Using Self-Insured Data as a Foundation for Value-based Payment Strategy

A Governance Institute Webinar

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Today's Presenters

John Beaman
Chief Business & People Officer
Adventist Health

John Beaman serves as Chief Business and People Officer, a role he assumed in March 2018. He has direct executive leadership and operational management of human performance, information technology, analytics, performance improvement, supply chain, enterprise risk management, construction, and facilities management. Previously, Beaman served as the Senior Financial Officer for Adventist Health. Prior to that, he was the Fiscal Officer at Adventist Health Simi Valley. While in that position, he helped the hospital achieve a financial improvement of $7.8 million annually.

Allen Miller
Principal & CEO
COPE Health Solutions

Allen Miller is the Principal and CEO of COPE Health Solutions and Chair of the board of its subsidiary, Analytics for Risk Contracting. For more than 25 years, Mr. Miller has led the planning and implementation of integrated delivery systems and networks to succeed in value-based payment throughout the country. His areas of expertise include value-based payment arrangements, population health management, large-scale strategic partnerships, and innovative payer-provider strategies. He is a nationally known expert on value-based payment transformation and is a frequent author and speaker for HFMA, Association of Physician Groups, American Medical Group Association, and The Governance Institute.

Learning Objectives

After attending this webinar, participants will be able to:

Describe keys to success for provider networks taking on risk.

Develop enhanced planning based on data to ensure the right care is provided to populations while managing global cost and improving outcomes.

Analyze and understand claims and related data to better develop and launch population health management infrastructure.

Describe the board's role in helping to strengthen and accelerate value-based payment (VBP) strategies.

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Program level: Overview · No advanced preparation required

Field of study: Business Management and Organization

Delivery method: Group Internet based

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Presentation Overview

- As CMS and employers push providers to take more premium risk, a key to success is to gain access to **accurate data** on the total cost of care for attributed or assigned membership.
- This enables **provider networks taking risk to proactively ensure access to the right care and education** for populations while managing global cost and improving outcomes.
- **Building the capabilities to understand and better manage health for a health system's own self-insured employees and families is highly translatable** to other populations and payers, including direct-to-employer strategies.
- By **leveraging employee utilization and cost and outcomes data**, health systems can optimize their network; understand patterns of care, benefits, and employee satisfaction scores; and improve quality and health outcomes.
- In this session, we explore a case study in which Adventist Health (AH) has leveraged the claims data for its employee health plan and explain how this data, resultant initiatives, and lessons learned are being used as a **foundation for larger value-based payment and direct to employer (D2E) strategies.**

Agenda

- Value-Based Payment and Keys to Success for Provider Networks
- Adventist Health Case Study
  - Overview
  - Analytics and Insights as Foundation for Success
  - Translating Self Insured Lessons Learned
- Shared Lessons Learned and Board Takeaways
- Q&A

Value-Based Payment and Keys to Success

HEALTHCARE CONTINUES TO MOVE TO VALUE-BASED PAYMENT

Polling Question #1

How much of your hospital or health system revenue today is earned through value-based payment agreements with at least upside shared savings opportunity?

A. <10%

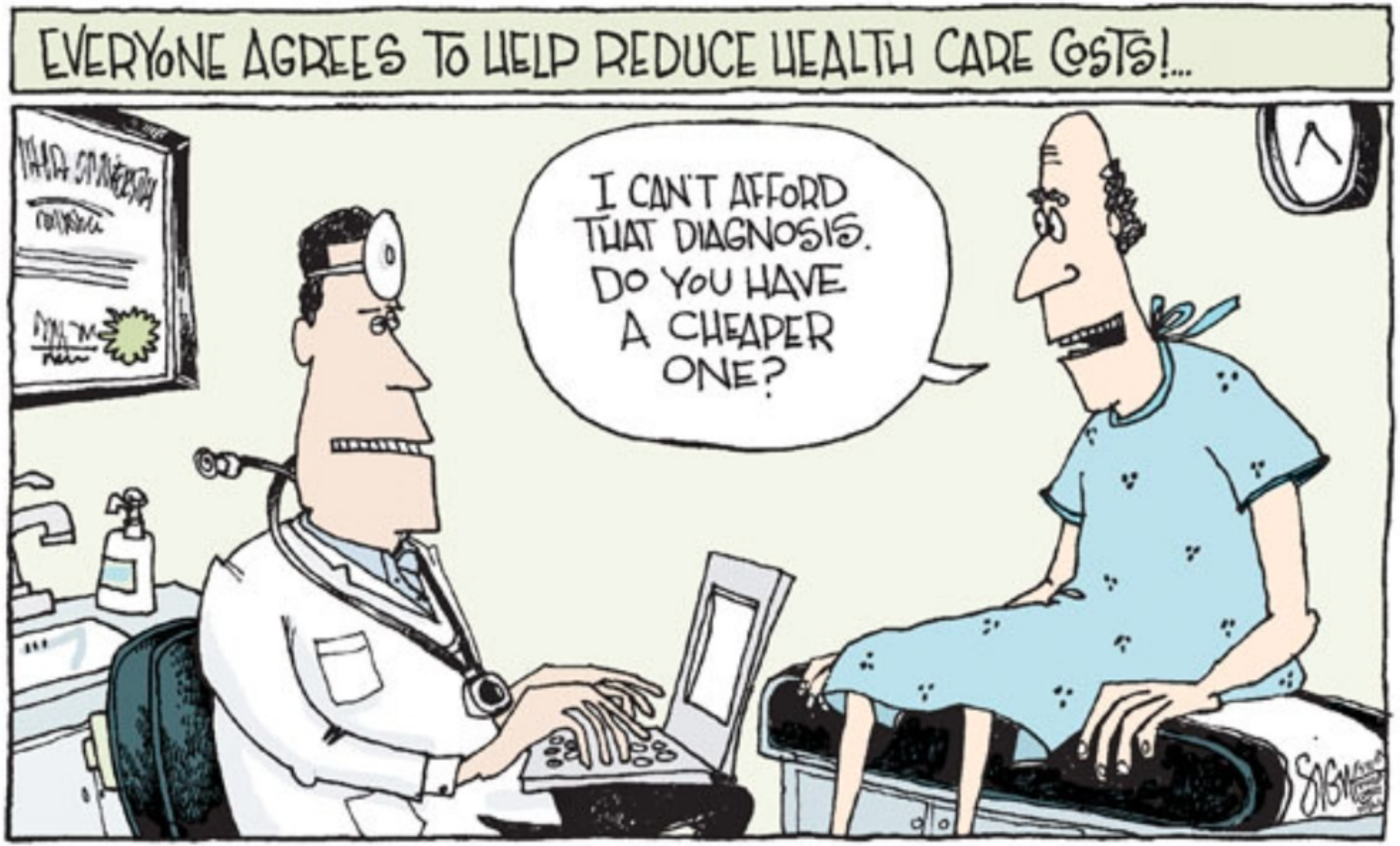
B. 11-25%

C. 26-50%

D. 51-75%

E. 76-100%

F. Unknown



Healthcare Continues to Move Toward VBP

Current Administration

VBP programs such as Medicare Direct, CHART, and Shared Savings ACOs accelerate competition for the fixed premium dollar

End of the Sustainable Growth Rate

Increased impact to Medicare reimbursement with penalties and bonuses, levels of provider participation, and four categories of reporting requirements that require interoperability

Risk-Based Contracting

Payers, from CMS and employers to health plans, are looking for competent providers who can take risk and delegation

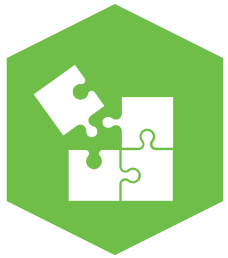
Medicaid Redesign and Expansion

Integrating care remains key and now includes models for maternal and child health populations

Healthcare Market Factors and Trends

Managed Care Transition

Integrating care remains key and now includes models for maternal and child health populations



Care Delivery Integration

Increasingly rapid migration of care from traditional locations to home and community care, sparked by financial incentives and penalties

Role of Data

Increasing demand for data-driven decisions and metrics to measure value and drive revenue; providers learning to use claims as well as encounter and clinical data

Workforce Shifts

Ever-increasing gap in skills – need for more non-traditional certificate training programs to supplement traditional degree and licensure pathways

Population Health Trends

Continuous increases in linguistic and cultural diversity within patient/member mix; aging patients/members desiring return to cultural roots

The Impact of COVID-19

Market and Utilization Trends

- COVID-19 impacts on utilization and cost have been **varied regionally** for the last six months
- At a national level, it appears that most acute-care hospitals and health systems are back to **~90-95% of pre -COVID-19 revenues and utilization rates**
- Today, we see:

  - Ongoing significant **reduction in emergency department (ED) utilization,** at a time when many hospitals have been expanding and modernizing EDs

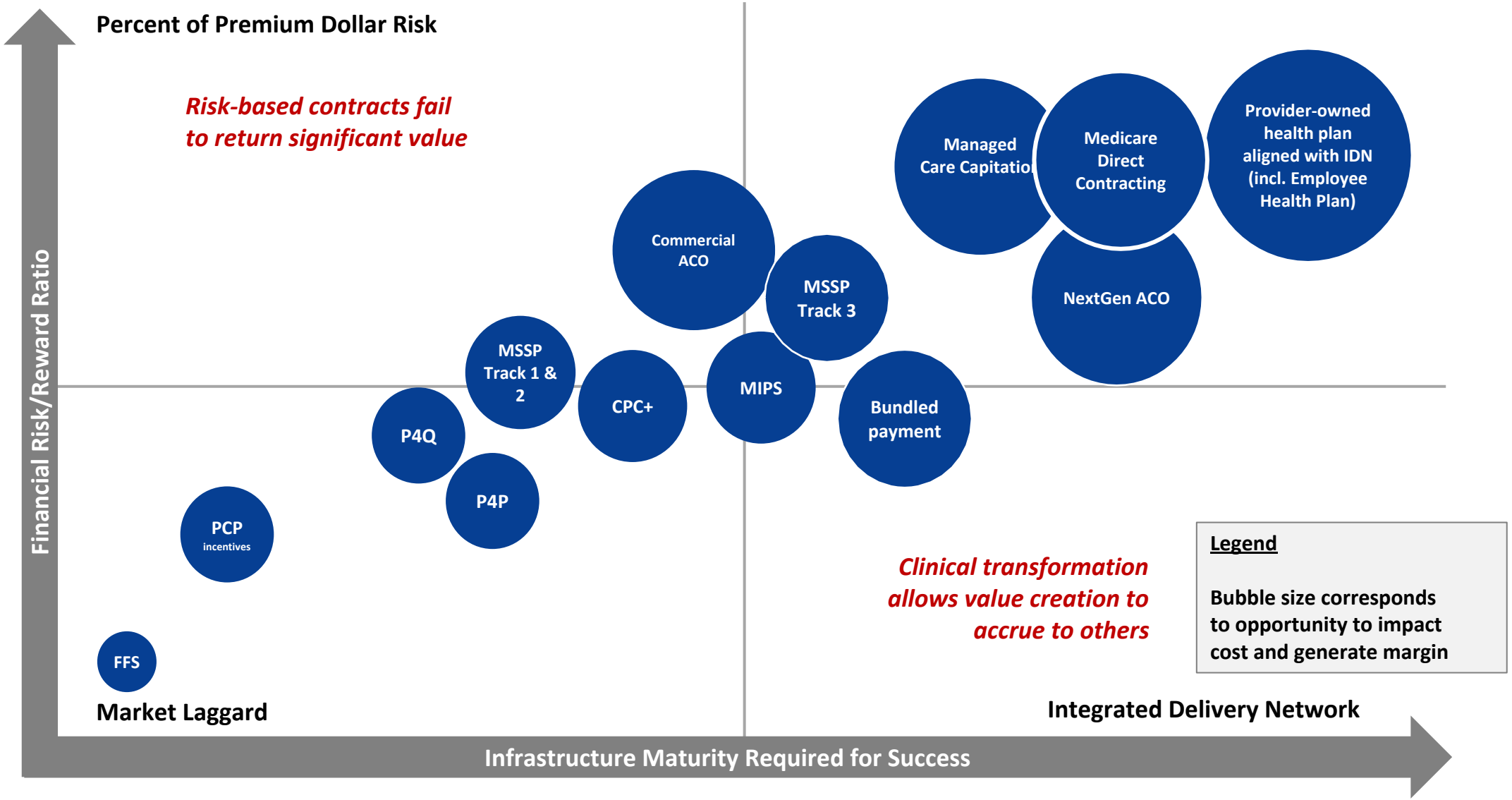
  - **Increased telehealth activity** and a lack of return to pre-COVID levels of in-person ambulatory utilization

  - **Expanded use of home-based monitoring, hospital at home, and other types of remote care,** likely signaling an ongoing transition from acute-care and post-acute admissions

Continued Transition to VBP

- CMS continues to incentivize providers to **move into advanced payment models** both for Medicare Advantage and Medicare fee-for-service (FFS)
- Physician groups and health systems have seen **capitated agreements weather the COVID-19 pandemic better** than FFS, but many hospitals and health systems are not ready to move away from lucrative FFS contracts
- Physician groups and IPAs without acute-care facilities are more **aggressively pursuing risk today**

Value-Based Payment Spectrum



Keys to Success in Risk-Based Contracts

Quality Management

- Improve quality outcomes and performance

Areas of Focus:

- STAR ratings
- HEDIS gap closure
- Member engagement
- Provider and staff engagement
- Ease of use of quality identification and action tools

Sample Initiatives:

- Consistent processes
- Provider and staff training and incentives
- Call center with Warm Line
- Member and provider portals, member app
- Remote monitoring

Revenue Optimization

- Increase total revenue
- Increase access to premium dollars for providers and payers

Areas of Focus:

- Appropriate product category
- Appropriate risk coding
- Contracting strategy
- Financial reconciliation for claims and eligibility

Sample Initiatives:

- Over 65 Medicaid enrollment to Medicare
- Dual eligible ID and enrollment
- Proper documentation
- Empanelment

Utilization Management

- Increase revenue and profitability of risk pools
- Improve total cost of care performance
- Reduce leakage

Areas of Focus:

- Appropriate site, level of care, proactive UR, aligned incentives
- Ease of access and leakage reduction
- Address SDH, CBO integration
- Rx dispensing channel
- High-volume/high-risk member management

Sample Initiatives:

- Open access
- Specialty economic profiling and large panel PCP affiliation
- ED concurrent UR
- Leverage specialty pharmacy, 340b
- Further integration of technology through care protocols

Attributes of a Successful Network

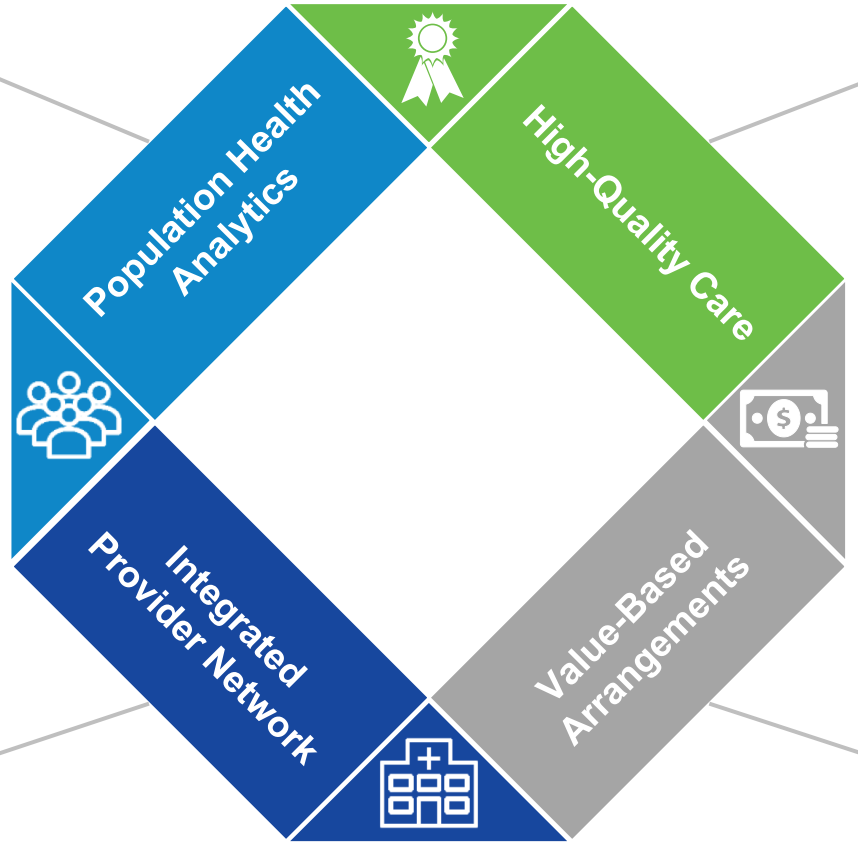
Data Analytics Is the Foundation for Achieving Key Success Factors

Key Success Factors

- Develop the infrastructure for population health data analytics
- Reporting capabilities to monitor success in real-time
- Ability to track high-risk and high-cost patients

Key Success Factors

- Adequate composition of providers to service the population
- Collaborative partnerships such as ACOs or IPAs
- Robust referral strategies
- Coordinated care model to connect providers and patients



Key Success Factors

- Effective incentives for providers to improve quality of care delivered
- Evidence-based best practices implemented and supported
- Dashboarding platform to monitor success and transparently share

Key Success Factors

- Focus on paying for value over volume
- Successfully transition Managed Care Organization (MCO) contracts from FFS to risk-based arrangements
- Prepare providers with the competencies and skills needed to be successful in VBP

Adventist Health: Case Study

LEVERAGING EMPLOYEE HEALTH PLAN DATA

Polling Question #2

Do you have an employee health plan?

A. Yes
B. No
C. N/A

Who is Adventist Health?

20+
Hospitals

35,000
Team members and physicians

$4.5B+
Annual revenue

2M+
Clinic visits

1.5M
Outpatient visits

150,000+
Admissions

750,000
ER visits

200,000+
Home Health visits

Background and Strategic Objectives

Affordable consumer health and well-being within reach for everyone

Adventist Health has a goal to engage
1.5 million value-based lives by 2030 across all lines of business

- Adventist Health's Employee Health Plan (EHP) was chosen as the pilot case for leveraging data to inform opportunities to improve performance, as well as to develop the "muscles" needed to succeed in VBP and population health management across all payers and lines of business.
- Adventist Health is on a journey to be top-decile in quality and top quartile in 2020.
- Self-insured population used as innovation and learning lab and the foundation for Direct to Employer (D2E) Network:
  - Consumer affordability, member-centric care models, access, and personal wellness
  - Top tier quality, member engagement, access, and performance
- Network optimization, care model advancement, and value-add differentiators are key:
  - Analytics
  - Population health muscles to manage utilization
  - Deliver a strong value proposition to their employees, families, and communities

Background and Strategic Objectives

Adventist Health's Collaborative Approach with COPE Heath Solutions and its subsidiary Analytics for Risk Contracting (ARC) for VBP and Population Heath Management launched in 2019:

1

- ARC as the analytics foundation
- Enhanced data-driven decision making
- Process improvement to drive improved outcomes for the self-insured population

2

- Define consistent population health metrics
- Create clinical and operational insights to optimize value of data
- Tactical focus on short-term improvements
- Support long-term business planning

3

ARC platform enables Adventist Health to identify initiatives for:

- Benefit design
- Improved member health, experience, and value
- Network optimization
- Cost reduction
- Physician alignment and compensation

4

Adventist Health expands risk based business:

- Direct-to-employer
- Payer collaboration around growth and total cost of care, including division of responsibilities for administrative costs
- Expansion of risk vehicles such as IPAs and California Restricted Knox Keene

Analytics and Insights as Foundation for Success

LEARNING FROM YOUR EMPLOYEE HEALTH PLAN

Polling Question #3

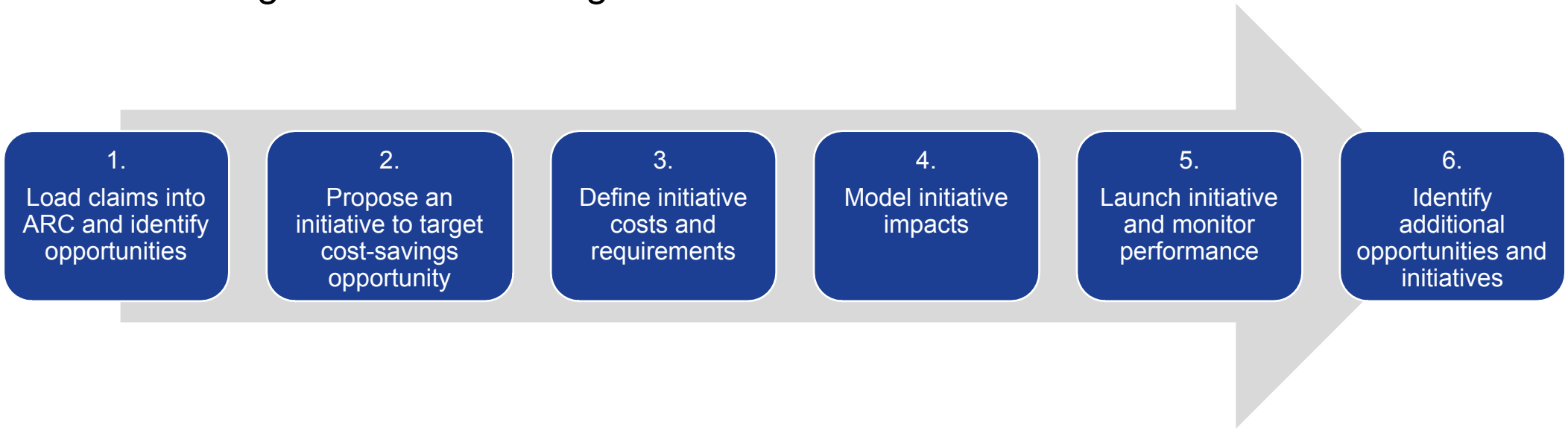
Do you have adequate analytic insights to assess your employee health plan and other VBP agreements for performance and opportunities for improvement?

A. Yes
B. No
C. Not sure
D. N/A

How was ARC Used?

Analytics Journey

- Adventist Health and COPE Health Solutions collaboratively leverage ARC to generate insights on potential initiatives to improve performance and value to members
- Co-design and implement strategic initiatives to realize Adventist Health's vision and strategic objectives
- Leverage ARC's financial modeling tools to project financial and utilization impact of potential solutions and design funds flow to align incentives



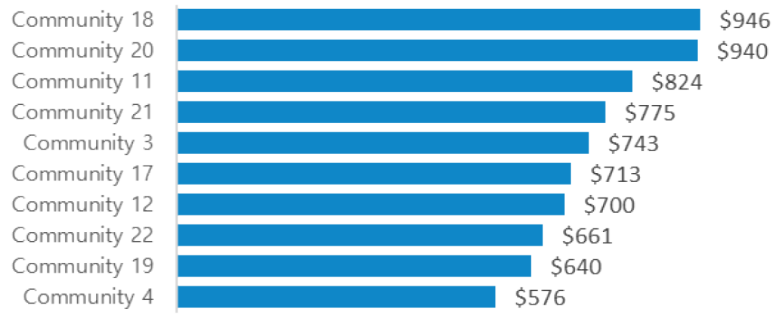
Adventist Health – Employee Health Plan At a Glance

Adventist Health's Self-Insured Employee Health Plan covers approximately 30,000 employees and their dependents, focusing on whole person care and living well

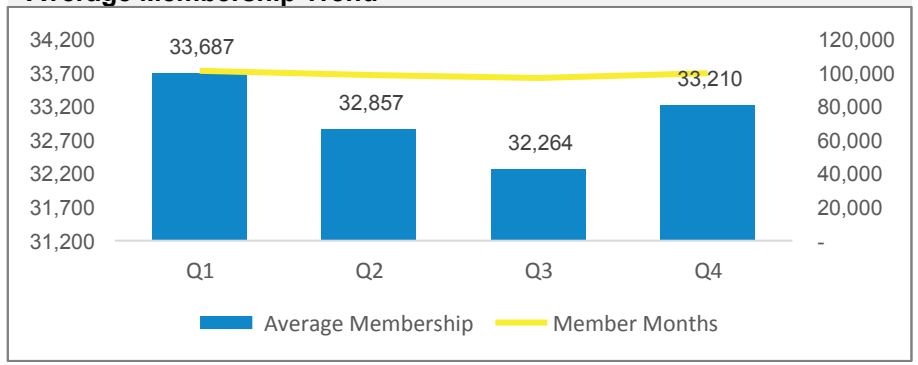
Overview for CY 2019

Avg. Membership Count	Avg. Risk Score	Avg. Chronic Conditions	Total Spend	Medical Spend	Pharmacy Spend
33,004	1.06	.64	$257,587,696 $650.38 PMPM	$ 416,468,615 $93.77 PMPM	$ 70,236,131 $557.05 PMPM

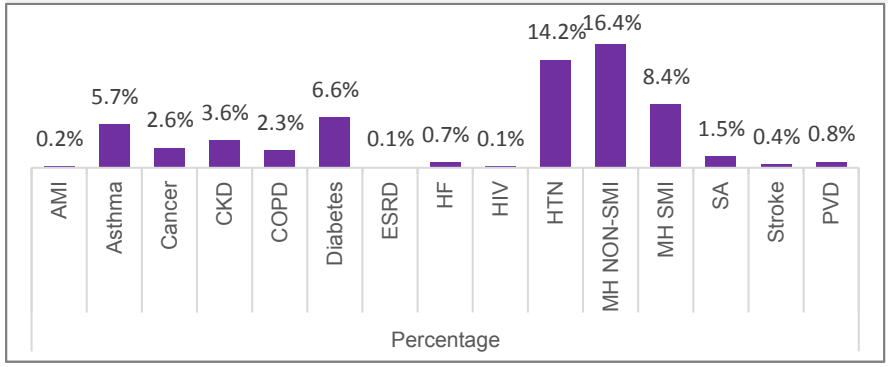
Top 10 Risk Pods PMPM - Medical



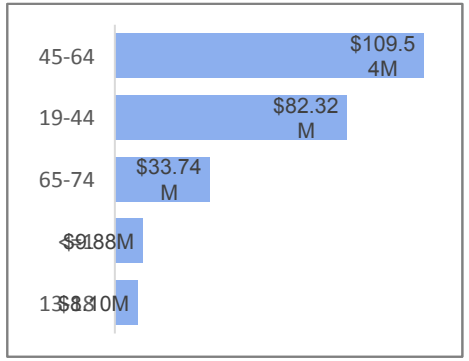
Average Membership Trend



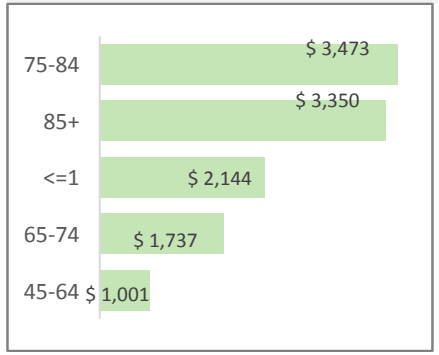
Prevalence of Chronic Conditions



Top 5 Age Range Gross Paid



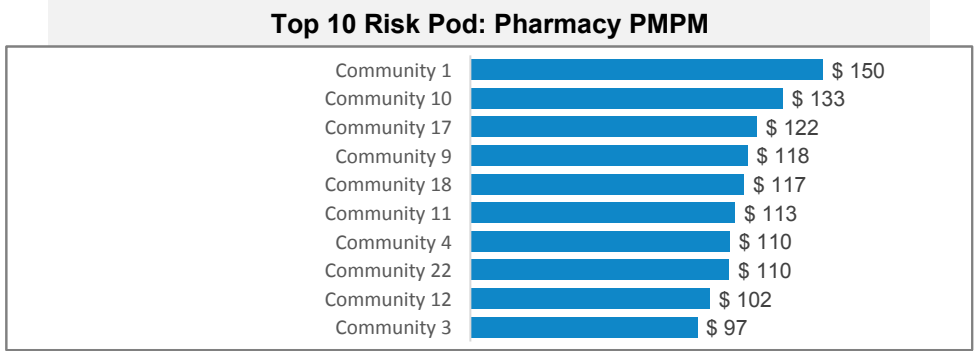
Top 5 Age Range PMPM

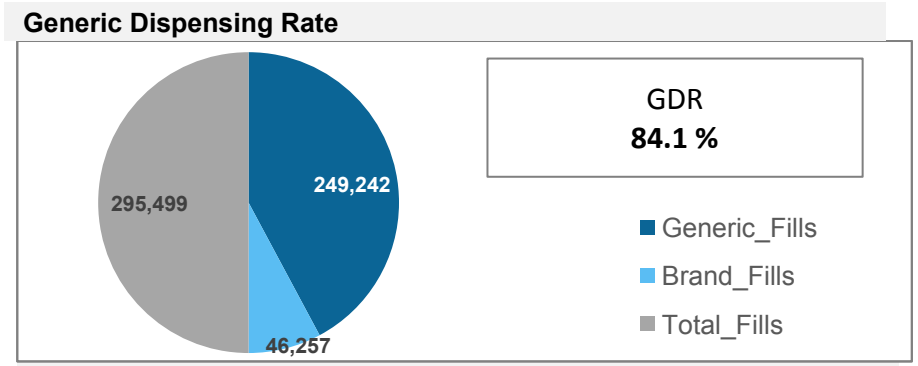


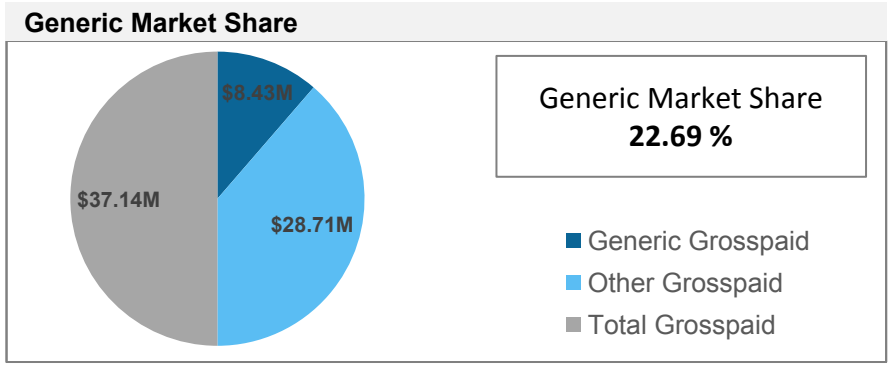
Adventist Health – Employee Health Plan At a Glance

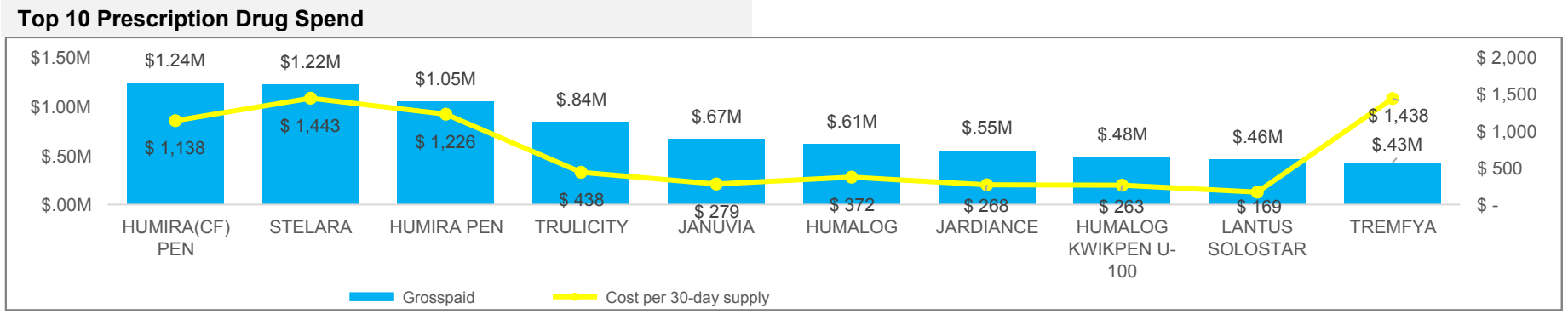
ARC enables us to understand the total cost of care, including pharmacy costs, for our employer health plan (EHP)

Pharmaceutical Utilization Overview for CY 2019









Sample Analytics Outputs

Revenue Optimization Opportunities

65+ Member Population

As expected, the 65+ age ranges PMPM are higher than the younger age group, but those PMPMs are substantially higher than various benchmarks of that age group.

The PMPM amounts were compared to two benchmarks, AH MSSP benchmark and ACO population.

- Current ACO benchmark is an estimated ACO MSSP benchmark based off 2019 ACP PUF file
- Per capita cost is based off 2018 Beneficiary Characteristics of the Age Group 65+.

As a self-insured plan, these members cannot be removed from ASI, but are eligible for Medicare plans. While there are restrictions on encouraging members to switch plans, there is an opportunity at a **medical management level** to lower the overall average PMPM for these three age groupings buy creating a more **care-centered model** for these age ranges.

A couple questions to consider prior to beginning a new initiative:

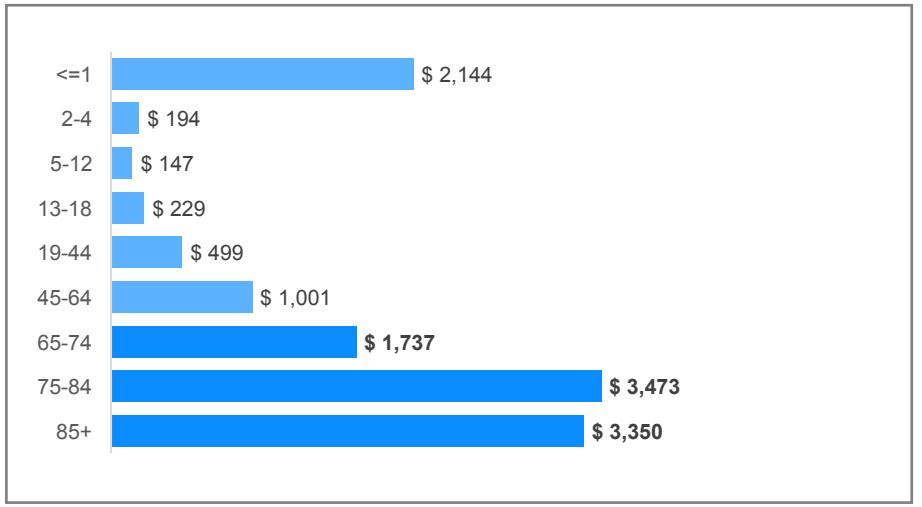
1. How is ASI currently engaging with the member population?
2. What are the high cost spend drivers of these age groups?

Examples of high cost Primary DX of the 65+ population:

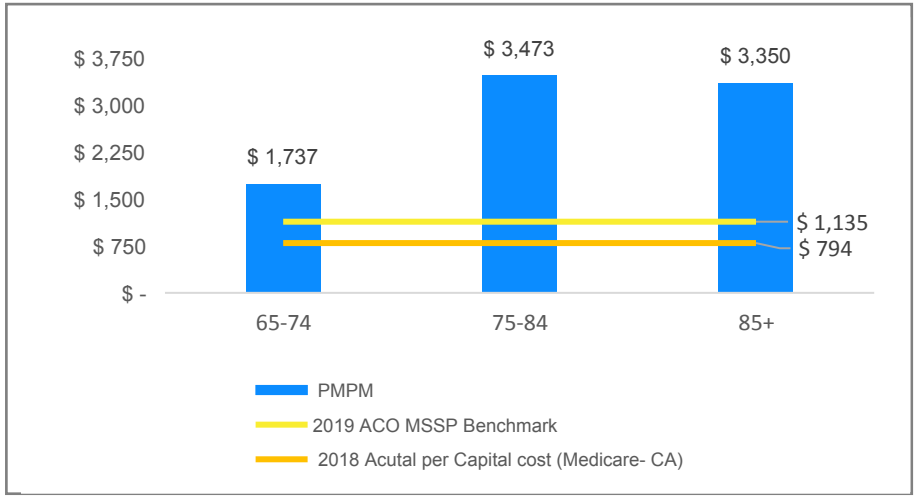
Dx 121.4 Non-St elevation myocardial infarction with a **75% spend increase** from $1,078,348 to $615,442

Dx Z12.11 Hypertensive heart disease with heart failure with a **144% spend increase** from $ 224,951 to $549,203

PMPM by Age Range



65+ Age Range PMPM Against Benchmarks



Sample Analytics Outputs

Risk Pod Financial Summary

Below are high-level performance measures per Risk Pod for the 2019 CY

	Expenses			
Risk Pod	**Medical Spend**	**PMPM**	**Pharmacy Spend**	**PMPM**
Community 1	$ 20,461,417 ▲	$ 567 ▲	$ 3,490,321 ▼	$ 97 ▼
Community 2	$ 11,518,935 ▲	$ 363 ▲	$ 2,978,097 ▲	$ 94 ▲
Community 3	$ 7,446,047 ▼	$ 743 ▼	$ 1,502,031 ▼	$ 150 ▼
Community 4	$ 4,982,809 ▼	$ 576 ▼	$ 1,019,237 ▼	$ 118 ▼
Community 5	$ 15,931,481 ▼	$ 442 ▼	$ 2,692,447 ▼	$ 75 ▼
Community 6	$ 12,698,809 ▼	$ 411 ▼	$ 2,007,204 ▲	$ 65 ▲
Community 7	$ 2,752,521 ▼	$ 507 ▼	$ 427,600 ▼	$ 79 ▼
Community 8	$ 8,437,530 ▼	$ 404 ▼	$ 1,744,637 ▲	$ 83 ▲
Community 9	$ 7,610,362 ▲	$ 501 ▲	$ 1,678,089 ▲	$ 110 ▲
Community 10	$ 4,587,074 ▼	$ 367 ▼	$ 1,271,942 ▲	$ 102 ▲
Community 11	$ 20,537,388 ▲	$ 824 ▲	$ 2,905,193 ▲	$ 117 ▲
Community 12	$ 9,409,184 ▼	$ 700 ▼	$ 1,789,024 ▲	$ 133 ▲

* Revenue amount is currently a placeholder and reflecting overall revenue and PMPM of entire plan

* Trend arrows currently represent YOY variance of PMPM from prior year, once Risk Revenue is included, trend arrows will denote an increase or decrease of MLR and ALR compared to the year prior. Green color indicates improvement in performance while red indicates decrease in performance

Red	Negative variance from the prior year
Green	Positive variance from the prior year
▲	YOY increase
▼	YOY decrease

Data Analytics Opportunity Summary

Better medical management through:

- Reduced preventable ED visits
- Repatriation of out-of-network (OON) utilization
- Drug dispensing type reallocation
- Chronic disease management

Optimal product and plan design including:

- Multiple benefit plan offerings (HMO, POS or EPO)
- PCP assignment
- Adjusted PPO plan design
- New contract philosophy and ensure best rates

Enabling local accountability via:

- Care delivery redesign opportunities
- Best practices and selective capitation in areas driving higher PMPM
- Adjustment to unique POD P/L and lowest cost management

Taking Action on the Data: Example, Biometrics Data

Data Points to Develop Targeted Health and Wellness Initiatives to Reduce Total Cost of Care and Improve Member Value

- Data indicated that members with a BMI or cholesterol level outside of normal range had a 30%+ higher PMPM compared to the average

PMPM by Biometric Result Range				
Result Range	**BMI**	**Blood Pressure**	**Total Cholesterol**	**Non-Fasting Glucose**
In Range	$638	$676	$701	$751
Out of Range	$823	$727	$725	$673
Overall Average		**$557**		

Taking Action on the Data: Example, Biometrics Data

AH developed pilot programs that focus on wellness and consumer affordability, while achieving greater affordability for both the plan (total cost of care) and our associates (out of pocket expense)

Implement Inspire Health Clinic as our primary living lab centered around a Functional Medicine Model to address underlying issues impact health

“Food as Medicine” – tailored food delivery program for hypertensive, diabetic, and pre-diabetic members

Translating Self-Insured Lessons Learned

LEVERAGING EMPLOYEE HEALTH PLAN ADMINISTRATIVE, MEDICAL MANAGEMENT, NETWORK AND MEMBER ENGAGEMENT CAPABILITIES FOR OTHER VBP GROWTH

Polling Question #4

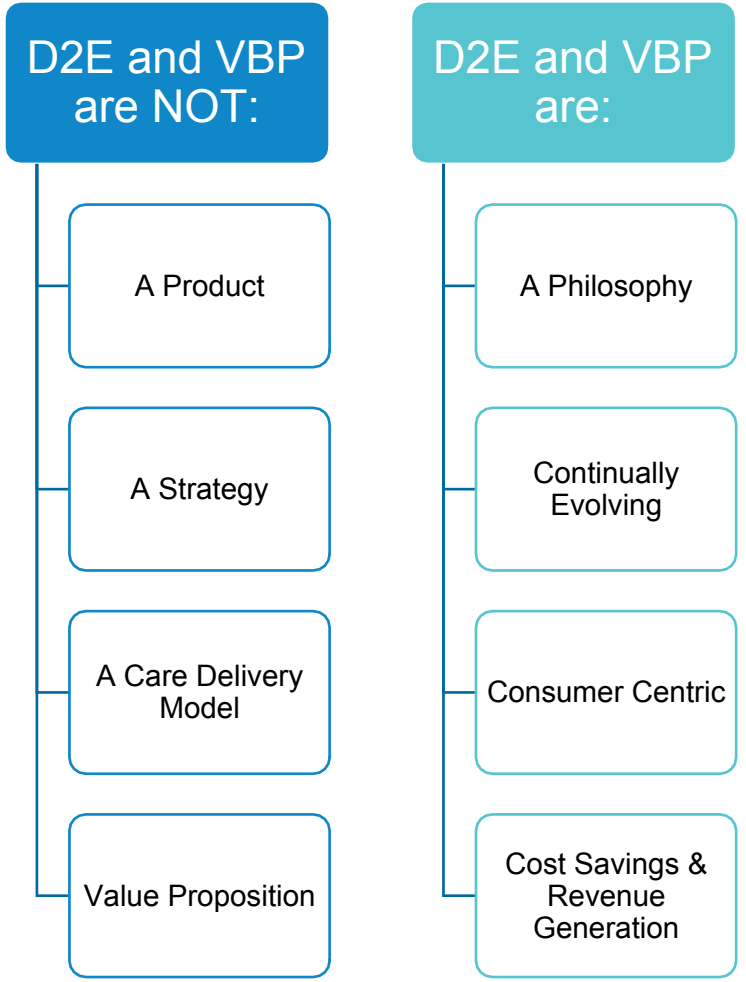
Are you leveraging your EHP as a learning lab for other VBP arrangements?

A. Yes
B. No
C. Not sure
D. N/A

Adventist Health Direct-to-Employer (D2E) and Overall VBP Philosophy

Our approach:

- A philosophy and one of our channels that will improve the well-being of consumers, community, and families
- Coordinate a team approach between the stakeholders
- Deliver insights from analytics for continual improvement
- Develop a product that continues to evolve to serve the market



Learning from Self-Insured Population

Product Design for Direct to Employer

- The initial product(s) will solve for the immediate needs of Adventist Health:
  - Adventist Health is the Index Client
  - How we learn from EHP and pilot offerings real-time within Inspire Health Clinic – ***Living lab***
  - Solve for niche self-insured employers

- Solving for Adventist Health's individual needs does the following:
  - Creates (elevates) the additional metric of experiential outcomes, not just financial performance and clinical outcomes
  - Creates the healthiest workforce
  - Achieves cost avoidance and savings for AH, providing template for consumer affordability
  - Shows the market that AH is purchasing its own product first, delivering best in class services and innovation, capable of adapting to multiple markets and employer types
  - Revenue for the health plan and incremental volume for markets

Next Steps for Adventist Health

How Adventist Health Plan Is Now Using ARC to Enhance Market Offerings

D2E Network Optimization Strategy

- ARC will improve the performance of the D2E network offering by strengthening the network management capabilities, beginning with self-insured
- **Result:** Expand product offering to other employers

All Payers and Risk Vehicles

- Load all payers, covering all risk vehicles and attributed members
- **Result:** Greater volume (per panel) yields improved insights and more statistically significant data to evaluate and profile providers, networks, and product performance

Workflow Alignment

- Detailing workflows to align with Cerner HealtheIntent and key roles within population health and MSO (e.g. care management, network, and finance)
- **Result:** Optimized use cases and application for business intelligence and clinical insights

Data Governance/ Population Health

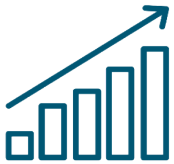
- Engaging in system-level data governance and population health to optimize adoption and integration, as well as map out long-term view
- **Result:** Aligned product development and enhancements, leveraging Adventist Health clinical expertise and drive for top-decile care

Summary and Key Board Takeaways

Shared Lessons Learned and Board Takeaways

Self-insured groups offer an ideal population around which to build population health competencies, refine member benefits and organize a high-performing network before scaling to D2E commercial offerings. ***How do we translate savings to our members – and ultimately the commercial consumer in the form of affordability and value? What are the most effective mechanisms to align financial incentives with our members?***

Organizations need to address the cultural and operational gaps in data-driven decision making in parallel to making analytic platform and solution decisions and investments. ***Are we ready for adoption? How will we support our teams through accelerated learning?***



Analytics serves as a supplemental capability to identify and prioritize opportunities, however the organization must be ready to translate the results to execution with clear accountability and resources to realize the opportunities. ***Who will own the initiative? What is the clinical and administrative dyad?***

Ensure there are measurable business results to justify the effort and expenses going into the initiatives. Don't be afraid to fail, but fail fast. ***How will incremental results be monitored and communicated? What is the decision-making authority at each level to mitigate gaps or escalate issues?***

Q&A

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