Taking a Ride on the Healthcare Roller Coaster

HFMA Lone Star Chapter
TAHFA Conference
October 24, 2014

Key Drivers of Change

Description – A high-level overview of the dynamic changes in the healthcare industry that profiles the key drivers of change and their impact on the industry

Objectives

• Key industry drivers
• Market reaction
• Observations and thought leadership
• Real solutions to industry issues
'Fess Up …

Who watches reality TV shows?

Top 5 Reality Shows

* Source: Time, Inc.
Top 5 Reality Shows (continued)

Project Runway – Starring Heidi Klum and Tim Gunn.

- **Premise:** Centered around the fashion industry.
- **Goal:** Glamour and fame.
- **Lesson Learned:** All about the “look” and how you “present.”

Top 5 Reality Shows (continued)

Newlyweds

- **Premise:** Centered around “star couple” life as newlyweds.
- **Goal:** Glamour, fame, and insights on human interaction.
- **Lesson Learned:**
  - Glamour and fame – yes.
  - Human interaction – not successful.
  - Both are remarried with kids.
Top 5 Reality Shows (continued)

The Bachelor
#3
• **Premise:** Supersized dating show.
• **Goal:** Popularity contest, human interaction, and only one winner.
• **Lesson Learned:** How to reinvent yourself to win “the prize.”

American Idol
#2
• **Premise:** Celebrity maker – I want to be a star!
• **Goal:** Be a big winner … or one of the top 5.
• **Lesson Learned:** Takes talent, determination, perseverance, and risks.
Top 5 Reality Shows (continued)

Survivor

• **Premise:** Real-world voyeurism with $1 million at stake, contestants divided into tribes and voted off the island, and last man or woman standing wins.

• **Goal:** Survival – winner takes all.

• **Lesson Learned:** You need others to stay in the game at least temporarily, and ironically, when all is said and done – survival alone is not always what it is cracked up to be.

Key Takeaways

• **Survival** is key.

• Glamour and fame are **temporary**.

• It is important to look good and "own it baby."

• Real life is not always as it appears, and neither is reality TV – there are **no retakes**.

• Huge **risks** and **rewards** are involved.

• To the winner who “takes all,” it does not always feel like a “true win.”

• **Reinvention** can be key to success.

• This is a **high $S$ stakes** game.
Providers need greater control over the premium dollar in order to maintain financial viability.

- Risk shifting from payors to providers
- Providers assuming traditional payor core competencies
- Market power from payor consolidation contributing to minimal revenue growth for providers
- Providers striving to gain greater control of revenue, manage clinical processes, and preserve/grow their patient base
- Opportunity for provider/payor relationships that are less transactional and more strategic
Background and Context

Continued Shift to Value – Providers Are Seeking More of the Premium Dollar

As reimbursement shifts from volume to value, accessing nontraditional components of the premium dollar will become increasingly important for providers.

Hospital Utilization

Past value-based reimbursement pilots have demonstrated that cost savings largely come from declines in inpatient service utilization, which will impact hospital margins.

Performance Summary From a Patient-Centered Medical Home Pilot Project

- Everyone likes cost savings until it comes out of your revenue stream.
- Early results indicate that the savings from alternative delivery models will come from reductions in ED visits and hospital admissions.
- Primary care and pharmaceutical expenses have typically increased.

<table>
<thead>
<tr>
<th>Metric</th>
<th>May 1, 2008 – March 31, 2010</th>
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</thead>
<tbody>
<tr>
<td>ED Expense</td>
<td>↓ 17%</td>
</tr>
<tr>
<td>Inpatient Expense</td>
<td>↓ 12%</td>
</tr>
<tr>
<td>Generic Dispense Rate</td>
<td>↑ 10%</td>
</tr>
<tr>
<td>Pharmacy Expense</td>
<td>↑ 23%</td>
</tr>
<tr>
<td>Diagnostic Imaging Expense</td>
<td>↑ 9%</td>
</tr>
<tr>
<td>Primary Care Office Visit Expense</td>
<td>↑ 11%</td>
</tr>
<tr>
<td>ED Visits Per 1,000</td>
<td>↑ 15%</td>
</tr>
<tr>
<td>Bed Days Per 1,000</td>
<td>↑ 13%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>↓ 12%</td>
</tr>
</tbody>
</table>

NOTE: Percentage of change is based on respective baseline.

Source: IQI 2010: AMGA National Summit on ACOs.

Hospitals face substantial risk to their revenue when value-based payment mechanisms such as the patient-centered medical home (PCMH) are employed.
Renewed Interest – Health Plan

The recent resurgence in the development of provider-sponsored health plans is largely due to changes in reimbursement and health insurance exchanges.

**Reimbursement Implications**
- Access to **all patient care-related data** to manage costs better.
- **Sponsor** managed **Medicaid** and **Medicare** plans.
- **Alternate sources of income** to supplement revenue loss from utilization reductions.
- Payment reforms giving providers experience with **managing financial risk**.

**Health Insurance Exchange Implications**
- Expand or gain **market share**.
- Exchange provides **new market**.
- Provider plans **set their prices**.

Value of Provider-Sponsored Health Plan

A health plan can serve as a strategic advantage for provider organizations as they grow and diversify their offerings.

**Value Proposition**
- Growth and distribution channel to enter new markets.
- Diversifies revenue streams.
- Focus on population management and wellness, supported by claims data.
- Opportunity to bend the cost curve by control of the premium dollar.
- Extends the provider’s brand to new patient populations and new geographies.
- Understanding both provider and health plan operations will distinguish the provider-sponsored plan from non-provider-sponsored health plans.
Provider Health Plan Growth

Some estimates indicate there are currently about 300 provider-owned health plans around the country, with more expected to be developed soon.¹

• In 2010, around 10% of community hospitals owned, or were part of systems that owned, health plans.¹
• A 2011 survey of 100 hospital leaders found that 20% of them intended to market an insurance plan.²
• As of 2012, 62% of the top 100 integrated not-for-profit health systems have health plans.³
• There are four primary populations/products commonly considered by provider organizations as they develop health plans:
  – Employee health plans (EHPs)
  – Medicare Advantage (MA)
  – Direct-to-employer narrow networks
  – Health insurance exchange products⁴

¹ Source: American Hospital Association.
² Source: The Advisory Board Company.
³ Estimate of 100 based on Premier, Inc., reports. Premier is an alliance of hospitals, non-acute care facilities, and healthcare suppliers.
⁴ Source: CitiGroup Global Markets, Inc., The Value Imperative: Landscape Reflects Acceleration in Transformation.

National Landscape

Baylor Health Care System and Scott & White Healthcare

Key Points About Merged System¹
• Created the largest not-for-profit health system in Texas.
• Guided by leaders from both Baylor and Scott & White.
• Operations span 24 counties from northern suburbs of Dallas to Brenham, Texas.
• Inclusion of the Scott & White Health Plan.
• $8.3 billion in total assets.
• $5.8 billion in total net operating revenue.
• 46 hospitals.
• Over 500 patient care sites.
• Over 6,000 affiliated physicians.
• Over 36,000 employees.
• 225,000 health plan members.
• 5,216 licensed hospital beds.
• 5.3 million annual patient encounters.

¹ Source: Baylor Scott & White Health.

“We are building a new national model for health care delivery engineered to meet the demands of health care reform, the changing needs of patients and payers and the extraordinary advances in clinical care.”
  – Joel Allison, CEO, Baylor Scott & White Health²

“The combination of Baylor and Scott & White’s geographic diversity and reputations for clinical excellence strengthen both organizations during a time of significant change.”
  – Jim Turner, Chair-Elect of Board, Baylor Scott & White Health¹
National Landscape
Tenet Acquires Vanguard

- $4.3 billion acquisition.
- Annual revenue: $15 to $16 billion.
- Texas revenue doubles: $3 billion.
- New health systems in Texas:
  - Baptist Health System, San Antonio.
  - Valley Baptist Health System, South Texas.
- Health plan.

Provider Organization Perspective
Required Capabilities

Providers managing a health plan assume some of the traditional, fundamental payor core competencies.

Functions such as benefit and product design and pricing strategies often require the most development.
Provider Organization Perspective

Required Capabilities (continued)

Providers must also consider essential competencies that they have and/or will need to have in place to execute a population management strategy to support the health plan.

<table>
<thead>
<tr>
<th>Provider Competencies</th>
<th>Joint Competencies</th>
<th>Payor Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization/governance</td>
<td>Funds flow and distribution</td>
<td>Marketing and sales</td>
</tr>
<tr>
<td>Care delivery transformation</td>
<td>Incentive design and dissemination</td>
<td>Population data management</td>
</tr>
<tr>
<td>Clinical innovation</td>
<td>Network development</td>
<td>Premium pricing</td>
</tr>
<tr>
<td>Clinical standards</td>
<td>Payor contract restructuring</td>
<td>Benefit and product design</td>
</tr>
<tr>
<td>Alignment with provider partners</td>
<td>Nonclinical IT infrastructure, maintenance, and standards</td>
<td>Pharmacy network</td>
</tr>
<tr>
<td>Clinical information technology (IT)</td>
<td>Quality and other performance standards</td>
<td>Claims administration and payment</td>
</tr>
<tr>
<td>Physician coaching</td>
<td>Performance reporting</td>
<td>Financial reporting</td>
</tr>
<tr>
<td>Disease management</td>
<td>Utilization management</td>
<td></td>
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<td></td>
<td>Provider credentialing</td>
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<td></td>
<td>Employee wellness programs</td>
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Population Health Management

- Setting the Stage
- What Is Population Health Management?
- Leverage the PCMH
Setting the Stage

**Impetus for Change**

Our healthcare system is on a trajectory of insolvency. Healthcare organizations will have to collaborate to succeed in a patient-centric, value-based system. By working together to develop best practices and standardized ways of practicing medicine, patient care can subsequently be improved.

- Uncontrollable and increasing healthcare costs
- Inadequate quality
- Insufficient access to care and information
- Inconsistencies and inefficiencies in care delivery
- Increase in chronic conditions such as obesity, diabetes, heart failure, and hypertension
- Aging population
- Workforce shortages (physicians and advanced practice clinicians)
- Payor contracting shifting from volume to value

**Focus on Providing Value**

The nation is looking to healthcare organizations to innovate and improve care delivery through better coordination and more efficient use of resources, while simultaneously reducing costs.

- Improve care delivery processes and outcomes.
- Improve access to care.
- Improve care coordination and care management.

- Reduce inappropriate utilization and costs.
- Invest in electronic health IT systems.
- Increase efficiencies.

- Develop and disseminate best practices.
- Promote quality-based reimbursement.
- Increase transparency and use of reporting tools.

This movement to value-based care entails a shift from the previously fragmented and inefficient healthcare system.
Across the country, provider organizations are responding to this shift through participation in various internal, payor, and government initiatives.

Setting the Stage
Redesigning Care and Payment Delivery Models

As patients demand lower costs and higher-quality care, the shift to value-based care and payment delivery is moving in the direction of managing the total cost of care through population-focused care models.

The Payment and Care Delivery Continuum Shifting Toward Risk- and Value-Based Models

Payment Models
- Fee-for-Service (FFS)
- Bundled Payment
- Payment for Episodes of Care
- Gain Sharing
- Global Payment With Performance Risk and P4P
- Global Payment With Financial Risk

Care Models
- Volume-Based Care Delivery
- Management of Episodes of Care
- Care Management
- Care Coordination
- PCMH
- Population Health

Across the country, provider organizations are responding to this shift through participation in various internal, payor, and government initiatives.

What Is Population Health Management?
Stratify Your Patient Population

PHM requires an understanding of your patient population and determining care needs, as well as the timing of interventions.

Low-Risk Patients: 75%
Healthy or have a well-managed chronic condition

Medium-Risk Patients: 20%
Multiple risk factors that may potentially become high risk if not addressed

High-Risk Patients: 5%
At least one complex illness, multiple comorbidities, and/or psychosocial problems; may be “super utilizers”

Once the patient population has been stratified into different risk levels, organizations can prioritize their efforts and redesign or expand upon their care model.

NOTE: Percentages based on national sources, including The Advisory Board Company, American Academy of Family Physicians, and Centers for Disease Control and Prevention.
The success and sustainability of PHM efforts require a comprehensive approach and strategy that considers the key components above.

What Is Population Health Management?
Overview

PHM requires a focus on the patient’s total health picture across the full continuum of care.

Integrated Care for the Patient Population

By understanding risk, recognizing multiple access points, and redesigning the organization’s clinical operations, practices may successfully develop a strategy that is flexible across the full patient population served.

Low Risk
- Does not require frequent appointments.
- Seeks convenience and immediate access to needed services.
- Wellness and prevention should be emphasized when opportunities arise.

Medium Risk
- Engages physician when necessary.
- A team-based, collaborative approach is most appropriate.
- Providers focus efforts to reduce chances of patients becoming high risk and increase the chances they will shift to low risk.

High Risk
- Benefits from one-on-one relationship with physician, coordinated through a high-risk care manager.
- Care is coordinated with specialists, proactive, and thorough.
- Utilizes lower-cost care management protocols when clinically effective and appropriate.
Leverage the PCMH
Innovative Approach to the PCMH Transition

Within the three-phased approach, we developed a qualitative and quantitative readiness assessment to assist clients in understanding and addressing any gaps in the transition to the PCMH model and, subsequently, larger PHM efforts.

A significant number of PCMHs fail after the first year because their transition considers only operational changes. Our approach considers operational changes, cultural changes, financial alignment, the IT infrastructure, and the organizational and management structure.

The components are analyzed and scored and then weighted based on a number of criteria necessary for a successful PCMH model.

Leverage the PCMH
Readiness Assessment – Key Components

The readiness assessment analyzes five key competencies/capabilities that are integral to a successful PCMH.

<table>
<thead>
<tr>
<th>Care Delivery Model</th>
<th>Organization and Management</th>
<th>IT</th>
<th>Financial Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine care management and population health processes and programs.</td>
<td>Define the vision, goals, and strategic objectives of the intended PCMH.</td>
<td>Review current EMR capabilities (e.g., documentation, e-prescribing, decision support tools).</td>
<td>Review current payor contracts and identify opportunities for improved alignment with new PCMH model (e.g., enhanced payments for care management, P4P, shared savings).</td>
</tr>
<tr>
<td>Ensure care coordination, follow-up, referral management, and transitions of care.</td>
<td>Review current communication plans.</td>
<td>Understand ability to exchange clinical information between providers, facilities, and patients.</td>
<td>Determine availability of grants or payor arrangements to fund up-front infrastructure and transformation costs.</td>
</tr>
<tr>
<td>Determine utilization of standard clinical protocols.</td>
<td>Determine availability of care delivery and/or continuous improvement committees.</td>
<td>Determine tracking and reporting capabilities (e.g., patient registries and physician dashboards).</td>
<td>Review physician compensation and incentives to ensure alignment with PCMH.</td>
</tr>
<tr>
<td>Ensure patient/family engagement and satisfaction.</td>
<td>Understand processes to align current and new physicians with the model.</td>
<td>Clarify plans for any future IT upgrades.</td>
<td></td>
</tr>
<tr>
<td>Review care team model.</td>
<td>Review quality and performance measures.</td>
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</tr>
<tr>
<td>Determine access and continuity of care.</td>
<td>Evaluate leadership.</td>
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Culture
Innovative Payment Methodologies

Market Overview
Runaway Healthcare Costs

The economics of FFS medicine have resulted in an accelerated growth in healthcare costs.

Features of Our System
• Reimbursement that rewards volume above all else
• Separation between the financing and delivery of healthcare
• Highly fragmented markets, consisting of largely independent players

Result
• Little consensus regarding what constitutes quality and how to improve outcomes
• Medical “arms race”
• Out-of-control costs
• Little to show for expenditures in terms of population health outcomes
Value, more than ever, is the competitive edge in the new healthcare environment.

Walmart and Lowe’s enter bundled pay deal with four health systems. The coalition of large U.S. employers will offer no-cost coverage for hip and knee implant procedures at four U.S. health systems.

BlueCross announces bundled payment agreements with leading orthopedic groups in Tennessee. Medical practices across the state will provide treatment under the new payment method for total knee and hip replacement.

PepsiCo strikes “rare” bundled payment deal with Johns Hopkins. Soda company to cover workers’ surgeries at Baltimore hospital.

Lowe’s and Cleveland Clinic hit “home run” with bundled payment deal.

A new breakthrough orthopedic PHO is established. National Orthopaedic & Spine alliance brings together best-in-class programs.

BlueCross announces bundled payment agreement with high-quality orthopedic groups in Tennessee. Medical practices across the state will provide treatment under the new payment method for total knee and hip replacement.

As organizations consider a bundled payment strategy, it will be important to answer the following questions:

- **Strategic Goals** – What are the objectives and goals for creating a bundle, and what are the definitions of success?
- **Operational Competency** – Does the organization have the capability to execute the desired bundle? What additional infrastructure is required to successfully initiate and capitalize on a bundled payment model?
- **Great Value** – Which services exhibit high value, measured by quality and cost? Which services have the most potential for increasing value?
- **Provider Alignment** – Is there sufficient alignment with providers, ancillary services, and physicians to execute a bundle?
- **Available Market** – Is there an addressable market of patients that could benefit from this bundle?
Considering a Bundled Payment Strategy

Bundles Could Serve as Part of a Broader ACO Strategy

- **Incentives Aligned for All Providers** – The highest degree of success can be obtained when PCPs, specialists, and the hospitals’ incentives are mutually supportive.

- **Achievable Savings and Sustainable Incentives** – All incentives will be funded from savings and distributed to partners in an equitable fashion using performance metrics.

- **Administrative and Operational Capabilities** – Stakeholders improve operational skills for executing and reporting a value-based arrangement. Participants should be able to understand the methodology, and the metrics and incentives should be easily tracked and calculated.

- **Patient Engagement** – Patients and family members will be encouraged to become active participants. Benefits will be designed to provide incentives to use qualified bundle providers.

- **Exportability** – Once the pilot bundled arrangement and infrastructure is developed for selected episodes, other value-based arrangements can use a similar process.

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Understanding Bundled Payments

**Bundled Payments Defined**

Bundled payments are defined as a negotiated payment of a predetermined amount for all furnished services related to an episode of care.

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1 **Other physicians who are involved in providing care related to an episode, such as anesthesiologists, pathologists, and radiologists.**

2 Post-acute services and post-acute physicians are highlighted because these services are more variable as far as bundle definition (i.e., the service period the bundle covers).

Chronic conditions that are not isolated to a single episode of care are not well suited for a bundled payment.
Bundled Payments and Population Health

**Bundled Payments as a Component of Population Health**

Bundled payments are only one element of the larger end-state goal of population health. Organizations can build upon their experience with bundled payment initiatives to move toward population health.

**Bundled Payment Model**
- Manages specific episodes of care
- Manages specific patient populations
- Offers care coordination within hospital or applicable facilities
- Is focused on improving quality of care, health outcomes, and costs for specific episodes of care

**Population Health**
- Manages all aspects of health, from prevention and wellness to complex care
- Emphasizes managing health for all patient populations
- Offers care coordination across all settings
- Is applicable to a much longer period than that of a single episode of care
- Is focused on improving the quality of care, health outcomes, and costs of care
- Encompasses the efforts of bundled payment models

**Payment Evolution**

**Clinically Integrated Models**
- Providers share responsibility for cost or utilization and have a significant positive gain for achieving targets.
- Members or owners share financial risk directly or through membership in another organization.
- Members may not account for more than 30% of physicians in the local market.

**Financial Integration**
- System-wide efficiencies across providers.
- Centralized ownership.

**Independent Contracting Decisions**
- Physician/Hospital Alignment
- “United Front”

**Potential Models of Integration**
- Coordinated Care
- Merger/Acquisition
- Clinical Integration
- Risk Sharing
- P4P

**Range of Clinical Integration**

**Less Integrated**
- Messenger Model
- Third-Party “Messenger”

**More Integrated**
- Care is provided in accordance with quality targets.
- The quality of care is reviewed and monitored.
- There are provisions for adequate peer review if quality targets are not achieved.
- Payments are based on historical activity to avoid referral incentives.

- Providers share responsibility for cost or utilization and have a significant positive gain for achieving targets.
- Members or owners share financial risk directly or through membership in another organization.
- Members may not account for more than 30% of physicians in the local market.

- System-wide efficiencies across providers.
- Integrated IT and efficient information exchange.
- Compliance with utilization review and performance standards.
Payor initiatives are putting downward pressure on provider reimbursement. Those providers positioned for a value-based system will emerge as market leaders.

The economic reality of reform has caused enormous changes in the insurance industry; plans are differentiating themselves through the creation of innovative products.

To properly position for the *evolving* healthcare environment, hospitals and physician groups need to simultaneously evolve – operationally, strategically, financially, and technologically.
Accountable care organization (ACO) growth continues to accelerate as providers seek to position themselves in the market. Recent literature suggests approximately 600 ACOs exist across all 50 states.

Historically, hospitals were the main sponsors of ACOs. More recently, there has been a dramatic increase in physician groups sponsoring ACOs.

ACOs are now located in all 50 states and the District of Columbia. California leads all states with 58 ACOs, followed by Florida with 55 and Texas with 44.

Source: Health Affairs, Leavitt Partners Center for Accountable Care Intelligence, www.healthaffairs.org.

Questions & Discussion

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