Achieving Value-based Care in Rural Populations through Provider-Sponsored Health Plans

February 11, 2014
Value-Based Care is No Joke
What is ‘Value-Based’ or ‘Accountable’ Care?

Value-Based Care = (Access + Quality = Outcomes) - Cost

<table>
<thead>
<tr>
<th>FEE FOR SERVICE</th>
<th>P4P</th>
<th>SHARED SAVINGS</th>
<th>BUNDLED PAYMENTS</th>
<th>SHARED RISK</th>
<th>CAPITATION FULL RISK</th>
<th>PROVIDER-SPONSORED PLAN</th>
</tr>
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<tbody>
<tr>
<td>License &amp; Regulatory Compliance</td>
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<td>Marketing and Sales</td>
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<td>Administration</td>
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<td>Analytics</td>
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<td>Clinical Integration</td>
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<td>Care Management</td>
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<td>Network Management</td>
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</table>

License & Regulatory Compliance
Marketing and Sales
Administration
Analytics
Clinical Integration
Care Management
Network Management
Why Value-based Care Makes Sense

- Greater mission – Health of Population
- Align incentives for bending the cost curve
- Protect enhance market share
- Not as risky as it seems

Timing the Move To Risk

Provider Risk

Economic Advantage to Provider

Cost and Utilization

Early move to risk
Late move to risk

Payer cost
Fixed costs
Variable costs

Provider Risk

Government-Based

Commercial

Variable costs

Fixed costs

Payer cost
Higher Quality and Lower Cost Tied to Coordination and Compliance

Longitudinal Experience Of Ambulatory Medicare Beneficiaries Assigned To Extended Hospital Medical Staffs (EHMSs)

Strata based on 2000-02 performance

<table>
<thead>
<tr>
<th>Measures of quality and costs</th>
<th>Highest</th>
<th>High</th>
<th>Middling</th>
<th>Low</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals/EHMSs</td>
<td>168</td>
<td>735</td>
<td>2,090</td>
<td>937</td>
<td>232</td>
</tr>
<tr>
<td>Number of beneficiaries</td>
<td>296,822</td>
<td>916,116</td>
<td>2,530,111</td>
<td>942,236</td>
<td>296,850</td>
</tr>
<tr>
<td>Mammography, ages 65–69</td>
<td>52.8%</td>
<td>50.5%</td>
<td>48.3%</td>
<td>45.5%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>12.6</td>
<td>12.9</td>
<td>13.9</td>
<td>13.5</td>
<td>13.7</td>
</tr>
<tr>
<td>Diabetic eye exams</td>
<td>41.7</td>
<td>41.8</td>
<td>40.7</td>
<td>39.4</td>
<td>39.0</td>
</tr>
<tr>
<td>Diabetes, HbA1c</td>
<td>59.5</td>
<td>57.7</td>
<td>55.8</td>
<td>54.7</td>
<td>53.1</td>
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<tr>
<td>Short-stay hospital discharges</td>
<td>337</td>
<td>347</td>
<td>366</td>
<td>389</td>
<td>404</td>
</tr>
<tr>
<td>Long-stay hospital discharges</td>
<td>13</td>
<td>17</td>
<td>17</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>SNF discharges</td>
<td>70</td>
<td>73</td>
<td>76</td>
<td>82</td>
<td>86</td>
</tr>
<tr>
<td>Medicare institutional days</td>
<td>4.05</td>
<td>4.18</td>
<td>4.44</td>
<td>4.81</td>
<td>5.21</td>
</tr>
<tr>
<td>Number of care transitions</td>
<td>0.84</td>
<td>0.87</td>
<td>0.92</td>
<td>0.98</td>
<td>1.01</td>
</tr>
<tr>
<td>Spending per beneficiary</td>
<td>$2,241</td>
<td>$2,381</td>
<td>$2,641</td>
<td>$2,731</td>
<td>$3,012</td>
</tr>
<tr>
<td>Physician services</td>
<td>$2,221</td>
<td>$2,372</td>
<td>$2,379</td>
<td>$2,514</td>
<td>$2,613</td>
</tr>
<tr>
<td>Acute care hospital</td>
<td>$4,467</td>
<td>$4,683</td>
<td>$5,020</td>
<td>$5,245</td>
<td>$5,626</td>
</tr>
<tr>
<td>Hospital and physician (total)</td>
<td></td>
<td></td>
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<tr>
<td>Concentration of care (medical staff)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Primary hospital</td>
<td>79.7</td>
<td>75.6</td>
<td>72.7</td>
<td>70.2</td>
<td>68.7</td>
</tr>
<tr>
<td>Primary and secondary hospital</td>
<td>67.6</td>
<td>84.1</td>
<td>81.6</td>
<td>80.1</td>
<td>77.7</td>
</tr>
<tr>
<td>Different physicians seen (average)</td>
<td>4.3</td>
<td>4.4</td>
<td>4.7</td>
<td>4.7</td>
<td>5.1</td>
</tr>
</tbody>
</table>


Note: Quality Index on graph is average of Quality measures from Exhibit. All four quality compliance measures, essentially delivery of recommended test or care) were averaged to one number.
Predictions and Perspectives

Massive Shift in Payment Models

![Bar chart showing the shift from Fee-for-Service to P4P/Full Risk Bearing/ACO payments from 2010 to 2020.]

- **2010:** 78% Fee-for-Service, 22% P4P/Full Risk Bearing/ACO
- **2015:** 53% Fee-for-Service, 47% P4P/Full Risk Bearing/ACO
- **2020:** 80% Fee-for-Service, 20% P4P/Full Risk Bearing/ACO

Source: Oliver Wyman

Likelihood of Hospitals Gaining Payer Capabilities in the Next 5 Years* (N=192)

![Bar chart showing the likelihood of hospitals gaining payer capabilities based on bed count.]

- **<100 beds:** 100% likely
- **100-299 beds:** 90% likely
- **300-499 beds:** 80% likely
- **>500 beds:** 70% likely

*Likelihood on a scale from 1 (not likely at all) to 7 (very likely).

Source: L.E.K. interviews and the L.E.K. Strategic Hospital Priorities Study 2012
What We Are Seeing in the Market

<table>
<thead>
<tr>
<th>Model</th>
<th>↑↓</th>
<th>Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinically Integrated Networks</td>
<td>↑</td>
<td>• Major momentum in many/most markets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Drivers different by market “type”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Some cross-system collaborations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Some IPA/Physician lead models, but mostly hospital / system supported</td>
</tr>
<tr>
<td>ACO’s and Full Risk contracts</td>
<td>↑</td>
<td>• Commercial and Medicare ~50/50</td>
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<tr>
<td></td>
<td></td>
<td>• Latest Batch of MSSP about to be released to applicants</td>
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<tr>
<td></td>
<td></td>
<td>• Data reporting/sharing often still problematic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seeing selected expansion of full-risk contracts – some provider inspired</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicaid risk contracts in some states</td>
</tr>
<tr>
<td>Provider-Sponsored Plans</td>
<td>↑</td>
<td>• Some marquis growth (Sutter, NSLIJ) and smaller players (CHOMP, Florida Hospital, solutions)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ABO says 1 in 5 systems to be payers by 2018</td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>←→</td>
<td>• Still limited in total application</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Still focused around cardio, ortho and birth episodes/procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Illinois Bone and Joint - Leader</td>
</tr>
<tr>
<td>PCMH</td>
<td>←→</td>
<td>• ~5000 accredited sites</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• New growth has slowed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Funding from commercial payers may be focused elsewhere</td>
</tr>
</tbody>
</table>

Source: Leavitt Partners Center for Accountable Care Intelligence, 2013

Growth of ACOs over time

Source: Leavitt Partners Center for Accountable Care Intelligence, 2013

ACOs by hospital referral region

Source: Leavitt Partners Center for Accountable Care Intelligence, 2013. CHS Oppenheimer presentation 12/13.
What is Different This Time Around

**Then**
- First round in 1980s and 1990s
- Some successes, but many failures
- Challenges
  - Lack of expertise
  - “Wrong” people in charge
  - Bad deals from the outset
  - Lack of data

**Now**
- Data
- Affordable Care Act
- Expertise
- Technology
- Cost Pressures creating imperative
  - Macro at the country level
  - Micro at the provider level
- Consumer Driven Healthcare
“Doing Nothing” Does Not Mean that Nothing Will Change

- Rate pressure
  - Rate freezes
  - Changes in payment methodology
  - Pricing transparency
  - Lower complexity care
- Utilization pressure
  - Shift towards outpatient and observation
  - Reduced ER visits
- Market pressure
  - Shifting referrals to competitor
  - Shift to lower cost diagnostic options
- High % of charges contracts are no guarantees of revenue

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<thead>
<tr>
<th></th>
<th>Status Quo</th>
<th>Risk Arrangement</th>
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</thead>
<tbody>
<tr>
<td>Utilization</td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td>Rates</td>
<td>↓</td>
<td>→</td>
</tr>
<tr>
<td>Market Share</td>
<td>↓</td>
<td>↑</td>
</tr>
</tbody>
</table>

What’s a Win?

- Status Quo: -15%
- Risk Arrangement: +2%
Setting a Plan

**OPTIONS**

- **FULL RISK**
  - Percentage of premium for all services
  - Certain services may be carved out (e.g., mental health, pharmacy)

- **SHARED RISK**
  - Shared risk arrangement with payers based upon agreed upon budget
  - Could be a percentage of premium or a set amount (e.g., 50/50 sharing)
  - Premium is reset based on medical expenses
  - Typically up and down-side risk

- **CORRIDORS**
  - Upper and lower limits of risk sharing
  - Beyond the corridor, the health plan takes the risk
  - Can do a corridor with full risk or shared

- **SHARED SAVINGS**
  - Budgeted dollars
  - Upside only
  - Premium is reset based on medical expenses
Evaluate Readiness

Least Influence

Market Intrinsic
- MSA Market Population
- Population Density of MSA
- MSA Payer Mix
- Population Trends
- MSA Utilization Rates

Value Prop
- Primary Care
- Specialist
- Hospital
- Payer

Market Competitive
- Value-based Competitors
- PCP Control
- Market Share Differentiable Service Lines
- MD Reimbursement
- Payer Relations

Org Capacity
- MD-Hospital Collaboration
- Financial Position and Strength
- Claims-Based Performance Data
- Cross-Continuum Services
- Executive Alignment
- Bandwidth

Physician Alignment
- Hospital – Private MD Relations
- Economic Alignment
- Clinical Alignment
- Urgency for Change
- P4P Experience

Collaboration Culture
- PCP – Specialty Relations
- System-ness
- Referral Management
- Forums

Care Continuum
- Service Distribution
- VNA & SNF
- PCMH
- Disease Mgt
- Care Coordination
- Pharmacy
- Pop. Health
- Patient Registry
- Patient Attribution

Greatest Influence

Technology
- EMR
- HIE
- Analytics
- Portal
- Patient Registry
- Patient Attribution

Least Influence

Valence Health
Rural Situation

- Generally more “mission driven” mentality and collaborative environment as patients & providers = friends and neighbors
- Fewer specialists, more mid-levels
- Less healthy patients
  - 40 percent of rural adults are obese
  - 44% of 18-34 year olds smoke
- Fewer resources (providers and patients)
  - Physician recruitment may be an issue
  - Specialists less available
  - Fewer commercially insured
- Physician compensation may be higher

A National Rural Health Snapshot

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of USA Population**</td>
<td>nearly 25%</td>
<td>75% +</td>
</tr>
<tr>
<td>Percentage of USA Physicians**</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Num. of Specialists per 100,000 population**</td>
<td>40.1</td>
<td>134.1</td>
</tr>
<tr>
<td>Population aged 65 and older</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Population below the poverty level</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Average per capita income</td>
<td>519K</td>
<td>526K</td>
</tr>
<tr>
<td>Population who are non-Hispanic Whites</td>
<td>83%</td>
<td>69%</td>
</tr>
<tr>
<td>Adults who describe health status as fair/poor</td>
<td>28%</td>
<td>21%</td>
</tr>
<tr>
<td>Adolescents (Aged 12-17) who smoke</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Male death rate per 100,000 (Ages 1-24)</td>
<td>80</td>
<td>50</td>
</tr>
<tr>
<td>Female death rate per 100,000 (Ages 1-24)</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>Population covered by private insurance</td>
<td>64%</td>
<td>69%</td>
</tr>
<tr>
<td>Population who are Medicare beneficiaries</td>
<td>23%</td>
<td>20%</td>
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<tr>
<td>Medicare beneficiaries without drug coverage</td>
<td>45%</td>
<td>31%</td>
</tr>
<tr>
<td>Medicare spends per capita compared to USA average</td>
<td>85%</td>
<td>106%</td>
</tr>
<tr>
<td>Medicare hospital payment-to-cost ratio</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of poor covered by Medicaid</td>
<td>45%</td>
<td>49%</td>
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</tbody>
</table>

Statistics used with permission from “Eye on Health” by the Rural Wisconsin Health Cooperative, from an article entitled “Rural Health Can Lead the Way,” by former NRHA President, Tim Sizemore, Executive Director of the Rural Wisconsin Health Cooperative.
Value-Based Care: Why and How in a Rural Setting

• Value-Based model increases incentive alignment and care coordination

• Greater coordination → higher quality → lower costs

• More health dials to turn (e.g. benefit design) more impact on patients

• Use market power and shared goals to drive participation
  • Providers
  • Payers
  • Employers

• Clinical Integration as Foundation

• Regional CIN or “micro ACO” across systems
• CO-OP
• Full risk or ACO for specific population (e.g. duals, diabetics, etc.)
• Health Plan
Getting to a Provider-Sponsored Plan

- First question – do you need to go all the way to the end of the spectrum
- Second question - Medicare Advantage, Medicaid, Commercial
- Third question – market reaction and opportunity
- Fourth question – who will perform which functions

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>System</th>
<th>Partner</th>
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</thead>
<tbody>
<tr>
<td>Elig &amp; Cap Mgmt</td>
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<td>?</td>
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<tr>
<td>Invoice Management–Group/Broker</td>
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<tr>
<td>UM – Precert &amp; Concurrent/DC</td>
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<tr>
<td>Care Management</td>
<td>?</td>
<td>?</td>
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<tr>
<td>Claims/Audit/ Recoup/Check</td>
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<td>?</td>
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<tr>
<td>In/Outbound Customer Service</td>
<td>?</td>
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<td>Data Integration–Trading partners</td>
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<td>Financial Statement</td>
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<tr>
<td>Provider Relations</td>
<td>?</td>
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<tr>
<td>Pay for Performance Support</td>
<td>?</td>
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</table>
Provider-Sponsored Plan: Could be Evolutionary

- **Form Clinically Integrated Network**
  - Agreed upon care models
  - Metrics
  - Define total of care
  - Beginnings of mid-shift

- **Shared Risk with Corridors**
  - Limited upside and downside
  - Increased behavior change

- **Shared Risk without Corridors**

- **Full Risk**
  - Increased risk and reward
  - Complete behavior change

- **Provider-Sponsored Health Plan**
"Starting with Employees"

Just a starting point

Need to follow VERY quickly with bigger move
Advantages of Rural Settings

- Physician loyalty
- Market power relative to payors
- Employer relationships
- Culture
- Competitive picture (sometimes)

Source: Medscape Family Medicine Compensation Report 2011


Family Medicine Compensation by Community Type

Source: Medscape Family Medicine Compensation Report 2011
Clinically Integrated Network: QHS

- Rural, Urban and Suburban participants
- 7 health systems
- 28 Hospitals
- Medical School of Wisconsin
- 4,000 physicians
- Clinical integration as prelude to value-based care
- Care Management
- Direct employer contracting
- Employee-based health plan

Client since 2012
Provider-Sponsored Plan: Hamilton

- Dominant payer in Dalton, GA, <150,000 people
- Commercial provider-sponsored health plan (Alliant) with 30,000 lives
- Operating since late 1990s
- Profitable for 10 of last 11 years
- Jointly owned by hospital and physicians
- Also support clinical integration with IPA
- Anchored by single hospital system
- Plan likely to expand to additional systems
• Medicaid health plan with more than 110,000 lives
• Dominant Plan in Service Area – 70%
• Plan revenues now exceed hospital revenues
• Plan is the largest feeder to the hospital
• Ongoing quality improvement programs
• Largest Valence client by revenue
• Client since 2002

### Initiative | Results
--- | ---
Cadena de Madres Program | • 8% reduction in Premature Birth
Maternal Fetal Medicine Specialist | • 17% reduction in birth resulting in NICU stay
Healthy Smiles | • 18% reduction in Dental OR cases

Client since 2002
Rural Challenges

• Scale and resources
  • Cash reserves
  • Human capital
  • Technology

• Sufficient continuum of care facilities and providers to manage “lives” vs. specific episodes

• Access to existing programs due to size of populations (e.g. IL ACE Medicaid program requires 5,000 lives)

• Geography of patients may impact care management programs (e.g. transportation to care settings)

• Actuarial accuracy and risk adjustment with smaller patient populations

• Culture – willingness to change
Questions?

- Phil Kamp
- CEO, Valence Health
- philamp@valencehealth.com