How to Get Paid for Your Population Health Program: Part 1

written by Dave Halpert | June 17, 2015

How can you succeed in Pay for Performance if you can't risk revenues on a program that may not produce results? Especially if your competitors have made the investment and can prove better outcomes, raising the bar for everyone?

It's not enough simply to tighten existing procedures or to focus on maintaining high standards

To stay competitive, you need to improve patients' outcomes and reduce costs over your own history and against other organizations, even without a lot of cash on hand. If you don't, you'll face even greater financial risks under ACO participation or independently through VBPM penalties.

But a successful population health initiative doesn't need to break your budget. In fact, it can actually boost your bottom line. Here are two basic steps to get you started in the right direction:

Step I: Target Your Focus to Produce Revenues and Savings

An all-patient population health initiative may seem attractive. However, if your goal is steering patients toward better outcomes while lowering cost of care, it's better to take a more strategic approach.

Focus on Medicare. The revenue advantages—and penalties—are already in place. Further, you're already participating in a Medicare value-based model, whether that means you are

voluntarily in an ACO or are reporting PQRS and involuntarily under Medicare's Value-Based Payment Modifier (VBPM). Either model places you at risk.

Given that reality, prioritize your population health initiatives among Medicare patients. More than two-thirds of Medicare patients have two or more chronic conditions, such as diabetes and hypertension. Within the co-morbid population, more than half had four or more chronic conditions—36 percent of the total Medicare population. These patients with multiple chronic conditions accounted for a whopping 93 percent of Medicare spending, reflecting a higher degree of hospital and emergency department utilization.

Four of these chronic conditions play a central role in the calculation of the VBPM, regardless of whether your PQRS measure selections apply to them. If you are in an ACO, these same conditions represent your big cost drivers:

- Diabetes
- Heart Failure
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)

When determining the VBPM quality composite, Medicare will look at your group's hospitalization rates for these conditions. To calculate the cost composite, Medicare tracks the costs associated with two groups: (1) All Beneficiaries, and (2) Beneficiaries with Chronic Conditions (the four mentioned above).

Poor outcomes and increased utilization for these patients puts the squeeze on your VBPM or ACO costs. Start with these patients to define a population health initiative that helps you succeed in VBPM or in an ACO. With a Registry partner, you can identify this group at the outset, rather than trying to figure it out while jumping from exam room to exam room.

Step 2: Start with Medicare Wellness Visits for Patient Measurement and Better Data

Here's where Medicare helps you to pay for your efforts. Medicare covers services that can help you set the stage for population health: Medicare Wellness Visits. There are two types:

- One "Welcome to Medicare" Preventive Visit (for patients who are within their first 12 months of Medicare Part B coverage)
- Yearly "Wellness" Visits (for patients who have been on Medicare Part B longer than 12 months)

Both of these are comprehensive visits and include creation, review and updates to individualized patient health and treatment plans. This is the time to determine where improvement is required, and how.

Medicare Wellness Visits offer a huge advantage, even if you're in an ACO. A Wellness Visit is one factor in Medicare's attribution methodology, so it will help that your patients are attributed to you as the primary care provider rather than another physician seen by the patient. Be certain that you, and not another provider group, will be rewarded for the time and effort spent on improving your patients' outcomes.

Each of these visits includes a Health Risk Assessment (HRA). The HRA can give you some additional insight into your patients' health beyond what you may have seen from previous records, as well as an opportunity to prevent negative outcomes. Missed screenings, fall risks and home safety concerns are all examples that signal potential adverse outcomes for your patient and threats to your efforts; having this information gives you the chance to act now so that your patients can avoid costly and detrimental events down the road.

Success Depends on the Right Infrastructure and Services

This simple two-step process will help you to build a firm foundation for your population health program by establishing your patients and using billable encounters to collect baseline data.

Moving forward, you'll need the tools to track costs and efforts, regardless of your Medicare participation model. Capabilities must include:

> Data from physician source systems, such as Practice Management and EMR, to capture patient demographics, visit, diagnosis and procedure data. Selected clinical data will also be important, but the key is to have transactional data for all patients from the ambulatory systems.
> Population health management software. There are a variety of vendors offering population health, but they don't all offer the same functionality. Here's what you should look for:
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> > Populations and projects that can be defined by multiple criteria;
> > Tracking of patient outcomes over time;
> > Ability to record and track interventions against patient outcomes;
> > Integration of data from your source systems, as well as direct data input capability;
> > Analytics, but much more—you should be able to see patient level detail;
> > Ability to track effectiveness of your efforts in improving outcomes over time, and reducing costs.

Two more steps will help you to round out your population health program. Next week, in Part Two, we'll explain how to get the most out of Medicare's Chronic Care Management (CCM) Services, and why you need Effectiveness Research to avoid the "anecdotal evidence" trap.

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