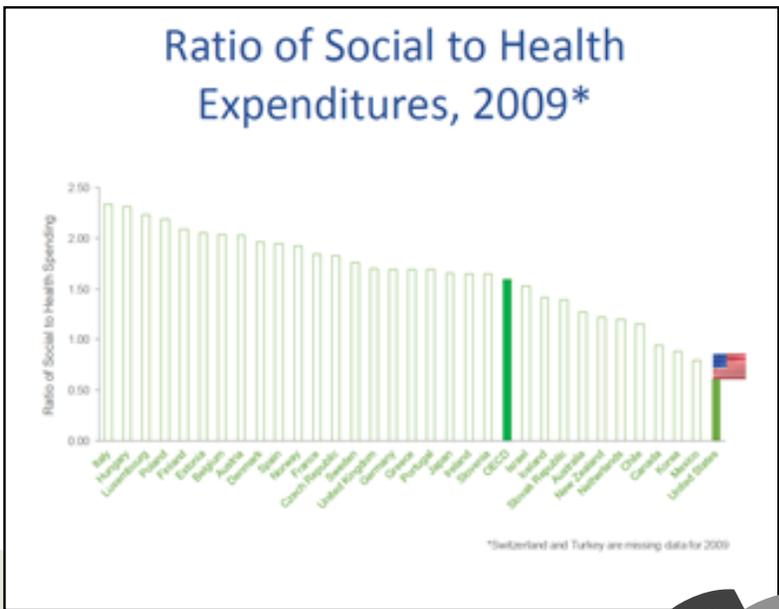
The U.S. ranks highest among other industrialized countries in healthcare spending as a percentage of gross domestic product (GDP) while remaining among the lowest in key health indicators.

In other industrialized countries, for every \$1 spent on healthcare, about \$2 is spent on social services.

In the U.S., for every \$1 spent on healthcare, about 55 cents is spent on social services.

The ratio of social to health spending is significantly associated with better health outcomes:

- *Less infant mortality, low birth weight, premature death*
- *Longer life expectancy*



National and Iowa Efforts Shifting to Population-Based Healthcare

State Innovation Model (SIM)

Iowa is one of 14 states selected to receive a SIM Round Two Test Award through the Centers for Medicare & Medicaid Services (CMS). Iowa was awarded \$43.1 million over a four year period to focus on improving population health, transforming healthcare, and promoting sustainability. Iowa's SIM grant focuses on the following three areas:

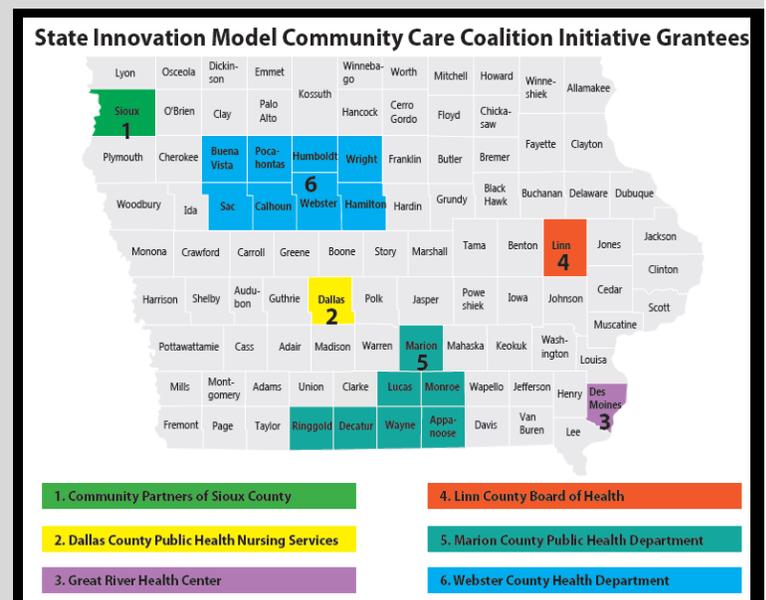
1. Improve Population Health
2. Transform Healthcare
3. Promote Sustainability

Iowa has four primary drivers that are the strategy behind the three aims and four goals of the Iowa SIM Program. The framework of the [SIM Goals and Drivers Diagram](#) illustrates this strategy. Access the drivers below to learn more.

1. [Population Health Improvement](#)
2. [Care Coordination](#)
3. [Community-Based Performance Improvement](#)
4. [Value-Based Purchasing](#)

Community Care Coalition

A key aspect of Iowa's SIM is the development and advancement of [Community Care Coalition \(C3\)](#) initiatives across Iowa. Six Community Care Coalitions (C3s), spanning 20 counties, will engage in broad-based healthcare system reform over the next three years that will lead to better health outcomes and lower costs. Additional C3 communities will be awarded in the subsequent two years. C3s are locally-based coalitions of health and social service stakeholders collaborating to promote the coordination of health and social services across care settings and systems of care. The C3s have two primary functions: 1) addressing social determinants of health through care coordination; and 2) implementing population-based, community applied interventions related to the [Iowa SIM Statewide Strategies](#).



Pioneer Accountable Care Organization (ACO) Model

The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as Accountable Care Organizations (ACOs) or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model is testing the impact of different payment arrangements in helping organizations achieve the goals of providing better care to patients, and reducing Medicare costs. Trinity Pioneer ACO (UnityPoint Health) was selected to participate in the Pioneer ACO Program. The Trinity Pioneer ACO covers an eight county region in Northwest Central Iowa. Webster County Health Department in Fort Dodge plays a key role in focusing on population-based healthcare within the ACO.

Since providers only share in ACO savings when they decrease costs, it is crucial for ACOs to switch from merely treating sickness to maintaining or improving health in order to prevent costly avoidable illness and unnecessary care. Public health plays a significant role within ACOs in many areas including patient engagement, addressing social determinants of health, population health management, needs assessment, health promotion, community health programs, and care coordination.

National and Iowa Efforts Shifting to Population-Based Healthcare

Iowa Medicaid Managed Care

The Iowa Department of Human Services has contracted with following three Managed Care Organizations (MCOs) for Iowa's Medicaid Modernization initiative to provide and pay for healthcare services to the vast majority of Medicaid members:

- [Amerigroup Iowa, Inc.](#)
- [AmeriHealth Caritas](#)
- [United Healthcare Plan of the River Valley, Inc.](#)

A MCO is a health plan that coordinates care for a member. On February 23, 2016 CMS announced that it approved the launch of [IA Health Link](#) (Iowa's Medicaid Modernization initiative) for April 1, 2016. The goals of Medicaid Modernization include improved quality and access, greater accountability for outcomes, and creating a more predictable and sustainable Medicaid budget. Medicaid agencies contract with MCOs to provide and pay for healthcare services. MCOs establish an organized network of providers and utilization guidelines to assure appropriate services are provided at the right time, in the right way, and in the right setting. This shifts the focus from volume to per member, per month capitated payments and patient outcomes.

There is a goal that each MCO will have 40 percent of their covered lives in a Value Based Purchasing arrangement by 2018.

Accountable Health Communities (AHC)

The Department of Human Services has announced a new funding opportunity of up to \$157 million over a five year period called the Accountable Health Communities (AHC) model. This is the first-ever CMS Innovation Center pilot project to test improving patients' health by addressing their social needs. AHC addresses a critical gap between clinical care and community services in the current healthcare delivery system by testing whether identifying and addressing the health-related social needs of beneficiaries' impacts total healthcare costs, improves health, and quality of care.

Comprehensive Primary Care Plus (CPC+)

Comprehensive Primary Care Plus (CPC+) is an advanced primary care model and CMS's largest investment in primary care transformation to date. CPC+ is a regionally-based, multi-payer care delivery and alternative payment model that rewards value and quality through an innovative payment structure to support comprehensive primary care. The model will offer two tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices. CPC+ is a five-year model that will begin in January 2017. CMS anticipates partnering with commercial and State payers in up to 20 regions around the country to support primary care practices. CMS will also engage directly with health information technology vendors that provide products to advanced CPC+ practices.

Transforming Clinical Practice Initiative (TCPI)

TCPI is part of a comprehensive strategy advanced by the Affordable Care Act that enables new levels of coordination, continuity, and integration of care, while transitioning volume-driven systems to value-based, patient-centered, healthcare services. Iowa Healthcare Collaborative (IHC) is one of 39 healthcare collaborative networks selected to participate in TCPI. IHC and its partners will receive up to \$32.5 million during the four-year initiative to provide technical assistance support to help equip clinicians in six states – Iowa, Georgia, Kansas, Nebraska, Oklahoma and South Dakota – with tools, information, and network support needed to improve quality of care, increase patients' access to information, and spend healthcare dollars more wisely.

National and Iowa Efforts Shifting to Population-Based Healthcare

Hospital Engagement Network (HEN) 2.0

The Iowa Healthcare Collaborative (IHC) has been selected to continue the work of the Partnership for Patients initiative through the Hospital Engagement Network (HEN) 2.0 contract awarded by CMS. The initiative began in 2011 with a goal to reduce preventable hospital-acquired conditions by 40 percent and readmissions by 20 percent. IHC has worked toward these goals since the beginning of the effort and will continue to engage hospitals to improve patient safety and health outcomes.

Medicare Payment Reform- From Volume to Value

The U.S. Department of Health and Human Services (HHS) will fundamentally reform how it pays providers for treating Medicare patients in the coming years. HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Healthcare and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments. HHS Secretary Sylvia Mathews Burwell said in a [statement](#), Medicare is "setting clear goals--and establishing a clear timeline--for moving from volume to value in Medicare payments. We will use benchmarks and metrics to measure our progress; and hold ourselves accountable for reaching our goals." The intent, according to HHS officials, is to cut down on the volume of unnecessary procedures while improving patient outcomes.

To help reinforce this direction, legislation was introduced regarding [Medicare Access & CHIP Reauthorization Act of 2015 \(MACRA\)](#) including MIPS (Merit-Based Incentive Payment System) & Alternative Payment Models (APMs). This represents the federal government's move to pay-for-performance incentives and increasing clinician accountability within fee-for-service.

