# The Payer–Provider Relationship as Your Strategic Advantage


A Governance Institute Webinar

*Moderated by*
Deirdre Baggot, Ph.D.
Partner, Oliver Wyman

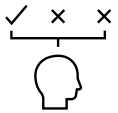
May 5, 2020

# Learning Objectives and Continuing Education

## After viewing this Webinar, participants will be able to:

**Payers' expectations**

Define the priorities and describe viewpoints of national payers regarding providers adoption of value-based care contracts



**Keys to success**

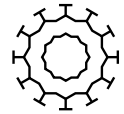
Describe the critical success factors in payer-provider partnerships when striking value-based care contracts

**Payment models**

Identify the different options available for payers and providers to structure value-based care reimbursement models

**Role of physicians**

Describe how physicians should be included and what their role should be in payer-provider value-based care discussions



**COVID-19**

Identify some COVID-19 impacts on the future health system

**Continuing education credits available**

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# Continuing Education (continued)

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**Program level:** Overview · No advanced preparation required

**Field of study:** Business Management and Organization

**Delivery method:** Group Internet based

**Maximum potential CPE credits:** 1.8

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- None of the presenters intend to discuss off-label uses of drugs, mechanical devices, biologics, or diagnostics not approved by the FDA for use in the United States

# Today's Presenters

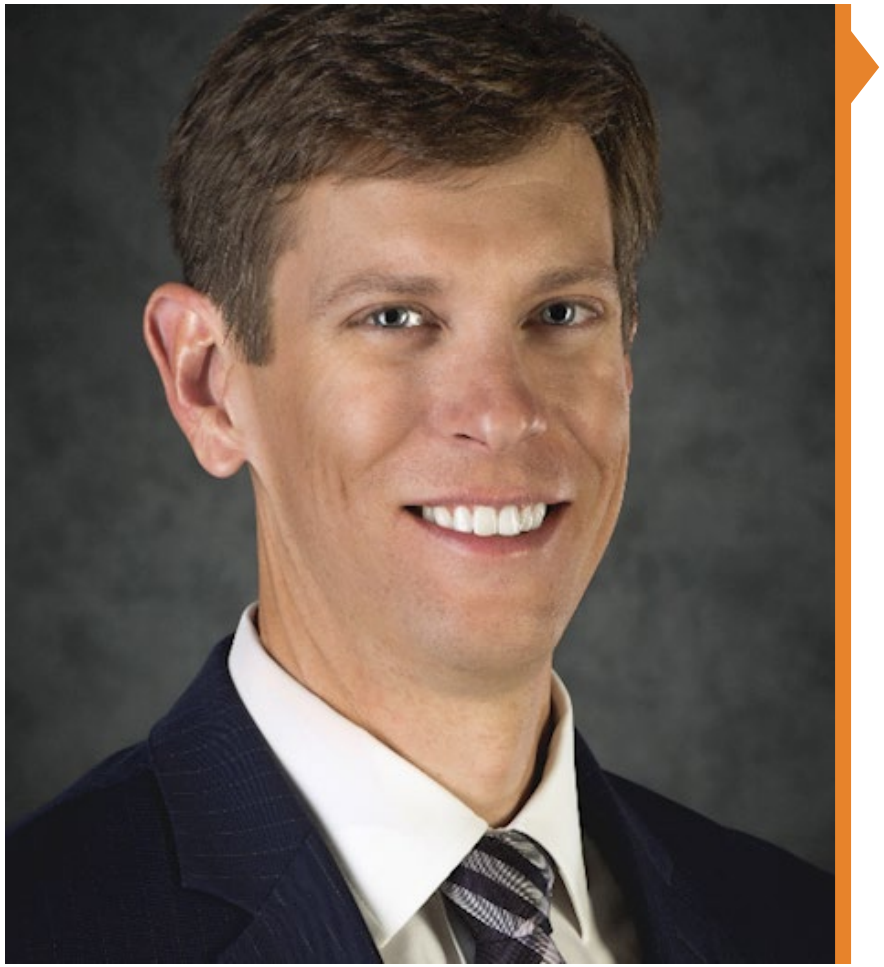
## Deirdre M. Baggot, Ph.D., RN.

Partner, Health & Life Sciences Practice, Oliver Wyman
Faculty, The Governance Institute

Deirdre specializes in developing strategies to transform clients for the shift to value and consumer-centric healthcare across provider and payer clients, as well as health enablement companies. She has developed multiple value-based healthcare provider and payer collaboration strategies, and has engaged in extensive value-based contracting, network design, and joint venture formations between provider systems and payers.

Deirdre is a former hospital executive who spent 10 years in academic healthcare, first at Northwestern Memorial Hospital and later at the University of Michigan Health System. She also is a Former Expert Reviewer, Centers for Medicare and Medicaid Innovation and served as an advisor to NY Medicaid on the development and piloting of eight chronic disease bundles from development to launch. Deirdre holds a Ph.D. from the University of Colorado, an M.B.A. from Quinlan School of Business at Loyola University Chicago where she was a Gregery LaVert Scholar and a Bachelor of Science in nursing (summa cum laude) from Southern Illinois University. In addition, Deirdre received a certificate in healthcare executive leadership from the Wharton School and LEAN certification from the University of Michigan.

# Today's Presenters



## Jordan Reigel, M.A., M.B.A.

### Vice President, Government Programs Payment Strategy, UnitedHealthcare

Jordan is responsible for designing and implementing value-based payment strategies in collaboration with healthcare providers and developing strategic relationships to drive improved health outcomes and make care more accessible and affordable for UnitedHealthcare's Medicare and Medicaid beneficiaries.

During his 13 years at UnitedHealthcare, Mr. Reigel has held various leadership positions involving payment strategy and network management, including Vice President of Network Management for the Mountain States Region. Prior to joining UnitedHealthcare, Jordan was focused on network design and strategic partnership development within a large, staff-model health plan.

In each of these roles he has focused on finding new ways to bring care providers and health plans together to collaborate toward achieving the triple aim of improving the patient experience, improving health outcomes, and increased care value.

# Today's Presenters

## Grace Terrell, M.D., M.M.M.

### President & Chief Operating Officer, Eventus Wholehealth

Grace Terrell, M.D., M.M.M., is President and CEO of Eventus WholeHealth, a company focused on integrated value-based medicine and primary care in the long-term care space. She is a national thought leader in healthcare innovation and delivery system reform, and a serial entrepreneur in population health outcomes driven through patient care model design, clinical and information integration, and value-based payment models. She is the former CEO of Cornerstone HealthCare, one of the first medical groups to make the "move to value" by lowering the cost of care and improving its quality for the sickest, most vulnerable patients; the founding CEO of CHESS, a population health management company; and the former CEO of Envision Genomics, a company focused on the integration of precision medicine technology into population health frameworks for patients with rare and undiagnosed diseases.

Dr. Terrell currently serves on the U.S. DHHS' Physician-Focused Payment Model Technical Advisory Committee and on the board of the AMGA, and is a founding member of the Oliver Wyman Health Innovation Center. She is the author of the recently released book, Value-Based Healthcare & Payment Models, published by the American Association for Physician Leadership.

# Today's Presenters

## Bruce Hamory, M.D.

### Partner & Chief Medical Officer, Health & Life Sciences, Oliver Wyman

Dr. Hamory, an infectious disease physician, is a nationally known speaker on the topic of redesigning health delivery to improve value by improving quality and reducing costs.

Prior to joining Oliver Wyman, he was Executive Vice President, System Chief Medical Officer (Emeritus) at Geisinger, and Managing Partner for xG Health Solutions. In that role, he led Geisinger's efforts to extend its innovations in healthcare delivery and payment systems to other groups and health systems. As Geisinger's System Chief Medical Officer from 1997 through 2008, he led the growth of the Geisinger Clinic from 535 to 750 physicians serving 35 countries. He oversaw the installation and refinement of an advanced electronic health record, led the development of a physician compensation plan incorporating pay for performance and pay for outcomes, and reorganized the Geisinger system from a geographic and departmentally based structure to a service-line structure incorporating several disciplines within a service line.

Dr. Hamory has served on advisory boards for several national groups concerned with the quality and safety of healthcare, the use of information technology in healthcare, as well as the integration of patient centered medical homes with public health.

# Agenda

60 minutes

- Welcome and provider context
- United Healthcare: The payer's perspective on best practices in provider/payer alignment
- Provider/payer value-based payment arrangements
- The role of physicians in provider/payer partnerships
- Q&A

30 minutes

**BONUS TOPIC**

- COVID-19: Key panelist insights and implications to provider/payer contracting
- The journey back from C-19
- Best practices in reopening and revenue recovery

*Coming together is the beginning.*
*Keeping together is progress.*
*Working together is success.*

– Henry Ford

# Polling Question 1

## How satisfied is your organization with its payer relationships?

A. Highly satisfied
B. Moderately satisfied
C. Neutral
D. Dissatisfied
E. Highly dissatisfied

# Payers and providers are facing greater pressure to deliver superior access, affordability, and consumer experience

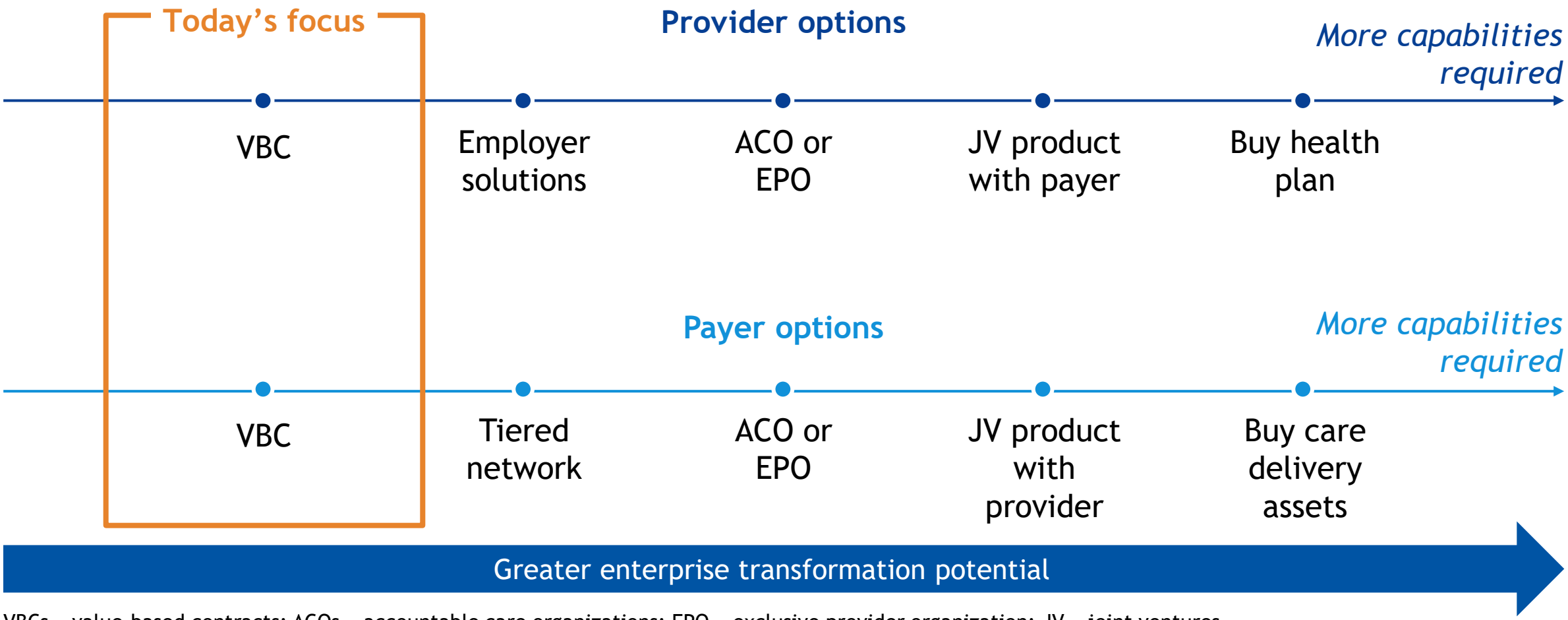
## Payer Context

- Rising premium pressure from commercial and government insurance heightens **price competition**
- Growing government segment intensifies performance pressure on **Star ratings**
- Increasing importance on **delivering a differentiated experience** to attract and retain new customers
- Yet capturing economic returns and membership growth requires greater influence over **consumer experience** and delivery of care

## Provider Context

- **Decreasing commercial and government reimbursement** threaten traditional business model
- Growing **consumer impact** on bottom line; patient experience affects provider compensation, loyalty drives volume, behavior change influences costs control
- Increased complexity of patients amidst out-migration of once profitable cases causing **margin pressure across most service lines**
- Yet clinical and business model transition to take on more **financial risks warrants new capability builds**

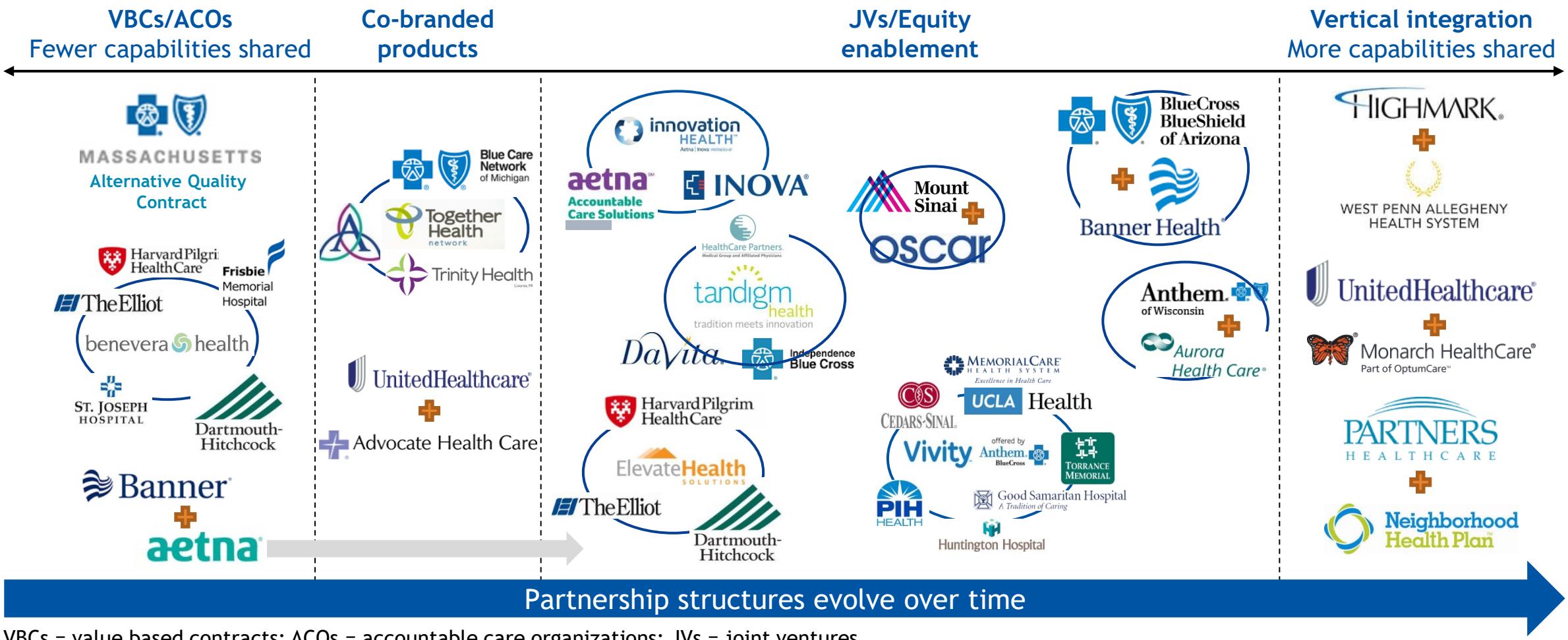
# Traditional Alignment Structures




VBCs = value-based contracts; ACOs = accountable care organizations; EPO = exclusive provider organization; JV = joint ventures

# Alignment Activities

***Sample of active and legacy partnerships***




VBCs = value based contracts; ACOs = accountable care organizations; JVs = joint ventures

# Payer–provider partnerships aimed at driving new value have made only modest gains

**For employers,** affordability is important, however they are not eager to disrupt benefits or network breadth

**No shortage of population health enablement offerings**, however most are point solutions as opposed to what is most needed which is an integrated consumer offering

**Payer perception** that providers VBC literacy is uneven (e.g., revenue levers in Medicare Advantage)

**Payers are vertically integrating** in a number of markets and may have little desire to partner given that they own care delivery assets directly

**Despite ubiquitous access** to clinical data via EHR, physicians struggle to make the data actionable. In addition, lack of industry agreement on performance measures proves frustrating for providers.

**Physicians often left out of early design conversations** resulting lack of integration between payment model and care model.

# Polling Question 2

**Partnership models between payers and providers do NOT include:**

A. Joint ventures
B. Vertical integration
C. Co-branded products
D. Shared incentives to reduce cost of care
E. Value-based care

# United Healthcare: Provider Payment & Innovation

## What has worked well?

- Uniformity on quality
- Specify and agreement on definition of success
- Address infrastructure on both sides
- Payout frequency and predictability

## What hasn't worked well?

- Unclear goals
- Lack of organizational support – program and leadership
- Lack of financial risk
- COVID

## Where are we headed?

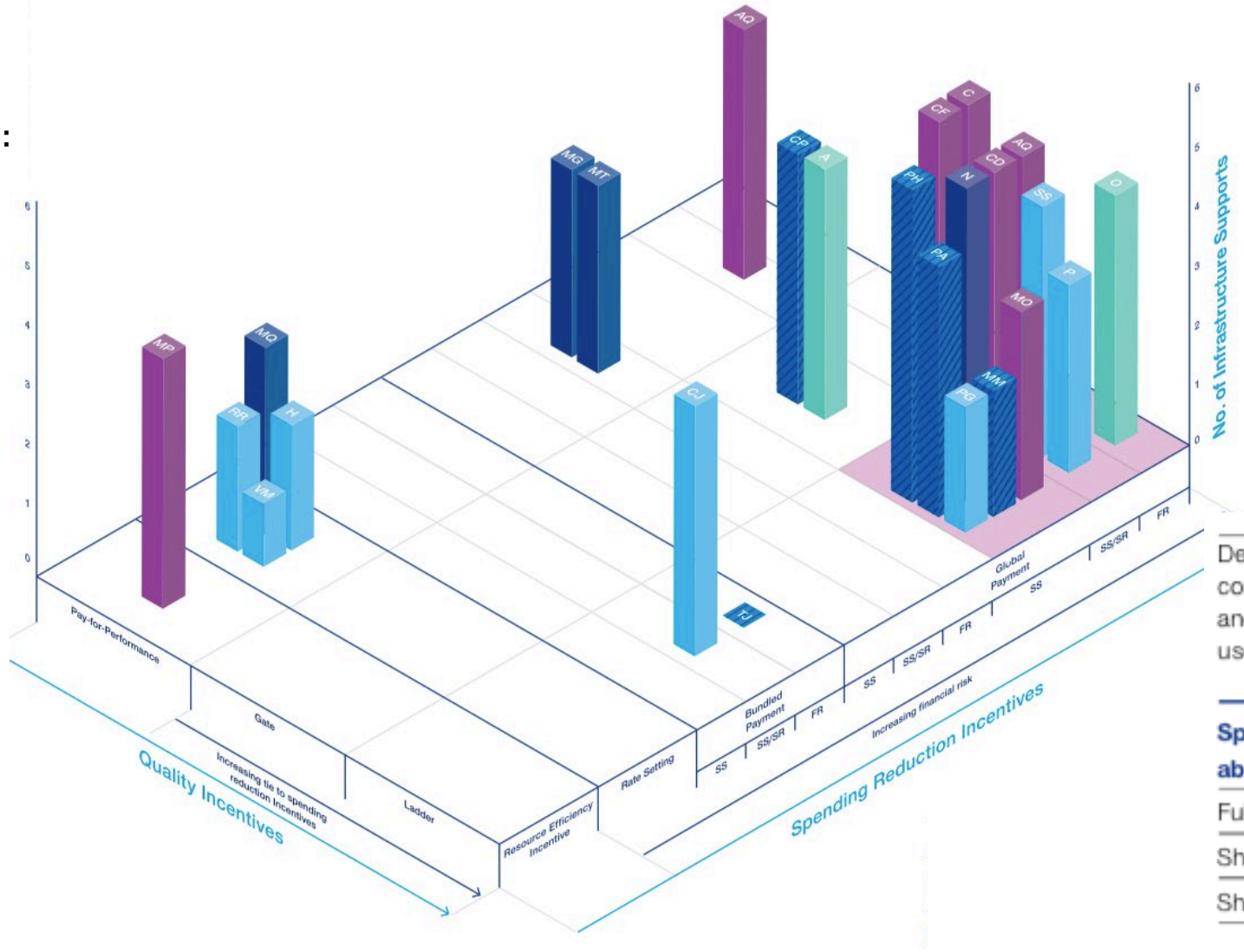
- Modular support offerings
- Concentric risk models
- Infrastructure and scale
- Telemedicine

# United Healthcare: Infrastructure Supports & Frequency of Use to Support VBC

| Infrastructure Supports – 6 Types | Description | Number of VBC programs (%) |
|---|---|---|
| Analyzed Data or Reports (AD) | Reports related to care spending, quality, or other key metrics. Report type, frequency and level of aggregation can vary. Although report delivery mode was not typically mentioned, some payers developed or provided access to Web-based portals for on-demand report creation. | 22 (92%) |
| Technical Assistance (TA) | Technical resources (e.g., performance improvement or redesign ideas and methods) that are typically geared toward building new capacities.<br>**Low intensity**: Self-serve training materials, to interactive training sessions via Webinars<br>**Medium intensity**: One-on-one direct assistance from consultants, coaches<br>**High intensity**: Peer-to-peer learning opportunities and collaboratives | 20 (83%) |
| Raw Data (RD) | Unanalyzed administrative or claims-based data. | 15 (63%) |
| Infrastructure Payment (IP) | In-kind or direct financials supports oriented towards capacity building and not typically contingent on performance achievement. | 12 (50%) |
| Risk Management Support (RM) | Additional strategies to protect participants from large losses or catastrophic individual claims. Usually accomplished via a claims cap at an absolute dollar amount or percentile of the distribution. | 8 (33%) |
| Access to Care Management and Tools (CM) | Personnel or tools that help patients get the care they need in a timely manner or coordinate care distributed across different providers. | 7 (29%) |

# United Healthcare:
# 3D Approach to VBC: Quality, Efficiency & Infrastructure

**Figure 9.**
**The three dimensions of value-based care (VBC) program design:** This 3D chart plots the 24 VBC programs evaluated for the systematic review to clearly differentiate the strongest combinations of quality incentives, spending reduction incentives and infrastructure supports for effective VBC program designs.




**Key**

**Multi:**
- Multi-Payer
- All-Payer

**Private:**
- Commercial

**Public:**
- Medicaid
- Medicare

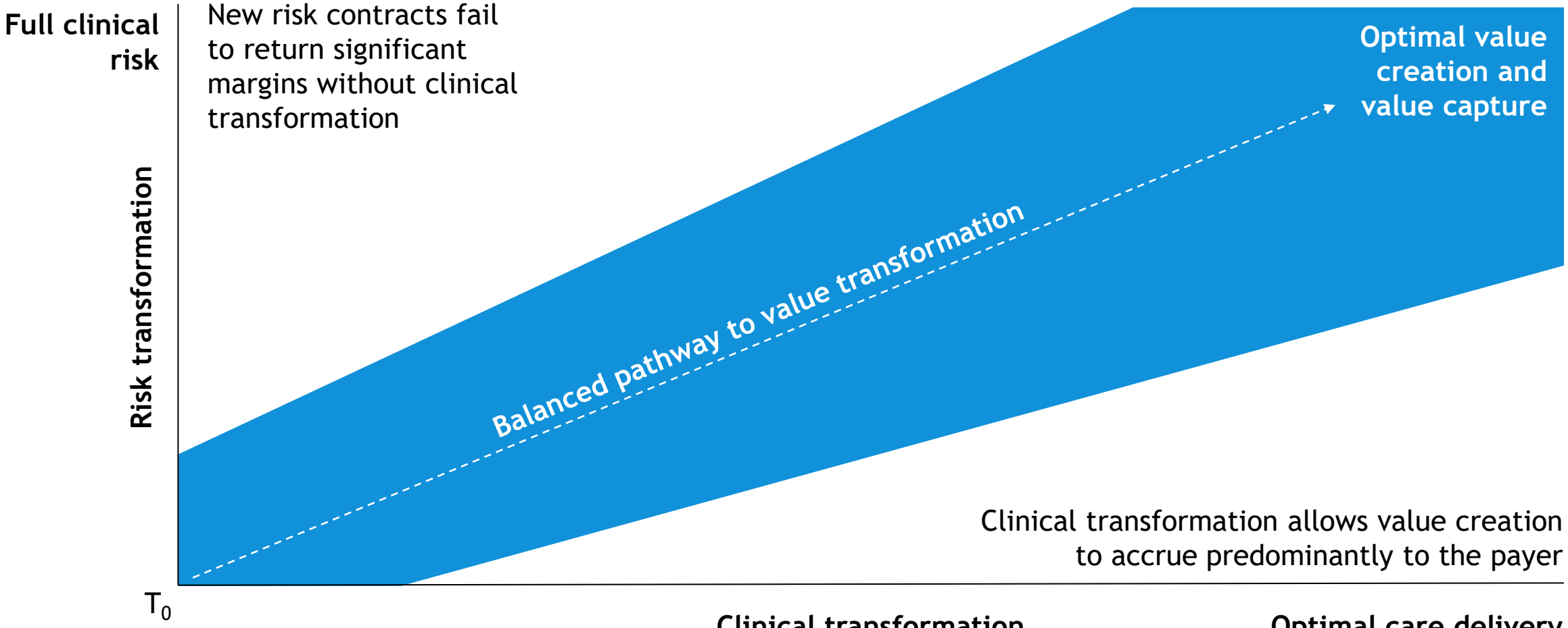
Denotes strongest combination of incentives and infrastructure supports used in VBC programs

**Spending reductions abbreviations**

| | |
|---|---|
| Full Risk | FR |
| Shared Savings | SS |
| Shared Risk | SR |

# The secret to succeeding in value-based care is integrating care models with payment models

# Solving for value-based care will require balancing contractual, clinical, and infrastructure initiatives



# Align Different Conditions with Different Payment Models

| | Fee-for-Service | Condition-based management fees | Bundled payments | Population-based global payments |
|---|---|---|---|---|
| **Condition** | Urinary tract infection | Multiple sclerosis | Total knee replacement | Frail elderly services |
| **Site of service** | Telemedicine, urgent care, primary care office | Specialty clinic | Focused factory | Team-based care across settings |
| **Care model** | Evidence-based medicine protocols | Whole-person care model | Outcomes measures, shared decision making, EBM protocols | ACOs, HMOs, CINs, other risk-bearing entities |

# Building the Right Value-Based Care Model for the Specific Use Case

| | | | |
|---|---|---|---|
| **What patient populations are to be included?** | • Healthy and independent people<br>• People with health risk factors<br>• Early-stage chronic disease | • People with acute illnesses<br>• People with complex chronic illnesses | • Late-stage complex conditions<br>• People at the end of life |
| **What components of care are to be included?** | • Total cost of care<br>• Professional services<br>• Facility services | • Pharmacy services<br>• Laboratory services | |
| **How to segment health conditions?** | • Episodes of care<br>• Types of care | | |
| **What episodes of care?** | • Preventive care (AWV/immunization)<br>• Minor episodes of care (urgent care) | • Major episodes of care (joint replacement)<br>• Catastrophic care (sepsis/trauma) | • Chronic care (diabetes, epilepsy)<br>• End-of-life care (hospice) |
| **What medical conditions?** | • Independent conditions (hypothyroidism)<br>• Preference-sensitive conditions (low back pain) | • Progressive, degenerative conditions (CHF)<br>• Conditions with episodic manifestations (gout, MS) | • Complex episodic conditions (COPD)<br>• Systemic conditions (metastatic lung cancer) |
| **What is the most suitable payment method?** | • PCMH for prevention/chronic conditions<br>• Bundled payments for acute episodic care | • Bundled payments/care coordination for chronic complex conditions | • FFS with P4P for simple transactional care (urgent care/telemedicine primary care) |
| **Which providers and services should be involved in the care?** | • PCMH for prevention/chronic conditions<br>• Bundled payments for acute episodic care | • Bundled payments/care coordination for chronic complex conditions | • FFS with P4P for simple transactional care (urgent care/telemedicine primary care) |
| **What information needs to be integrated?** | • Care coordination<br>• Cohort management<br>• Clinical, financial data | • Clinician engagement | |

# Polling question 3

**What will be the most suitable care model for cancer patients?**

A. Evidence-based medicine protocols
B. Whole-person care model
C. Outcome measures
D. ACO

# Polling Question 4

**Are physicians directly involved in payer contracting in your organization?**

A. Yes
B. No

# Physician Impact

- Dissemination and scale of best practices
  - Clinical excellence and teaming models
- New care model development
- Performance and contracting
- Leadership and communication
- Total cost of care:  Efficiency and cost
- Consumer experience and patient engagement
- Quality and safety
- Innovation and research


QUESTIONS

# COVID-19

## KEY INSIGHTS FROM PANELISTS

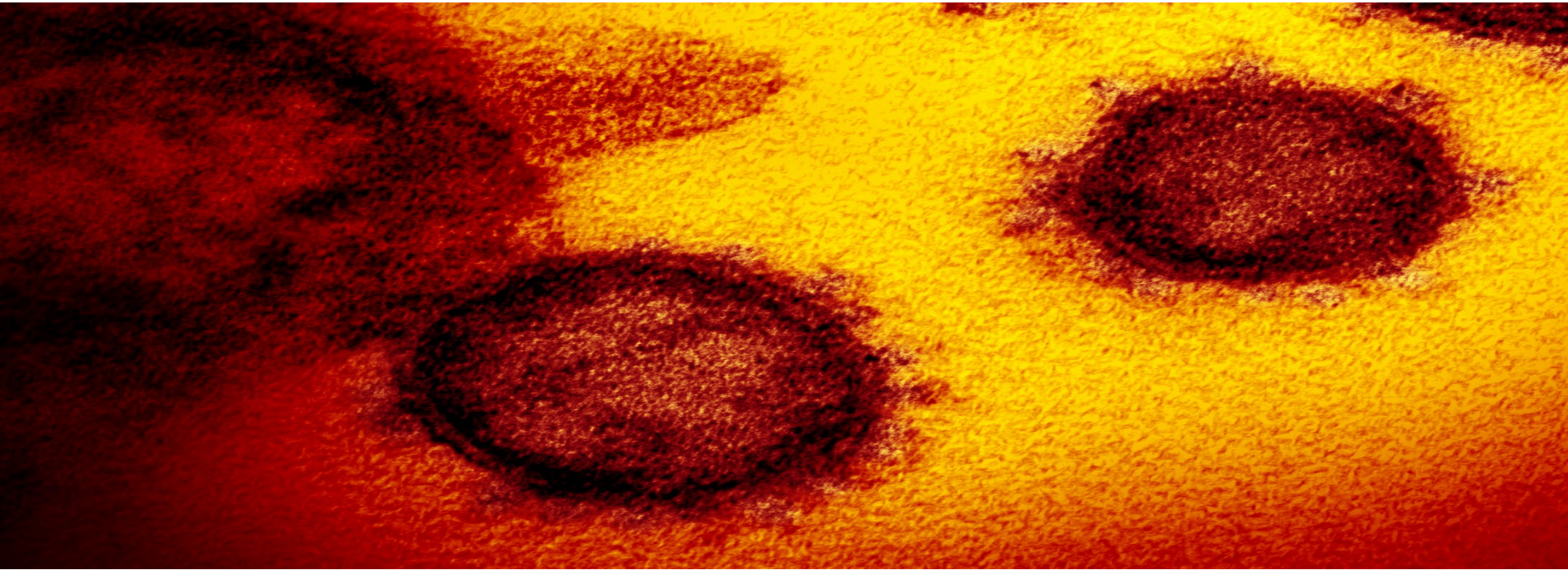
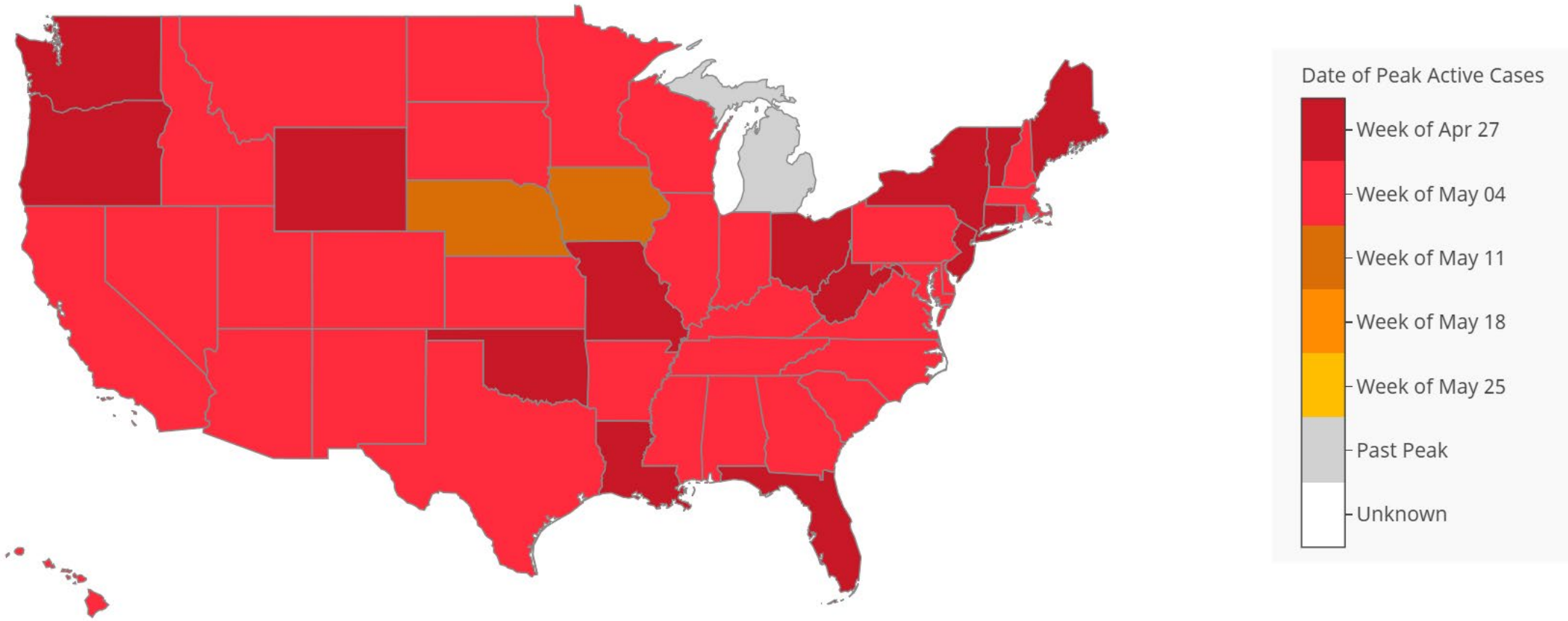


Image source: Visuals3D on Pixabay

# Peak Active Cases in Early May




Source: Oliver Wyman's COVID-19 Pandemic Navigator as of April 28 – see https://healthmap.us-west-2.owlabs.io/map for more info

# C-19 Board and Leadership Implications

**Jordan Reigel**
UnitedHealthcare

Payer implications

**Grace Terrell, M.D., M.M.M.**
Eventus WholeHealth

Primary care and mental health services in nursing homes

**Bruce Hamory, M.D.**
Oliver Wyman

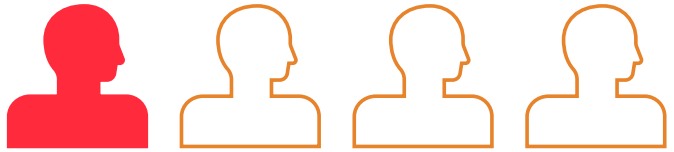
New normal and planning for future waves

**Deirdre M. Baggot, Ph.D., RN**
Oliver Wyman

Reopen and revenue recovery

# The Health of Our Communities Requires RAPID and Safe Opening

## Cancer Patients and Care



**1 IN 4 CANCER PATIENTS**

report delays in their care because of the pandemic –
**NYC alone saw 1,000+ cancer surgeries delayed**

## Cardiac Intervention for Serious Heart Attacks


**38% DECREASE**

> *We should have higher incidences of these events, but we are seeing dramatically fewer in the hospital system. That has to mean **they are at home or in the morgue**.*
>
> *- Cardiovascular Surgeon*

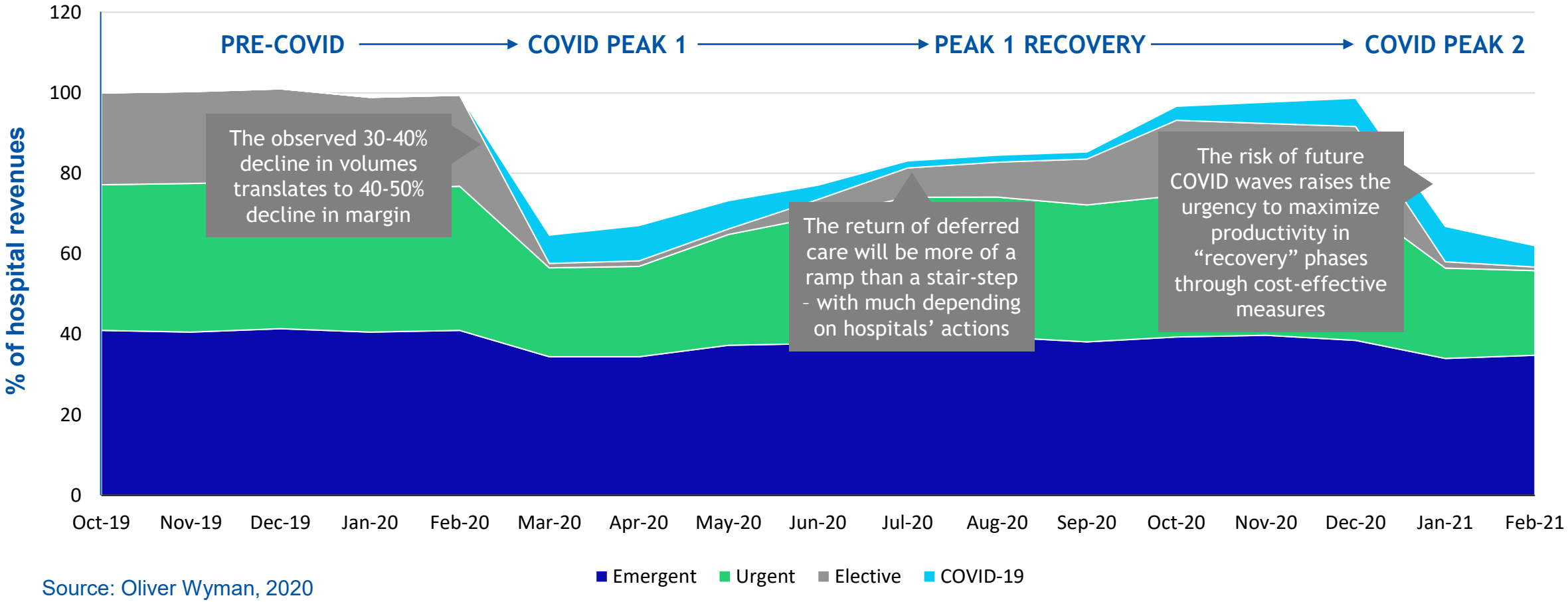
**UK STUDY REVEALS 50% DECLINE**
in Emergency Room admissions for Chest Pain as a result of C-19

Source: Cancer Action Network, NY Post, The Guardian, JACC

# COVID-19 Has Devastated Most Hospitals' Financials

## REPRESENTATIVE HOSPITAL REVENUE IMPACT FROM COVID-19

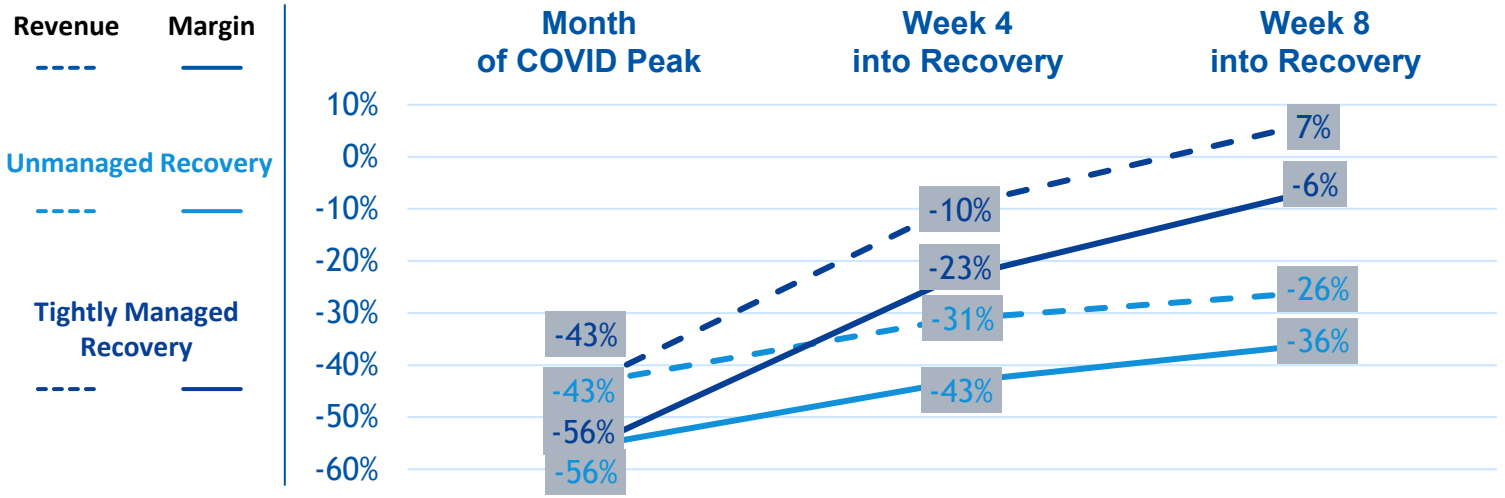
Illustrative




Source: Oliver Wyman, 2020

# Rapid Hospital Revenue Recovery

## Scenarios for Run-Rate Revenue and Margin vs. Prior Year




**Volume Impact by Service Type vs. Prior Year**

| | | | | |
|---|---|---|---|---|
| Unmanaged Recovery | Emergent | -15% | -10% | -10% |
| | Urgent | -40% | -15% | -10% |
| | Elective | -100% | -95% | -80% |
| Tightly Managed Recovery | Emergent | -15% | 0% | 0% |
| | Urgent | -40% | 33% | 75% |
| | Elective | -100% | -95% | -90% |

## Sample Accelerating Actions

- Aggressive use of virtual visits, starting today, to fill schedules back up
- Safety protocols defined, implemented and monitored
- Effective clinical and staff rotations to mitigate burnout
- Consumer confidence campaign to spur demand
- Extended hours in diagnostic and procedural areas to tackle back-log

## THE IMPACT

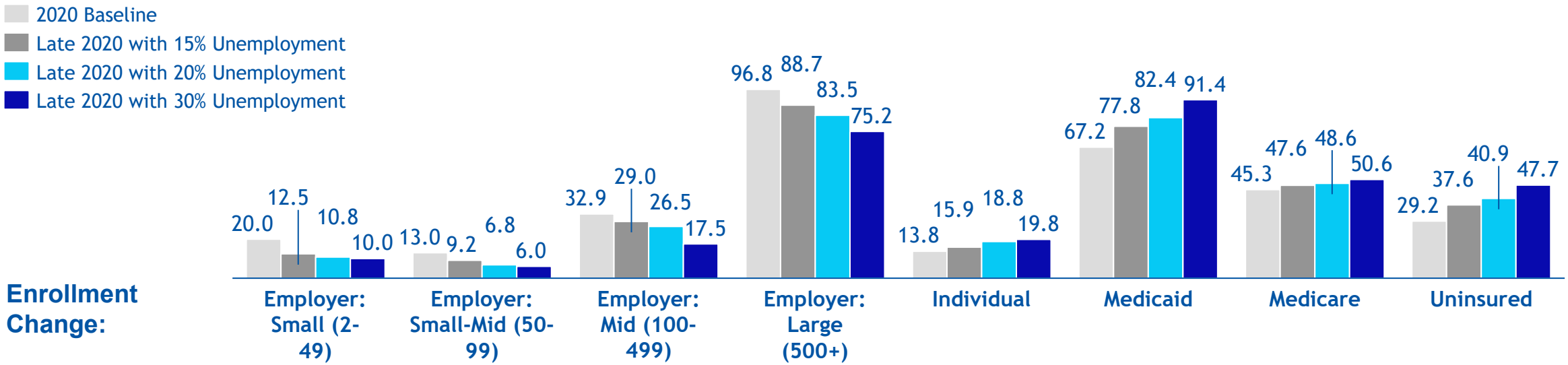
- Patient benefit is greatly improved with supercharged throughput serving urgent needs
- Run-rate margin by week 8 is improved from (-36%) to (-6%) from a normal year baseline
- This difference in margin ramp over 2 months equates to ~2% of a full-year's operating margin

Source: Oliver Wyman, 2020

# Restoring elective volume is not without challenges

## Unemployment will drive payer mix shifts and impact elective case volumes

### US National Payer Mix Scenario Analysis (MM)




**Enrollment Change:**

**Unemployment**

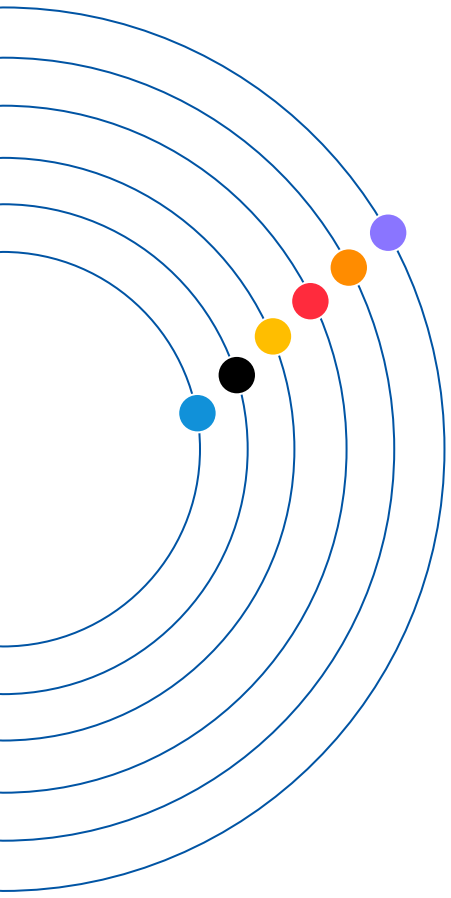
| 2020 Baseline | 20.0 MM | 13.0 MM | 32.9 MM | 96.8 MM | 13.8 MM | 67.2 MM | 45.3 MM | 29.2 MM |
|---|---|---|---|---|---|---|---|---|
| 15% | -7.5 MM | -3.8 MM | -3.9MM | -8.1MM | 2.1 MM | 10.7 MM | 2.3 MM | 8.4 MM |
| 20% | -9.2 MM | -6.2 MM | -6.4MM | -13.3 MM | 5.0 MM | 15.2 MM | 3.3 MM | 11.7 MM |
| 30% | -10.0 MM | -7.0 MM | -15.4MM | -21.6 MM | 6.0 MM | 24.2 MM | 5.3 MM | 18.6 MM |

Sources: U.S. Census Bureau, Bureau of Labor Statistics, Kaiser Family Foundation, AHRQ, MarketScan, Medicaid.gov, Pew Research, Mercer, Oliver Wyman analysis

# Elective Surgery Reopen

## Six actions to take now

THERE IS A GREAT DEAL THAT HEALTH SYSTEM LEADERS AND PHYSICIANS CAN AND SHOULD BE DOING RIGHT NOW IN AN EFFORT TO ENSURE A SAFE AND SUCCESSFUL REOPENING OF SURGICAL VOLUMES



**01** **Establish a Command Center for Reopen** to provide real-time transparency into operations and ensure workforce safety. The Command Center will execute a phased approach beginning first with urgent and non-elective cases followed by elective cases.

**02** **Plan for a 24/7 Operation** with a staffing model that allows for extended hours in lab, diagnostic testing and procedural areas to accelerate "catch-up" with pent up demand and off-set extended case duration and room-turnover for sanitation and other safety steps.

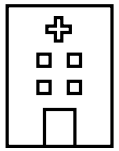
**03** **Ensure Testing Adequacy** to screen all patients for C-19 prior to surgery.

**04** **Deploy Best in Class Re-opening Procurement Team** to transparently and innovatively plan and manage of the supply chain of PPE and other critical supplies.

**05** **Mandate Personal Physician Outreach** with patients via virtual and televisit to allay patient fears and drive consumer confidence.

**06** **Implement Proactive and Flexible Scheduling** to address backlog using clinical urgency prioritization criteria.

# Components of a Smart Surgery Recovery Program



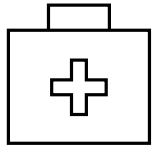
## SUPPLY CHAIN

### Testing/PPE

- Deploy an aggressive supply chain procurement strategy with real-time transparency into predicted shortages and surge capacity
- Forecast and predict in real time to enable rapid return of elective cases
- Simulate and plan for future C-19 waves to prevent case cancelations

### Ventilators

- Vent equipment
- Vent component parts
- Vent Drugs
- Demand transparency and planning to enable surge capacity for potential future waves



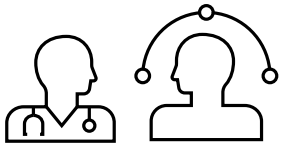
## CARE DELIVERY

### Capacity

- Prioritize case scheduling based on clinical urgency and acuity
- Implement widespread telehealth and digital surveillance to free up scarce capacity
- Conduct predictive modelling to enable visibility and advanced planning

### Staff

- Surveillance, rapid testing, antibody testing
- Flexible cross functional staffing models
- Communicate source of truth and pay attention to staff well-being while assessing signs of burnout
- Rapid Response to rumour mill



## PATIENT ENGAGEMENT

### Proactive communication

- Mandate personal physician outreach to surgery patients who have been delayed
- Aggressively reschedule diagnostics and procedures
- Use patient navigators
- Develop physician and scheduler scripts related to safety measures to ensure consistent clear messaging to patients

### Access

- Virtual, in-home
- Extended hours to restart diagnostic testing
- New and segregated care settings
- Supporting primary care to keep doors open which is vitally needed in a pandemic especially in rural areas


QUESTIONS

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