Aligning New Payor Arrangements with Care Transformation on the Journey to Population Health Management

Joe Damore, VP Population Health Management, Premier Healthcare Alliance
Chuck Lehn, President, Banner Health Network
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Today’s Agenda

Introduction

National Market Developments/Changing Environment

Care Transformation

New payor arrangements

Lessons Learned

Banner Health Experience

Summary/Questions

Please note that the views expressed by the conference speakers do not necessarily reflect the views of Health Forum and the American Hospital Association.
Premier: the largest healthcare alliance in the U.S.

Our mission: to improve the health of communities

- Owned by health systems
- Uniting more than 2,800 hospitals – 57% of U.S. community hospitals—and nearly 95,000 alternate sites of care
- $40+ Billion in group purchasing volume – saving $5 Billion through collaboration, integrated data, and sharing of best practice
- Database representing 1 in every 4 U.S. hospital discharge
- 2.5 Million real-time clinical transactions per day

MAKE HEALTHCARE SUPPLY CHAIN EFFICIENT AND EFFECTIVE

DELIVER CONTINUOUS IMPROVEMENT IN COST AND QUALITY TODAY AND ENABLE SUCCESS IN NEW HEALTHCARE DELIVERY / PAYMENT MODELS

INTEGRATE DATA AND KNOWLEDGE TO CREATE MEANINGFUL BUSINESS INTELLIGENCE THAT DRIVES IMPROVEMENT
Transitioning to population health means having a foot in more than one camp

- Pay for volume
- Fragmented care
- FFS
- Treating sickness
- Adversarial payors
- Little HIT
- Duplication & waste

- Pay for value
- Accountable care
- Global payment
- Fostering wellness
- Payer partners
- Fully wired systems
- Right care, right setting, right time

Laggards | Late Majority | Early Majority | Early Adopters | Innovators
The Journey to Population Health Management

Acute care Hospital
- Acute care
- Ambulatory surgery
- Outpatient diagnostic and treatment

Continuum of care
- Primary care network
- Home care
- Ambulatory care network
- Retail Health
- Employed specialists
- Wellness center

Integrated health network
- Clinically integrated network
- Electronic record connectivity

Population health
- Global budgeting
- Shared savings
- Bundled payment
- Care management
The Transformation Journey

Value-based purchasing: HACs, quality, efficiency, cuts

Bundled payment

Global payment

HAC & readmissions penalties

Shared savings

FEE-FOR-SERVICE MOVING TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK

High-performing hospitals
- Most efficient total cost
- Most efficient supply chain
- Best outcomes in quality, safety
- Waste elimination
- Satisfied patients

High-value episodes
- DRG and episode targeting
- Care models and gainsharing
- Data analytics
- Cost management

Population management
- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration
Create the vision for population health management

Clinical Integration

Integrated Leadership

Medical Home

People Centered Foundation

Population Health Data Management

Payor Partnerships

Payor Partnerships
Four stages in the Journey to Population Health Management

1. Preparatory
   - Education
   - Assessment
   - Gap analysis
   - Operational plan

2. Transformational
   - Primary care
   - Patient Centered Medical Home
   - Clinical integration
   - Care management
   - Network development
   - Health informatics

3. Implementation
   - Defined population
   - Payor partner

4. Expansion
   - Employee health plan
   - Commercial arrangement
   - Medicare
   - Medicaid
   - Employer contracting
   - Uninsured
Growing number of ACOs nationwide

- 252 Medicare ACOs in 43 states
- Over 430 Medicare and Commercial ACOs
- 500 providers in CMS Bundled Payment initiative
Major Market Developments

- Growth of Population Health Arrangements
  - Government programs (MSSP, Medicaid, etc.)
  - Commercial Health Plans
- Consolidation of Providers
- Growing adoption by Physicians
- Growth in Provider Sponsored Health Plans
- Declining inpatient utilization/cost savings
- Major investments in HIT (EMR, HIE, analytics, etc.)
- Evidence Based Medicine Growth (“Choosing Wisely”)
- Growing Employer Support (Catalyst for Payment Reform)
- Reduction in FFS payment system
- SGR Funding/Simpson Bowles 2.0
- Implementation of State Exchanges
“The past 50 years have been marked by advances in the science of medicine.

The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered”.

– Charles H. Mayo
Care Transformation/Creating Alignment

- Primary Care Network Development
- Physician Led Clinical Integration
- Patient Centered Medical Home
- Network Development/Alignment
- Care Management
  - High Risk Population
  - Chronic Disease Management
  - Care Transitions
- HIT Tools
  - EMR
  - HIE
  - Analytics
  - Care management (Evidence Based)
  - Triple Aim based Metrics
- Patient Engagement
- Leadership/Cultural Transformation
A New Definition of Value

Value = Health + Experience Expenditures

Healthy Days

Overall Experience

Care Delivery Expenditures &
Non-Healthcare Delivery Costs (opportunity cost)
The Bridge from FFS to accountable care arrangements

Accountable Care Core Components

- People Centered Foundation
- Patient Centered Medical Home
- High Value Network
- Population Health Data Management
- ACO Leadership
- Payor Partnerships

Foundational Philosophy: Triple Aim™

Measurement
Wide variation in key capabilities

Implementation Collaborative

Readiness Collaborative

People Centered Foundation (PCMH)

Payor Partnerships

ACO / Physician Leadership

Population Health Data Management

Health Home

High Value Network

Payor Partnerships

ACO / Physician Leadership

Population Health Data Management

Health Home

High Value Network

*Data from 75 markets  Blue = High  Green = Average  Red = Low
Key Insights from alliance members for Population Health

- **Primary Care network development**
- **Patient Centered Medical Home**
- **Physician-led / professionally managed**
- **Clinically Integrated Network**
- **Care Management programs**
- **Population Health Analytics**
- **Aligned Payer arrangements**

29 markets | 23 systems | 100+ hospitals | 5,000+ MDs, 1.5M accountable care covered lives

86 markets | 67 systems | 300+ hospitals | 12,000+ MDs
Accountable care market segments

- Employee Health Plan
- Self-funded Employers
- Private Health Plans
- Medicaid Program
- Medicare Program
- Uninsured
- Retail Health Insurance
Major Payor Developments

- Rapid movement toward consumer driven health plans and new payment arrangements

- Components of new payment models
  - Transformational funding
  - Care management
  - Shared Savings

- Early Adopters include the following:
  - Regional Blue Cross plans (MN, MA, IL, HA, etc.)
  - Commercial Health Plans (Aetna, Cigna, etc.)

- Partnering with MSSP ACOs
  - Universal American (31 MSSPs)
  - Walgreen’s (3)

- Building delivery systems
  - Cigna- Primary Care Network (PCMH)-Phoenix
  - Highmark purchases hospitals/physician networks
  - United HealthCare-Monarch physicians group (2300 physicians)
  - Aetna purchases Active Health
  - Da Vita acquires Healthcare Partners
  - Informatics acquisitions by United and Aetna

- Growth in Provider Sponsored Health Plans
- Medicaid managed care/ACOs
New payor arrangements

Commercial arrangements with Blues plans

- Minnesota Blue Cross and major delivery systems (35% of hospitals/systems)
- Horizon Blue Cross with AtlantiCare
- BCBS Michigan with Marquette General Hospital
- HMSA with Hawaii Pacific Health
- Blue Cross of Massachusetts-AQC program
- Blue Shield of California/CHW/Hill Medical Group (CalPers)
- CareFirst BCBS in Maryland building largest PCMH network
- BCBS Illinois-Advocate ACO arrangement
- Texas BCBS and Texas Health Resources form ACO arrangement

Other commercial arrangements

- Cigna continues to expand its Collaborative Accountable Care to 52 programs in 22 states covering nearly 510,000 lives
- Texas Health Resources, Riverside Health System, Bon Secours partner with Aetna to form an ACO
- Aurora Health Care, Memorial Herman, and Banner Health both form ACOs with Aetna
ACO Shared Savings Model

Population health cost reduction waves

Costs

Hospital efficiency

Use rate changes

Population health innovations
Lessons learned: New Payor arrangements

- Which population segments are we going to target?
- What role should the payor play (care management, etc.)?
- What criteria should we use to evaluate potential payor partners?
- What are the important areas in contracting with a payor?
  - Transparency
  - Timely, comprehensive, and accurate claims data
  - Shared savings
  - Care management funding/role
  - Transformational funding
Factors that differentiate organizations with high ACO readiness

- Full or partial ownership of a health plan with pop health management capabilities
- Existing collaboration with other health systems in the community
- Existing risk-based contracts with payers including bundled payments
- A sophisticated EHR and HIE implementation strategy across the continuum of care
- Clinical integration across the continuum of care
- Patient-centered medical home with employed or community providers
- Positive relationships with primary and specialty care providers in the market
- Active governance structures that include physician leadership (e.g. CIN, PHO)
Factors that do **NOT** differentiate organizations with high ACO Readiness

- Market share
- Number of employed physicians
- Disproportion of the market with government financed health services
- Financial strength (strong for the entire group)
- Medicare spending level – low cost areas are not further along
- High proportion of commercially insured patients
- Already in active execution of a clinical integration strategy across the system
Common barriers to success

- Leadership commitment
- Cultural change
- Size / market presence
- Financial resources
- Physician relations
- Lack of primary care network
- Information technology
“Americans always do the right thing, after they have tried everything else”

– Winston Churchill
Both political parties recognize the need to “bend” the cost curve by changing from a volume based to a value based system.

Care Transformation and new payor arrangements are creating alignment for consumers, physicians, other providers, payors, and purchasers.

Health delivery and health plans are becoming more integrated and roles are changing.

The momentum to accountable care and population health is growing.

The early results are positive in lowering costs, enhancing quality, and improving health.

Inpatient medical admissions are declining as chronic disease management programs expand.

Health delivery systems are looking for new revenue opportunities, the redeployment of assets, and lowering costs to Medicare payment levels.
Banner Health at a Glance

- 23 Acute care hospitals
- Medical group with 1,039 providers
- Behavioral / Home Care
- Outpatient surgery
- $5 Billion in net revenue
- 36,705 employees
- 77% of net revenue in Arizona
Banner Health Network
Vision Statement

Banner Health Network Vision:
To be the health system of choice in markets we serve for those that entrust their health and wellbeing to us…

Triple Aim Goals:
1. Improving the patient experience of care
2. Improving the health of populations
3. Reducing the per capita cost of health care

Arizona Integrated Physicians
Banner Physician Hospital Organization
Community
Banner Medical Group
Banner Health
Our Value Proposition...

For Consumers that entrust their wellbeing in the network, their experience will include care that is safe, convenient and well-coordinated, respectful, provided by the care team they trust to understand their needs, listens to their concerns and engages them in decisions regarding their health and wellbeing…

For Physicians that practice within the network will have the ability to partner in a system of care and drive innovative coordinated care models leading to professional satisfaction and financial sustainability…

For Payers that choose to partner with the network will benefit from a coordinated health solution that delivers on the triple aim resulting in the realization of their brand promise…

For Purchasers that choose to partner with the network will benefit from a coordinated health solution that delivers on the triple aim resulting in improved productivity and employee satisfaction…
Value Proposition in an ACO Type Model

Expense reduction
- Decrease unit cost
- Decrease utilization
- Increase new membership

Revenue generation

Delivery Efficiency (service/care)
- All care team members practicing at the top of their license
- Streamlined work flow
- Process automation
- Decrease the cost of delivering a service (i.e. hospital bed day)

Appropriate Utilization (level/type)
- Population health risk management strategies
- Care coordination and navigation
- Evidence based medicine
- Fraud and abuse mitigation

New Business Revenue
- Shared Savings, Care Coordination, Risk and Joint Venture arrangements with payers
- Specialty focus care delivery programs/models with bundle payments

... while increasing quality and member experience
Banner Health Network

We Value: People above all... Excellence... Results... Trust...

Our Vision: Position the Banner Health Network as the delivery system of choice for payers, physicians and populations in markets we serve...

Financial
To achieve financial sustainability and grow on what must we focus?

Customer
To achieve our vision, how should we appear to our members?

Operations
To satisfy Banner Health Network members, at what operational processes must we excel?

Learning
How will we sustain our ability to change and improve?

Theme: Strategic Growth
F1 Drive Financial Performance
F2 Strengthen and Grow the Banner Health Network

Theme: Member Engagement
C1 Provide members with a coordinated and engaging experience across the network

Theme: Clinical Performance
O1 Improve the health and wellbeing of the population we serve

Theme: Physician Engagement
L1 Support network physicians in providing a well coordinated, safe and efficient care experience

Theme: Infrastructure
L2 Develop and implement infrastructure to support the network's integrated delivery system

We Value: People above all... Excellence... Results... Trust...

To achieve financial sustainability and grow on what must we focus?

To achieve our vision, how should we appear to our members?

To satisfy Banner Health Network members, at what operational processes must we excel?

How will we sustain our ability to change and improve?

Banner Health Network

2013 Banner Health Network Strategy Map

Plan the Work and Work the Plan

2013 Banner Health Network Strategy Map
# BHN Payer Update

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# BHN Payer Update (cont.)

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Payer Relationship

• Pioneer ACO

Current Members/Stats/Brief Description

• Effective 1/1/12
• 57,000 members

Why We Entered into It

• Strategically aligned with Banner’s movement toward clinical quality and commitment to Patient Centered Medical Home Model (PCMH).
• Created a funding source to support PCMH. Pioneer ACO allowed for first in market entry and is consistent with Medicare Advantage models.

First-Year Experience

• Preliminary positive financial results.
• Extensive work needed to capture and report quality metrics, especially in mixed Medical Group and IPA environment.

Lessons Learned

• High turnover in attributed population. Need to manage attribution by making sure members are seen each year.
• Communication with members is a challenge for the opt-out process due to lack of understanding of program, member trust, and inaccurate demographic information.
Payer Relationship

- Blue Cross Blue Shield Advantage

Current Members/Stats/Brief Description

- Effective 10/1/12
- Approximately 23,000 Medicare Advantage (MA) lives in Maricopa County (Greater Phoenix area)

Why We Entered into It

- Blue Advantage was a strategic partnership between Banner Health and Blue Cross Blue Shield of Arizona (BCBS AZ) including joint ownership of a Medicare Advantage Plan previously owned by Banner Health.
- The combined resources and reputation of the two organizations are being leveraged to create a more competitive product for current and prospective members.

First-Year Experience

- The BCBS AZ branding has been well received in the market.
- First-year sales lower than anticipated, likely due to timing of transaction and late introduction of products to members.
- Long term, BCBS AZ and Banner feel this product will be a market leader.

Lessons Learned

- Operational challenges integrating a provider-owned MA plan with a payer organization, but not insurmountable.
- Medicare members require significant value proposition to switch plans.
Wellness  Hospice  Long Term Care  Home Care  Post Acute Care  Hospitals  PCPs  Specialists  Ancillary  Community Resources  Pharmacy

THE HEALTH NEIGHBORHOOD

Health Print
- Medical
- Behavioral
- Social

Health Home
- Accountability for outcomes
- Member activation and engagement
- Care Coordination of the Health Neighborhood
There is a single, standardized model for Case Management; the setting varies.

- A standardized process requires standardized assessment tools, action plans, and workflows.
- Supporting programs are developed that support and mimic the standardized approach to case management. (IAC and Bundled Payment)
Care Coordination Within the Health Neighborhood

- Dedicated Case Management Team
  - Clinic-based Case Manager
  - Corporate-based Case Managers (telephonic and home-based support)
  - Social Worker
  - Case Management Assistant

- Geographic Teams
  - Coordinate local, community-based resources
  - Create incentives to wrap around other services for members without duplication, i.e. Banner Home Care
  - Partner with area hospitals to assure smooth transition of patients back to PCP
  - Integrate with specialized area-based projects, i.e. Bundled Payments, IAC

- Demographic Specific Data Analysis to Prioritize Area Needs
East Valley Case Manager Alignments
April 24, 2013

Map showing case manager alignments with names labeled:
- Dana
- Maria
- Claudia
- Kathy
- Chris
- April
- Janice
- Suzanne
- Beth
- Sherry
- Kristy
- Pat
- Michelle

Banner Health Network logo
BHN I/T Infrastructure – Achieving Industry Leadership

- Care coordination - Seamless transitions of care at every encounter
- Easy-to-receive care
- Providers have the information needed to proactively manage a panel of patients (managing people)
- Information is reconciled and propagated through the medical records and to the care team
# ActiveHealth Product Suite

## ActiveHealth
- INEXX
- Active Health CareTeam Suite
- iTriage
- MyActiveHealth

## Collaborative Care Layer
- EMR Light (MU Certified)
- Care Management
- Medical Management
- Population Registry (Physician)
- Productivity Management
- Workflow Automation
- Alerts
- Decision Support
  - Members
  - Providers

## Innovation
- Re-engineered user interface
- Integrated patient support tools
- Mobile environment

## Analysis Layer
- Risk Stratification
  - Cost
  - Clinical
- Care Engine (Rules)
- Population Management
- Utilization Tools
- Care Gaps (Trigger)
- Episode Grouper
- Predictive Analysis
- Med Reconciliation
- Practice Level Comparisons

## Innovation
- Ability to make complex queries
- Use of data for real time continuous quality improvement

## Integration Layer
- EMPI
- Create Relationships Across the Data
- Unstructured to Structured Usable Data
- Member Messaging Engine
- Creation of Cleanest Record
- Identify Opportunities for Action
- Identify Clinical Concepts

## Innovation
- Portability across all of Banner and the globe
- Care Management across all venues of care
- Reinventing patient relationships through any mode – (video, etc.)

## Data Layer
- Claims
- Lab
- Pharmacy
- External EMR’s
- MS4
- NextGen
- Cerner
- EDW

## Innovation
- Highly flexible electronic patient centric care team networking for care planning & communications
Overall Lessons Learned

- New business models ranging from shared savings to joint ventures have developed faster than we anticipated.
- Physicians will adapt to accountable care principles if you have specific clinical and financial models to invite them into, such as patient-centered medical home, bundled payments, shared savings, or other mechanisms to align quality, service, and cost goals.
- Finance and administrative work dominate time and attention during the start-up phase.
Overall Lessons Learned (cont.)

- Clinical performance, innovation, and member service are the keys to long term success. We plan to stay focused in these areas.

- Identifying specific areas of financial quality or service improvement is a great way to align interests of all parties toward a common goal.

- Don’t underestimate the extent to which communication is needed for these relationships to be successful. In-person meetings of any type (formal or informal, large or small) seem to be the most useful method of transmitting information.
Questions and answers