Moving Beyond the ACO: Four ‘Game-Changing’ Approaches to Value-Based Contracting

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Agenda

- Environmental context that is changing the game
- Creating customer value by disrupting traditional purchaser – provider – health plan relationships
  - Direct to employer contracting
  - Narrow networks
  - Provider sponsored health plans
  - Super ACOs and other alliances
- Case in point: Integrated Health Network of WI
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  - Super ACOs and other alliances
- Case in point: Integrated Health Network of WI
The most disturbing graph in our industry: more families are paying more and more out of pocket

Employers have spent a decade shifting away from offering a complete insurance benefit

More and more workers have a high deductible

* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/HSOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/HSOs are for in-network services.

Exchanges are increasingly dominated by high deductible plans

**Average annual deductibles**

- Individual: $4,164
- Family: $7,771

### Annual Deductibles of Individual Plans Selected on eHealth

*November 2014 – February 2015*

- $3,000-$5,999: 34%
- $2,000-$2,999: 12%
- $1,000-$1,999: 11%
- $500-$999: 3%
- < $500: 7%
- $6,000+: 34%

### Annual Deductibles of Family Plans Selected on eHealth

*November 2014 – February 2015*

- $9,000-$11,999: 23%
- $6,000-$8,999: 28%
- $3,000-$5,999: 11%
- $2,000-$2,999: 11%
- $1,000-$2,999: 7%
- < $1,000: 7%
- $12,000+: 11%

As deductibles and out-of-pocket maximums rise, more and more services are shifting to “retail”, increasing consumerism.

One large metro health system’s vulnerability:
$75-100M annual operating income

Source: Advisory Board, BDC Advisors client
Agenda for today’s discussion

● Environmental context that is changing the game

● Creating customer value by disrupting traditional purchaser – provider – health plan relationships
  ➔ Direct to employer contracting
  ➔ Narrow networks
  ➔ Provider sponsored health plans
  ➔ Super ACOs and other alliances

● Case in point: Integrated Health Network of WI
“Employers are frustrated with the consistent uptick in medical costs, and they are frustrated because they can’t figure out how to deal with the healthcare system in the same manner they deal with other suppliers”

Tom Williams
Vice President, Accountable Care
Stanford Health Care
Employers are using five tactics to address their healthcare challenges:

- Value-based benefit design
- High-performance or tailored networks
- Centers of Excellence
- ACO Direct Contracts
- Employee Clinics & Intensive Outpatient

4 of 5 can involve direct contracts with employers.
Direct to employer arrangements span many employer types and a broad spectrum of contracts.

<table>
<thead>
<tr>
<th>Employers</th>
<th>DTE Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
<td><strong>Contracting with ACOs</strong></td>
</tr>
<tr>
<td>Government</td>
<td>All Services</td>
</tr>
<tr>
<td>Companies</td>
<td>Physician Only</td>
</tr>
<tr>
<td>Companies</td>
<td><strong>Common Center of Excellence Services</strong></td>
</tr>
<tr>
<td>Companies</td>
<td>Transplants</td>
</tr>
<tr>
<td>Companies</td>
<td>Cardiac</td>
</tr>
<tr>
<td>Coalitions</td>
<td><strong>Common Center of Excellence Services</strong></td>
</tr>
<tr>
<td>Coalitions</td>
<td>Transplants</td>
</tr>
<tr>
<td>Coalitions</td>
<td>Cardiac</td>
</tr>
</tbody>
</table>
Large employers are pursuing Centers of Excellence arrangements for high cost diagnoses

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Yes, with incentives</th>
<th>Yes, but no incentives</th>
<th>No, but considering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>16%</td>
<td>50%</td>
<td>15%</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>12%</td>
<td>39%</td>
<td>19%</td>
</tr>
<tr>
<td>Knees, hips, or spine</td>
<td>18%</td>
<td>19%</td>
<td>31%</td>
</tr>
<tr>
<td>Cardiovascular/cardiac</td>
<td>9%</td>
<td>22%</td>
<td>30%</td>
</tr>
<tr>
<td>Cancer</td>
<td>3%</td>
<td>26%</td>
<td>31%</td>
</tr>
<tr>
<td>Fertility</td>
<td>6%</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>Other procedures</td>
<td>1%</td>
<td>11%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Note: Other centers of excellence programs include maternity, NICU, sleep apnea, pancreas, cornea, and kidney.

Direct to employer: the opportunity for providers

- Capture of the premium dollar
- Capture of “net new” volume
- Leverage of population health management infrastructure
- Strengthening of patient provider relationships
- Acceleration of Accountable Care Organization development
Market Imperative: Individual consumers and major employers are demanding narrow network products

- Consumers in the open market are **weighing affordability and breadth** of network; they are expressing a preference for **affordability**
  - 54% of individually insured or uninsured surveyed by Kaiser prefer a cheaper narrow network plan over more expensive broad network plans

- Consumers are **not looking for unlimited choice**, they are looking for **a few good choices**

- A **narrower, coordinated-care network**, with access to and control over medical records **is preferred by patients** over expanded choice of providers

Source: [http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html?_r=0](http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html?_r=0);
[http://www.modernhealthcare.com/article/20150605/NEWS/150609938](http://www.modernhealthcare.com/article/20150605/NEWS/150609938);
Narrow networks require a meaningful value proposition to attract business

*These narrow networks can be established with employers, health plans, or as a provider sponsored health plan*

- Integrated delivery systems are better situated to deliver a narrow network than a health plan or a group of affiliated providers
  - Must deliver what consumer wants
    - Scope of services
    - Geographic coverage

- Defining the value proposition to win new business
  - Quality
  - Utilization
  - Cost
    - Unit cost
    - Episodes of care
    - Total cost of care
  - Price, price, price
    - How much to discount?
      - 1-2%
      - 5-7%
      - 8-10%
      - 15%
Providers must create value to succeed as a narrow network

Example: Boeing Contractual Service Requirements with Roper St. Francis in Charleston, SC
(many with financial penalties for non compliance)

- Enhanced access
  - PCP: same day appointments, after hours care
  - Specialist: maximum wait time of 10 days
- Intensive outpatient care program
  - To manage patients who are medically complex
- Nurse advice line 24/7
- Dedicated web portal
- NCQA level III Patient Centered Medical Home (PCMH) accreditation (or equivalent)
  - For large clinics
- Process for proactively reminding patients of needed services
  - Health maintenance
  - Chronic disease care
Provider-sponsored health plans: learning to swim upstream

- Requires provider systems to think differently...like a health plan
- Market positioning, for example, differs significantly:

**Providers**

**Health Plans**

[Images of provider and health plan examples]
PSPs account for 13.8 million lives or 10% of total enrollment in Commercial, Medicaid HMO and Medicare Advantage

PSPs 7.3 million Medicaid lives account for a significant 16% of total managed Medicaid, while their 5.1 million Commercial lives account for only 6% of total Commercial lives

*Note: Data excludes Kaiser Permanente
Source: AIS Health Plan Directory, 2015; Mark Farrah Associates data, 2015; BDC Advisors analysis
7 strategic drivers propel health systems to develop a PSP

1) Increase volumes
   - Narrow networks at affordable rates can increase volumes for providers
   - Potential to carve out local network arrangements with national companies

2) Greater control of premium
   - Capture financial benefits of shifting delivery system to focus on population health
   - Providers may have better success in influencing patient behavior because they are closer to patients than a traditional health plan

3) Obtain data needed for PHM
   - Provides necessary data, technology platforms to develop clinical informatics to successfully manage a population
   - Clinical informatics platform enables the diffusion of best practices

4) Direct relationship with ultimate payer
   - Public and private exchanges disrupt traditional intermediaries, enabling providers to establish a direct relationship with consumers and employers
   - Competitive advantage through brand loyalty for plan and provider programs

5) Counterweight to hospital finances
   - Health plan profitability is frequently counter-cyclical to the profitability of provider operations (e.g. Presbyterian in New Mexico and Sentara in Virginia)
   - Rating agencies see geographic and product diversity as key credit strengths

6) Better physician alignment
   - Develop physician leaders on medical staff through enhanced leadership opportunities
   - Opportunities to test new payment mechanisms, care management models, and disease management protocols

7) Maintain pricing power with plans
   - Providers with their own health plans have additional leverage in their negotiations with other payers
Product segments present unique market opportunities for PSPs

**Commercial**
- Maintain / grow profitable commercial volume as enrollments decline in traditional service area and in a broader geographic footprint
- Public exchanges provide opportunity to leverage strong local brands to develop direct customer relationship

**Medicare Advantage**
- A strongly aligned physician network presents unique benefits in MA, including influencing plan choice and revenue streams via effective risk scoring
- Medicare Advantage provides significant upside compared to the alternative, a Medicare ACO

**Managed Medicaid**
- Depending on state rates, Medicaid can be a profitable program
- Effectively managing Medicaid utilization reduces unprofitable acute Medicaid activity
- Lessons learned from Medicaid population may be applied to managing other populations
Most PSPs participate in multiple product segments

More than half of PSPs offer products in multiple market segments, 42% offer plans in only one segment

<table>
<thead>
<tr>
<th># Segments</th>
<th>Products</th>
<th>% Plans</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 segments</td>
<td>Comm / MA / MCD</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comm / MA</td>
<td>14%</td>
<td>PROVIDENCE Health &amp; Services, Tufts Medical Center, HHC New York City Health + Hospitals, UPMC, SENTRY HEALTHCARE</td>
</tr>
<tr>
<td></td>
<td>Comm / MCD</td>
<td>10%</td>
<td>SUMMA Health System, WELLSTAR Health System, SANFORD Health, JOHN'S HOPKINS MEDICINE, John Hopkins NorthShore, Partners Healthcare, UW Health</td>
</tr>
<tr>
<td></td>
<td>MA / MCD</td>
<td>6%</td>
<td>VCU Health System, Samaritan Health Services, Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>1 segment</td>
<td>MCD</td>
<td>17%</td>
<td>Texas Children's Hospital, MedStar Health, CHRISTUS Health, CHRISTUS HEALTH, COMMUNITY MEDICAL CENTER, SHARP</td>
</tr>
<tr>
<td></td>
<td>Comm</td>
<td>15%</td>
<td>CoxHEALTH, MEMORIAL HERMANN, BAPTIST HEALTH, MJHS HEALTH</td>
</tr>
<tr>
<td></td>
<td>MA</td>
<td>10%</td>
<td>Trinity Health, Baptist Health, MJHS HEALTH</td>
</tr>
</tbody>
</table>

Source: AIS Health Plan Directory, 2015; BDC Advisors analysis
Provider-Sponsored Plans – Key Drivers of Success

- **Network strength**
  - Experience managing risk
  - Defined strategy to engage physicians; need them to endorse the product offering

- **Price**
  - Will need to provide better value (lower-cost) than other products in the market

- **Product**
  - Aggressive focus on member outreach and physician engagement important particularly in Medicare Advantage and Medicaid Managed Care plans, which have been a “sweet spot” for provider-sponsored plans

- **Care model design**
  - Effective care management is the difference between success and operating at a loss

- **Distribution costs**
  - This factor includes the decision of whether to rely on brokers or use an expanded, grassroots effort to recruit for Medicare Advantage or managed Medicaid offerings

- **Service and member experience**
  - Developing a reputation for excellence locally is an essential to success

- **Brand**
  - The branding should be sufficient to differentiate the local provider offering from national players and local Blue Cross products
Need for greater scale is driving new market alliances: the “super” ACOs

- **Stanford Health Alliance**
  - Network
    - 2600+ Specialists
    - 350+ Primary Care Providers (PCPs)
    - 80+ Urgent Care Centers
  - Technology
    - Patient and provider portals
    - Web appointments
  - Driving expansion strategy beyond Stanford employees

- **Integrated Health Network of Wisconsin**
  - State-wide Clinically Integrated Network
  - 1 of 2 integrated systems “super ACO” covering state
Kurt Janavitz
CEO, Integrated Health Network of Wisconsin, Brookfield, WI
What is Integrated Health Network of WI?

IHN is a broad-choice network of major Wisconsin health systems working together to deliver great health care.

- **Eight Owner Members**
  Seven health systems plus an academic medical center
- **53 hospitals**
- **8,400+ providers**, including clinically integrated physician partners
- **1,180 clinical locations**
- **100+ Associate network members**
Owner-Led IHN Team

Board and committees, comprised of C-suite Owner Members and IHN leaders, meet monthly to:

- Set direction
- Monitor progress
- Discuss opportunities
- Take IHN initiatives back to Member organizations

Seven CI Workgroups monitor quality, share best practices
- Metric & Performance Measurement
- Value & Performance Improvement
- Inpatient
- Readmissions
- Orthopedics
- Pharmacy
- Depression
Complex market dynamics and challenges:

- WI has fragmented provider markets
- Individuals seek care across systems

Led us to create an innovative model that:

- Represents an alternative to mergers and acquisitions
- Drives economies of scale

Collaboration and integration are the only ways to deliver population health.
Many Players, One Team

IHNN was founded on the idea that “Coopetition” among Members would optimize patient care.

- Competition promotes innovation and lower costs
- Collaboration drives best practice and improved efficiency
  - Shared data and management infrastructure
  - Unique contracting structure

For patients to win in WI, providers need to work together across health system boundaries.
IHN is a tailored network of major health systems working together to deliver high quality, affordable health care that meets the full continuum of needs.

**IHN’s Members are stronger together through:**

- Centralized data analytics
- Patient care coordinated across Member health systems
- Emphasis on patient/provider relationships
- Shared contracting capabilities
Data Capabilities That Fuel Care and Quality

IHN’s platform aggregates disparate data for 3.1 million lives
Clinical data for all patients from eight Member systems
• Clinical claims submitted to payers
• EMR – vitals and health maintenance
• Laboratory
Comprehensive payer claims data provides a 360° view of approximately 200,000 lives managed through 12 contracts
• Eligibility
• Post-adjudicated claims
• Risk score

IHN data analysis drives:
Care coordination
Quality monitoring
Care Model: IHN’s “Secret Sauce”

1. Transitions of Care Outreach
2. Complex Conditions Care Coordination
3. “Frequent Flyer” Outreach
4. Care Gap Closure

Clinical Data
Claims Data
Financial Data
Contracting with Payers as a Super CIN
Funds Distribution Model

IHN’s intent is to reward high achieving providers who are engaged in improving patient health, enhancing patient experiences and controlling health care costs, and our Members are putting their money where their mouth is.

The Funds Distribution Model is meant to drive communal improvement by:

• Promoting accountability while members succeed or fail together
• Equalizing improvement in absolute PMPM spend with improvement Y/Y
• Reducing the need for constant micromanagement penalties
• Balancing the view of taking care of all IHN Patients, with the value of individual contracts
Member owned plan (NHP) wanted to enter the Health Insurance Exchange (HIX) utilizing the network of providers in IHN

**Benefits for Network Health Plan (NHP)**
- Opportunity to partner with Owners’ network of providers
- Ability to shift performance risk to providers

**Benefits for IHN**
- Unique opportunity working w/ Member owned payer
- Unique opportunity to use CI data to impact population

**Final population – 3,500 members**

**Immediate focus:**
- Identify High Risk members for care navigation
- Align with IHN Member system
- Contact member
- Schedule PCP visit
- Correctly code visit to minimize risk adjustment variability

**Average Risk Score for HIX Patients – Based on CI Data**

- Bronze
- Silver
- Gold

**Bar Graph**

- Avg Retro Risk Score
- Avg Pro Risk Score
The Health Insurance Exchange market place in Wisconsin, and many other parts of the country, has irrational pricing:

- What consumers are willing to pay in premium is less than they will incur in health care spend

To combat this irrationality, IHN worked with NHP to develop a Risk Corridor concept based on what the level of claims experience will be:

- IHN Members - full risk for experience between the rational claims level and where the product is priced in the market
- IHN and NHP share risk 50%/50% in the corridor 5% above the rational claims level
- NHP takes all risk above +5%

IHN is at risk for successful care management/population health activity
Challenges of Patient Attribution

IHN currently operates under six different attribution methodologies, by contract/population

- Current payer contracts do not utilize prospective, absolute attribution methodologies
- Attributed patients are not limited to IHN’s provider network
- Payers may exclude select products/patient populations from shared savings contracts (ex: Medicare Advantage HMO vs. PPO)
- Significant time spent by IHN and Member system resources resolving attribution issues
- Patient “churn” poses a barrier to ongoing, successful care management and patient engagement
Consistent management and engagement is key
• The attributed lives managed by IHN for 11 and 12 months had the lowest PMPM
Patient Engagement Yields Results

Total spend for Engaged patients 26% lower than Non-Engaged patients

Percentage Spend Change 2014 - 2015

Among Engaged patients:

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Non-Engaged</th>
<th>Engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>2%</td>
<td>40%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>Physician</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>20%</td>
<td>14%</td>
</tr>
</tbody>
</table>
Prior State: IHN’s managed populations experienced readmission rates above expected levels.

Intervention: IHN’s Transitions of Care program contacted 95%+ of managed patients who had been discharged from an inpatient facility within 72 hours.

Result: The IHN Care Model has contributed to driving readmission rates below national expected levels year over year.

Reducing readmissions improves quality, decreases patient and employer costs, and improves patient satisfaction.
Through population health management, IHN increased the network’s composite quality score (representing key chronic and preventive care measures) over the last two years.

Completed year one of a major payer contract with the following results:

- Breast cancer screenings: \(\uparrow7\%\)
- Colorectal cancer screenings: \(\uparrow>5\%\)
- Diabetic screenings: \(\uparrow>4\%\)
- Use of generic prescriptions: \(\uparrow>2\%\)

Improved quality decreases patient and employer costs, and improves patient quality of life.
Making a Difference – Driving Savings

Significant savings were achieved in calendar years 2014 and 2015 for two of IHN’s Member self-insured groups. The most significant factors were reduced readmissions and emergency room utilization.

<table>
<thead>
<tr>
<th>Employer</th>
<th>Forecasted 2014 &amp; 2015 Spend Increase</th>
<th>Actual % Spend Increase</th>
<th>% Savings Actual vs. Forecast</th>
<th>Savings per Employee</th>
<th>Total Savings 2014 &amp; 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System 1</td>
<td>21.0%</td>
<td>1.3%</td>
<td>19.5%</td>
<td>$3,473</td>
<td>$23,113,393</td>
</tr>
<tr>
<td>Health System 2</td>
<td>15.6%</td>
<td>2.1%</td>
<td>13.2%</td>
<td>$2,497</td>
<td>$18,119,039</td>
</tr>
</tbody>
</table>

Real cost savings happen when the provider, employer and patient are aligned.
Thank You

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