Clinical and Financial Integration: Managing Risk in a Changing Marketplace

Frank Williams, Evolent Health
Health Forum and the American Hospital Association Leadership Summit
July 23, 2015
We Have Seen Many Industries Undergo Transformation

Major factors driving change:

- Regulatory Catalysts
- Advances in Technology
- Financial Crises
- Rapidly Changing Buying Patterns
- Discontinuous Innovation

Across industries...

- Airlines: Southwest, Ryanair
- Financial Services: Citibank, mint.com, Lending Club
- Media: POLITICO, PANDORA, Netflix
- Healthcare: How rapidly will transformation happen? To what extent will current players be disintermediated?
Looking Back: Industry Veterans Reflecting on Their Own Path

- **David Siegel**
  President & CEO
  Frontier Airlines

- **Steve Hills**
  President & General Manager
  The Washington Post

- **Jeff Carney**
  President & CEO
  Mackenzie Investments

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**Drive the Vision**
- Push for greater velocity to lead rather than follow the market
- Provide heavy senior leadership presence to drive urgency
- Keep goal in mind at all times

**Create an Environment**
- Separate structures to drive organizational focus and prevent the old from killing the new
- Include new talent and develop an entrepreneurial culture

**Set Expectations**
- Establish realistic financial expectations: understanding new economics and investment horizon, allowing business to compete
We’re Living in Two Worlds

Headlines tell two very different stories…

“Community Health Q3 profit soars; acquires Gaffney Medical Center”

“Survival of the Biggest: CHS-HMA merger puts more pressure on stand-alones to seek partners”

“Tenet completes $4.3 billion acquisition of Vanguard Health Systems”

“Expanding profits: Medicaid 'expansion' boom for hospitals”

“Medicare pay cut looms despite positive steps in CMS rule”

“More providers, insurers showing appetite for narrow networks”

“Private insurance exchanges broaden employer options”

“WakeMed, Key Physicians partner for potential Medicare ACO”
Traditional Strategy Dependent Upon Price, Network Assumptions Which Are Being Challenged

Traditional Assumptions Underlying Provider Growth Strategy

**Entrenched Payer**
- Maintain broad provider networks
- Pass excess cost growth on to employers through brokers

**Established Provider**
- Expect steady public-payer, commercial price growth
- In-network for most plans

**Price-Insulated Patient**
- Open access to broad provider network
- Seek care with little concern for out-of-pocket payment

Source: The Advisory Board Company
Medicare is a Microcosm for Trends Across the Health Care Payment Landscape

1. Medicare Payment Innovation
   - New risk-based payment models
   - Growth of Medicare Advantage

2. Market-Based Medicaid Reform
   - Growth of Medicaid Managed Care
   - Commercialization through “Private Option”

3. Increased Commercial Market Competition
   - New dynamic individual market
   - New channels for competition in group market

Source: The Advisory Board Company
Growing Wave of Medicare Beneficiaries

Projected Number of Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>Beneficiaries (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>33.7</td>
</tr>
<tr>
<td>2000</td>
<td>37.1</td>
</tr>
<tr>
<td>2010</td>
<td>42.0</td>
</tr>
<tr>
<td>2020</td>
<td>55.6</td>
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</table>

Average Inpatient Case Mix By Volume

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Self-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>2022</td>
<td>58%</td>
<td>15%</td>
<td>25%</td>
<td>2%</td>
</tr>
</tbody>
</table>

$n = 785$ Hospitals

Hospital payment rate cuts, 2013–2022

$260B$

Reduced Medicare and Medicaid DSH$^2$ payments, 2013–2022

$56B$

Reduced Medicare payments due to sequestration and 2013 budget bill

$151B$

Source: The Advisory Board Company
Medicare Advantage Growth Unlikely to Abate, Precipitating Individualization of the Medicare Market

Projected Number of Medicare Advantage Enrollees

Enrollees (M)

2009

10.4

2010 Projections

2020

19.0

2013 Projections

8.2

29.5% of Medicare beneficiaries

(1.9%) Initial proposed 2015 MA\(^1\) payment rate cut

0.4% Final announced 2015 MA payment rate increase

Medicare

Source: The Advisory Board Company
Medicaid Budget Pressures Creating Impetus for Reform and Pushing Risk to Providers and Payers

Three Non-Traditional Models for Medicaid Reform

- **Expansion of Traditional Medicaid**
- **Full Medicaid Managed Care**
  - E.g., Florida’s Statewide Medicaid Care Program
- **Provider-Led Care Management**
  - E.g., Oregon’s “Coordinated Care Organizations”
- **Exchange-Based Privatization**
  - E.g., Arkansas’ “Private Option”

Source: The Advisory Board Company
Seeing a Resurgence in Commercial Spending

Rate of Increase in Health Care Personal Consumption Expenditures
Percent Change in Real Dollars

Fastest Growth in Seven Years

“We’re at the highest level of growth since the slowdown began. You have to go back seven years to see growth like this.”

Paul Hughes-Cromwick
Senior Health Economist, Altarum Institute

Source: The Advisory Board Company
Employers Will Not Stand Pat

Percent of Employer Plans That Will Incur the Cadillac Tax

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>16%</td>
</tr>
<tr>
<td>2029</td>
<td>75%</td>
</tr>
</tbody>
</table>

Reduction in average value of private health benefits due to the Cadillac Tax, 2029 (3.1%)

Spectrum of Options for Controlling Health Benefits Expense

- **Drop Coverage**: Trade Cadillac Tax for employer mandate penalty
- **Shift to Private Exchange**: Cap growth of employer contribution
- **Convert to Self-Funding**: Hope for success in controlling total cost growth

Source: The Advisory Board Company
The Rise of the Exchanges

Projected Size of the Potential Retail Market in 2018

Source: The Advisory Board Company

- Public Exchange: 25M
- "Private Option" Medicaid Expansion: 5M
- Private Exchange: 40M
- Medicare Exchange: 17M
- Total Retail Market: 87M
Consumers Are Buying Down, Leading to More Demand for Narrow Network Exchange Products

Metal Tiers of Plan Chosen on Public Exchange

All Enrollees

- Bronze: 20%
- Silver: 65%
- Gold: 5%
- Platinum: 9%
- Catastrophic: 2%

Enrollees Without Premium Subsidies

- Bronze: 33%
- Silver: 25%
- Gold: 21%
- Platinum: 12%
- Catastrophic: 10%

Average Monthly Premiums By Metal Tiers

<table>
<thead>
<tr>
<th>Metal Tier</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophic</td>
<td>$129</td>
</tr>
<tr>
<td>Bronze</td>
<td>$163</td>
</tr>
<tr>
<td>Silver</td>
<td>$203</td>
</tr>
<tr>
<td>Gold</td>
<td>$240</td>
</tr>
</tbody>
</table>

Source: The Advisory Board Company
A Top U.S. Employer is Creating Narrow Networks to Drive Volume Toward High-Value Institutions

This will cover >300K employee lives in the top 20 U.S. markets in narrow networks

Top 20 markets are illustrative
Providers Can’t Afford the Status Quo

Actual and Projected Future Health System Margins*

- 2011: 4%
- 2020: (17%) (projected)

*Source: The Advisory Board Company
The Transition to Value-Based Care is Accelerating

Public and private sector forces will drive growth in provider risk lives

Expected Expansion of Provider Risk

Providers and Health Systems will be at financial risk for half of the nation’s population’s health outcomes by 2018

Source: McKinsey report
## The Market is Moving Rapidly

### Government

<table>
<thead>
<tr>
<th>CMS</th>
<th>90% of Medicare FFS payments link to quality / value by 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid.gov</td>
<td>70% of Medicaid enrollees currently served through managed care delivery</td>
</tr>
</tbody>
</table>

### Payers / Employers

<table>
<thead>
<tr>
<th>Humana</th>
<th>75% of individual Medicare Advantage members in VBC by 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>86M lives in retail market by 2018</td>
</tr>
</tbody>
</table>

### Providers

<table>
<thead>
<tr>
<th>Dignity Health</th>
<th>75% of payments in accountable care by 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premier Health Partners</td>
<td>75% of business in value-based arrangements by 2020</td>
</tr>
</tbody>
</table>
New Realities of Today’s Market

1. Pricing no longer a growth lever; health systems must compete on value

2. Employers amplifying consumer quest for value

3. Risk of disintermediation as traditional and new competitors compete for patients and physicians

4. Both private/public payers are shifting risk to providers
Providers Uniquely Positioned to Deliver

- Strong local brand
- Culture and mission
- Well formed network
- Access to whole patient data
- Ability to integrate care

- Integrated care
- Patient engagement
- Physician alignment
- Narrow network

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Balanced, Integrated System Management Creates Performance That is Sustainable Over Time

- Sufficient scale under value to support infrastructure investment
- Population health performance integrated with provision of care
- Care delivery network aligned with value-based model
- Financial and administrative management to support value-based payments
- Physician-led organizational and practice transformation across the system
- Technology that drives workflow through continuum of care
Efficiency, Execution and Scale are Critical to Drive Performance

Example Health System
3,000 Beds • ~$3B in Revenue • Metropolitan Statistical Area (MSA): 2,000,000 people

Health System Value-Based Care P&L (Year 5)

Case 1 – Poorly Performing System

- Revenue: $150M
- Cost: $158M
- Margin: -$8M

- 25K lives under value
  - Employees
  - Shared savings contracts
- Limited integration and scale

Case 2 – Well Performing System

- Revenue: $1,000M
- Cost: $950M
- Margin: $50M

- 200,000 lives under value
  - Employees and self-insured
  - Payer-delegated risk arrangements
  - Provider health plan: MA and commercial
- Full clinical / financial integration and scale
A Range of Health Plans and Partnerships Can Bring Systems to Scale Rapidly

- Employee Plan
- Payer Partnerships
- Provider-Sponsored Health Plan

Managed Lives

- System Employees
- Payer Partnerships
- MSSP
- Medicare Advantage
- Commercial
- Total
Despite an Integrated Network, Physician Engagement is Essential

I’m working on both sides—I’m a doctor working with doctors, but I’m also an administrator working with doctors…this paradigm of physicians versus hospitals is dead. It’s dead and I hope it dies faster than it is dying right now. Without an absolutely shared governance, where hospitals are as invested in patient outcomes as physicians are, and physicians are as invested in service outcomes and financial outcomes as hospitals are…we have no chance of improving anything.

- Senior Executive, Large Southern Health System
Many care management programs have not maximized outcomes because they focus on the patient, leaving the physician sidelined.

Success hinges on engaging the patient through productive interactions with their care team.

Best facilitated through “all-payer,” unified approach to processes, incentives, metrics and systems.
Leveraging Data, Intelligence, and Integrated Approach to Drive Better Outcomes

Female, 67 years old presents with:
- Uncontrolled diabetes; weight gain
- No mammogram in previous 3 years

Other latent risk factors not evident on initial appointment:
- Depression (recent widow)
- Low income; housing insecurity; transportation issues

Data Aggregation and Stratification
Multiple data elements trigger patient as high risk, prompting MD office outreach

MD Visit and Patient Centered Assessment
Whole patient view identifies additional clinical issues including depression

Comprehensive Care Plan Generated
Care Manager introduced and patient enrolled in Complex Care Clinical Program

Home Visit and Patient Engagement
Care Manager makes home visit to advise on medication, nutrition and exercise regimen

Care Team Deployed to High ROI Activities
Care team coordinates patient transportation for future follow-up office visits

Integrate data across multiple sources, and identify patient using embedded rules to intervene in care

Patient enrollment in Complex Care Clinical Program, allowing access to full range of resources

PBM Services identifies unfilled diabetes medication, and coordinates with patient to fill and pick up

Clinical data identifies missed Risk Coding (RAF) opportunity and signals MD office to recode

Integrated Value-Based Care Platform
Focus on Change Management

**Imperative to Change:** Cost of inaction, building urgency levers, communication

**Challenge of Incumbency:** Inertia, daily challenges of managing organization foster slow pace of change

**Institutional Memory:** Past experiences with value-based contracts may cause hesitation

**Responsibility to Community:** Mission, role in community requires conservative decision making

- Continually analyze data to drive decision-making
- Focus on strategic paths that create clear option value
- Take calculated risk
- Accelerate strategy as competencies and performance grow

Balancing the Pace of Change

“*In over our head*”

“Too far, too fast”
Business Model Innovation

Business model innovations have reshaped entire industries and redistributed billions of dollars of value…Wal-Mart and Target, which entered the market with pioneering business models, now account for 75% of the total valuation of the retail sector. Low-cost U.S. airlines grew from a blip on the radar screen to 55% of the market value of all carriers…We have found that new business models often look unattractive to internal and external stakeholders—at the outset. To see past the borders of what is and into the land of the new, companies need a road map.

- Clay Christensen, HBR
We’re Experiencing Southwest Versus United All Over Again
With the Right Platform in Place, Opportunity to Reshape Health System Economics is Compelling

**Illustrative Revenue**
Across Value-Based Lines of Business

<table>
<thead>
<tr>
<th>Year</th>
<th>Members (thousands)</th>
<th>Net Margin</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>20</td>
<td>$140M (7%)</td>
<td>$0.2B</td>
</tr>
<tr>
<td>Year 2</td>
<td>140</td>
<td></td>
<td>$0.8B</td>
</tr>
<tr>
<td>Year 3</td>
<td>300</td>
<td></td>
<td>$1.2B</td>
</tr>
<tr>
<td>Year 4</td>
<td>490</td>
<td></td>
<td>$1.5B</td>
</tr>
<tr>
<td>Year 5</td>
<td>640</td>
<td></td>
<td>$2.0B</td>
</tr>
</tbody>
</table>

Managing as distinct business unit key to growth strategy
A Balanced Approach to Value-Based Care Transformation is a Gradual Shift

- Cost of care exceeds global payments, resulting in negative margins.
- Value created accrues predominantly to payer.
- Full financial risk.
- Value-based contracting.
- Fully integrated population health manager.

FFS and gain share.

Population health transformation.

Highest value creation and capture.
Nationallly, Providers Vary Along a VBC Spectrum, from Gainshare to Full Capture of Premium Dollar
Leading Systems are Growing Captive Health Plans or Creating Capitation Agreements Around These Networks

<table>
<thead>
<tr>
<th>Example Systems with an Owned Health Plan Approach</th>
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<tbody>
<tr>
<td>GEISINGER</td>
</tr>
<tr>
<td>Intermountain Healthcare</td>
</tr>
<tr>
<td>SHARP</td>
</tr>
<tr>
<td>Premier Health</td>
</tr>
<tr>
<td>UPMC Life Changing Medicine</td>
</tr>
<tr>
<td>North Shore LIJ</td>
</tr>
<tr>
<td>JOHNS HOPKINS Medicine</td>
</tr>
<tr>
<td>PRESBYTERIAN</td>
</tr>
<tr>
<td>Adventist Health</td>
</tr>
<tr>
<td>MedStar Health</td>
</tr>
<tr>
<td>Indiana University Health</td>
</tr>
<tr>
<td>Sutter Health</td>
</tr>
<tr>
<td>Sentara Health</td>
</tr>
<tr>
<td>INOVA HEALTH SYSTEM</td>
</tr>
<tr>
<td>CENTRA</td>
</tr>
<tr>
<td>Baylor Scott &amp; White Health</td>
</tr>
<tr>
<td>PROVIDENCE Health &amp; Services</td>
</tr>
<tr>
<td>Banner Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example Systems Creating Performance Contracts Around System’s Narrow Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>VANDERBILT HEALTH</td>
</tr>
<tr>
<td>Advocate Health Care</td>
</tr>
<tr>
<td>Population Health Alliance of Oregon</td>
</tr>
<tr>
<td>abouthealth</td>
</tr>
<tr>
<td>Banner Health</td>
</tr>
<tr>
<td>Trinity Health</td>
</tr>
</tbody>
</table>

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A Balanced Approach With an Integrated Solution Can Take Different Forms Across a Range of Situations

Example Health System A

Situation

- Statewide system health plan losing millions annually despite large investment in pop health

Solution

- Foster physician, financial and clinical alignment through development of a population health services organization and physician governance model

Results

- Reduced MA inpatient admits/1000 by 28%
- In 90 days, saved $5M in SG&A
- Recorded $16M year-over-year gross margin improvement
Example A MA Complex Care: Early Case-control Study Results Suggest ~$2 Million in Avoided Costs

Methodology

1 Sample Selection
- Managed; n = 120
  - Identify cases in embedded PATH that have at least 3 engagement months and a status of Enrolled, Engaged, Goals Met, Insurance Terminated, Lost Contact, Transferred, On Hold
- Controls (Unmanaged); n = 225
  - Cases that have no engagement month, with a status of Unable to Reach, Identified, Outreach in Progress, Insurance Terminated, Lost Contact, Transferred, On Hold

2 Matching Process
- Age
- Gender
- Charlson Comorbidity Index
- Member Months
- Propensity Score (logistic regression model including 12 mo of historical cost and use)

3 Outcome Measurement
- Total Spend (Med + Rx)
- Inpatient Utilization
- ED Utilization
- PCP Utilization
- Specialist Utilization

Preliminary Results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Managed</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spend</td>
<td>$1,381</td>
<td>$3,232</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total IP Admits</td>
<td>666</td>
<td>2,030</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Acute IP Admits</td>
<td>543</td>
<td>1,393</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Acute IP Days</td>
<td>2,505</td>
<td>7,861</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sub-Acute IP Admits</td>
<td>123</td>
<td>637</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sub-Acute IP Days</td>
<td>2,820</td>
<td>19,741</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ED Visits</td>
<td>806</td>
<td>1,214</td>
<td>0.14</td>
</tr>
<tr>
<td>PCP Visits</td>
<td>6,254</td>
<td>5,891</td>
<td>0.56</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>6,096</td>
<td>7,144</td>
<td>0.26</td>
</tr>
</tbody>
</table>

Note: Spend in PMPM, utilization in units/1,000

Annualized Cost Avoidance of ~$2M

Time Period for Comparison:
- Complex Care cases created 4/1/14 – 8/20/14
- Baseline period = 12 months prior to case create date (or anchor date)
- Study period = case create date (or anchor date) to 11/20/14; average member months in outcomes period 7.2 and 6.3 for managed and controls respectively
- Study period claims incurred thru 11/20/14, paid thru 2/9/15
A Balanced Approach With an Integrated Solution Can Take Different Forms Across a Range of Situations

Example Health System B

Situation

- Challenging competitive and payer dynamics
- Declining inpatient volumes and reimbursement

Solution

- Affiliated with a local IPA and aligned PCPs through ACO infrastructure

Results

- Four populations under management in value-based contracts
- Pursuing additional pop health and risk arrangements with payers
Example B MSSP Complex Care: Preliminary Case-control Study Results Suggest ~50% Total Cost Reduction

Methodology

1. Sample Selection
   - Managed; n = 117
     - Identify cases in that have at least 1 engagement month and a status of Enrolled, Engaged, Goals Met, Insurance Terminated, Lost Contact, Transferred, On Hold
   - Controls (Unmanaged); n = 1,224
     - Cases that have no engagement month, with a status of Unable to Reach, Identified, Outreach in Progress, Insurance Terminated, Lost Contact, Transferred, On Hold

2. Matching Process
   - Age
   - Gender
   - Charlson Comorbidity Index
   - Member Months
   - Propensity Score (logistic regression model including 12 mo of historical cost and use)

3. Outcome Measurement
   - Managed (n=107)
   - Controls (n=107)
     - Total Spend (Med + Rx)
     - Inpatient Utilization
     - ED Utilization
     - PCP Utilization
     - Specialist Utilization

Preliminary Results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Managed</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spend</td>
<td>$1,469</td>
<td>$2,999</td>
<td>&lt;0.001</td>
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<tr>
<td>Total IP Cost</td>
<td>$522</td>
<td>$1,713</td>
<td>&lt;0.001</td>
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<tr>
<td>Total IP Admits</td>
<td>848</td>
<td>1,917</td>
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<tr>
<td>Acute IP Cost</td>
<td>$314</td>
<td>$1,245</td>
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<tr>
<td>Acute IP Admits</td>
<td>576</td>
<td>1,337</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Acute IP Days</td>
<td>3,008</td>
<td>10,164</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ED Visits</td>
<td>1,152</td>
<td>1,150</td>
<td>0.98</td>
</tr>
<tr>
<td>PCP Visits</td>
<td>7,968</td>
<td>8,328</td>
<td>0.68</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>47</td>
<td>46</td>
<td>0.90</td>
</tr>
</tbody>
</table>

Note: Spend in PMPM, utilization in units/1,000

Overall cost reduction of ~50%

Time Period for Comparison:
- Complex Care cases created 2/1/14 – 8/20/14
- Baseline period = 12 months prior to case create date (or anchor date)
- Study period = case create date (or anchor date) to 11/20/14; average 7.5 member months in outcomes period for both managed and control cohorts
- Study period claims incurred thru 11/20/14, paid thru 2/9/15
Importance of First-Mover Advantage: Value-Based Care Moves Market Share and Reduces Volume

A small, independent MD-based ACO in western Kentucky started in the first wave of MSSP in 2012

- Partnered with a small ACO-enabler to build and operate infrastructure
- ACO was second-best performing MD ACO for MSSP in 2014

$5.8M in total savings
$484K in savings/PCP/yr

Health System B, a competitor, lost 20% inpatient volume as a direct result
High Performance Health Care

Benefits of a Value-Based Care Strategy

- Solidifies referral streams and maximizes volume under fee for service
- Higher net system margins under successful managed care approach
- Well positioned for rapid fee for service price declines
- Improved patient experience, quality; mission alignment

Well-Positioned Health System

| Engaged and Competent Physician Network | Central and Accountable Infrastructure to Support Scale | Broad Base of Aligned Contracts (Payer or Health Plan) | Direct to Consumer / Employer Capability | Cost Structure Enabling Attractive Pricing |
The **tipping point** is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and **spreads like wildfire**.

- Malcolm Gladwell, *The Tipping Point*