Provider-Payer Partnerships: Innovative & Collaborative Value Models

Deirdre M. Baggot, Ph.D., RN

Craig E. Samitt, M.D., M.B.A.

Barbara M. Price

1

Panel Discussion
Provider-Payer Partnerships

THE GOVERNANCE INSTITUTE

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

September 20, 2021

The Governance Institute® | A SERVICE OF nrc HEALTH

2

Disclosure Policy

- As a Jointly Accredited Provider, the Governance Institute's policy is to ensure balance, independence, objectivity, and scientific rigor in all of its educational activities. Presentations must give a balanced view of options. General names should be used to contribute to partiality. If trade name are used, several companies should be used rather than only that of a single company. All faculty, moderators, panelists, and staff participating in the Governance Institute conferences and Webinars are asked and expected to disclose to the audience any real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the continuing education activity. This pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. Significant financial interest or other relationships can include such thing as grants or research support, employee, consultant, major stockholder, member of the speaker's bureau, etc. the intent of this policy is not to prevent a speaker from making a presentation instead, it is the Governance Institute's intention to openly identify any potential conflict so that members of the audience may form his or her own judgements about the presentation with the full disclosure of the facts
- It remains for the audience to determine whether the presenters outside interests may reflect a possible bias in either the exposition or the conclusion presented. In addition, speakers must make a meaningful disclosure to the audience of their discussions of off-label or investigational uses of drugs or devices
- All faculty, moderators, panelists, staff, and all others with control over the educational content of this Webinar have signed disclosure forms. the planning committee members have no conflicts of interests or relevant financial relationships to declare relevant to this activity. The presenters have no financial relationships with the Governance Institute
- This educational activity does not include any content that relates to the products and/or services of a commercial interest that would create a conflict of interest. There is no commercial support or sponsorship of this conference
- 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

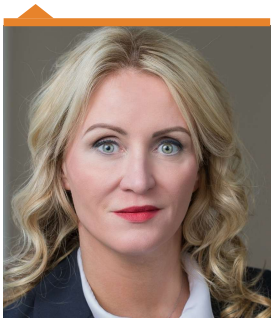
3

Introductions

Craig Sammitt, M.D., MBA
Former CEO, BCBS Minnesota

Barbara Price, MBA
SVP, Scripps Health

Deirdre M. Baggot, PhD
Moderator
Partner, Health and Life Sciences
Oliver Wyman



4

Panel Discussion Agenda

60 minutes

- Panel welcome and context
- Current state of provider-payer partnerships
- Business Imperative for provider-payer partnerships
- Provider-payer value-based payment arrangements
  - A path to common goals and partnering for impact
  - Lessons learned
  - Where we go from here

15 minutes

- Q&A

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

– Henry Ford

5

Context: Providers and payers are facing heightened 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

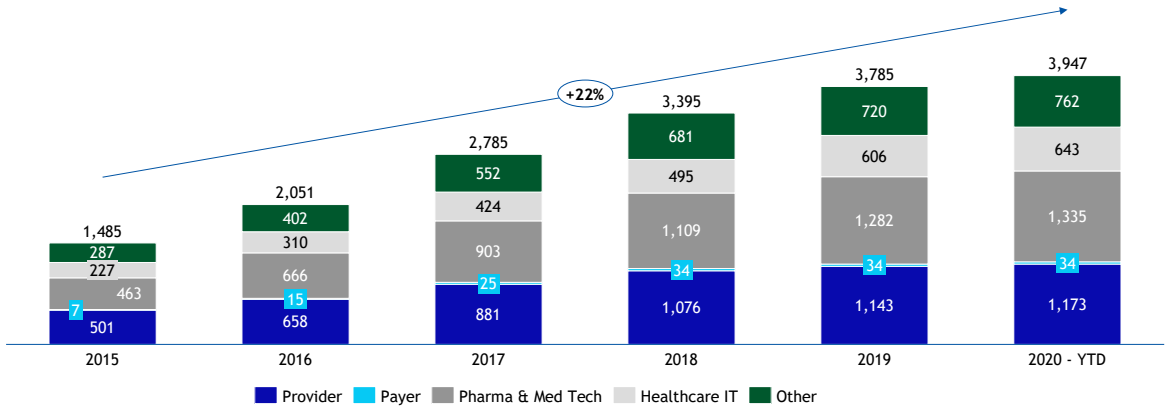
Provider Context

- **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**

6

While Providers and Payers are figuring out how to work together, Private Equity healthcare growth has been explosive

PE Healthcare Activity
As of July 2021

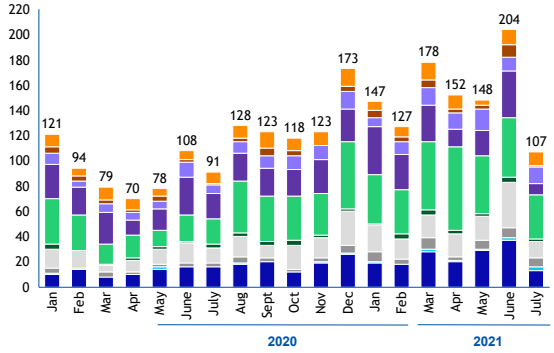


Source: Preqin

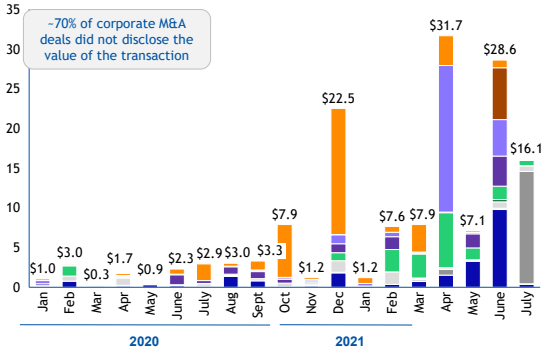
7

Compared to 2020, healthcare M&A has grown by 245%

# of North American corporate M&A deals by subindustry
January 2020 to July 2021



$ of North American PE corporate M&A by subindustry
January 2020 to July 2021, $Bn



Biotechnology
Healthcare Distributors
Healthcare Equipment
Healthcare Facilities
Healthcare Services
Healthcare Supplies
Healthcare Technology
Life Sciences Tools and Services
Managed Healthcare
Pharmaceuticals

Source: S&P Market Intelligence

8

Traditional Alignment Structures

Traditional Provider Options

More capabilities required

VBC → Employer solutions → ACO or EPO → JV product with payer → Buy health plan

Traditional Payer Options

More capabilities required

VBC → Tiered network → ACO or EPO → JV product with provider → Buy care delivery assets

Greater enterprise transformation potential

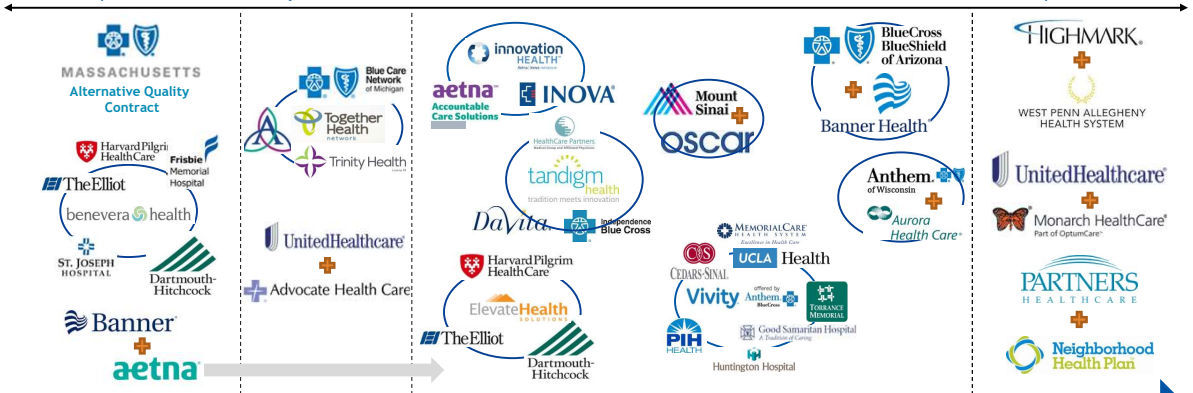
VBCs = value-based contracts; ACOs = accountable care organizations; EPO = exclusive provider organization; JV = joint ventures

9

Alignment activities

Sample of active and legacy partnerships

VBCs/ACOs Fewer capabilities shared → **Co-branded products** → **JVs/Equity enablement** → **Vertical integration** More capabilities shared



Partnership structures evolve over time

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

10

Medicare

Several variants of high-intensity care models are rapidly becoming tablestakes

Dedicated, purpose-built MA practices

- Highly effective & compelling but typically limited by partner footprint
- Humana contracts/terms typically advantaged from getting in "on the ground floor"
- Opportunity to transform these models with virtual care and share in more of the upside

Targeted upgrades to community-based PCPs

- Consumer centric models wrap around and/or enable independent PCPs
- Highly geo-dependent based on provider dynamics/ availability of PCPs
- Much more challenging to execute across fragmented provider base, why acquisitions can make sense

Health at home/virtual models

- Growing opportunity, with many pursuing its promise; ripe for virtual hybrid to enhance impact
- Open question remains, how much of the historic PCP model these can replace and how much value can be created from "hospital at home" approaches that reduce patient stays?

Other strategic considerations

- Purpose-built models - MA category killer
  - Operate with sub-70% MLR equivalent
  - Most value accrues to the provider
  - Oak St $9B+ IPO now over $14B
- Virtual care transforms economics
  - COVID accelerated adoption by seniors
  - Up to 2x patient load per clinic possible
  - Opens more possibility for rural areas
- CMS Direct Contracting can more than double market size
  - Owned provider assets can tap into this value
  - Early indication on PD economics is good, but need to watch carefully
    - Will not be as lucrative as MA risk/payment model

11

Commercial

COMMERCIAL PROVIDER/PAYER PARTNERSHIPS HAVE SHOWN MIXED RESULTS (1)

Narrow Network ACO-JV or Partner *Traditional payer/provider partnerships Physicians manage quality, cost, and coordinate care with a targeted product*	• Complex and slow – success requires long-term commitment, strong alignment on how to create customer value and compromise on $ to deliver customer value • Challenges include misaligned incentives/bad economics, narrow network not competitive, conflict with other provider contract terms weakens deal/offer & leadership turnover/shift in commitment • Can work in right context: Aetna-Banner success given statewide network and Banner commitment to value vs struggled with Sutter and TX Health given network breadth & net-cost – not enough customer value to take narrow network
Experience-driven Narrow Network ACO *Consumer experience led product design and differentiation with a materially lower cost narrow network*	• Interesting and unique value proposition of convenience and ease for patients with Oscar front end, virtual care and seamless data and information exchange • Product designed market-back to hit a compelling price point for a specific segment – 20% lower than other Commercial carrier ACA product, but 10% higher than Medicaid platform-based ACA products • Tight integration with interoperable data systems amongst partners enabling ubiquitous data exchange in real-time, which allows for better decision-making
Virtual IDN *Stitch together regional providers to compete against established IDN*	• Vivity value prop seemed to be "if you build it, they will come." – Did not have significant customer experience value add nor adequate lower cost • Inferior to Kaiser model and unable to yield real TCoC savings, plus highly complex to implement across multiple large entities • Multiple system entities that used to compete now need to collaborate, for only one payer's population only (i.e., limited provider mindshare) – Highly complex and slow

12

Commercial

COMMERCIAL PROVIDER/PAYER PARTNERSHIPS HAVE SHOWN MIXED RESULTS (2)

PCP Build *PCP based superior experience—can be targeted at specific customer segments* *Physician can steer downstream*	• PCP hub enhances experience, increases retention/loyalty, and controls cost by directing downstream care decisions • Requires customer density in local geo and can be expensive to stand up clinics and fill patient panels(in local Pop. and market share) • Effective partner operator or commitment to owner/operator is key to success • Difficult models to scale and capital intensive, can disrupt existing PCP-patient relations • Works best when you are dominant player in market	Kansas City / SPIRA CARE GUIDEWELL / Sanitas Medical Center
Physician Enabler *Enable independent MDs to operate as ACOs and contract for value and remain independent by providing critical infrastructure*	• Infrastructure load alone is often not enough. Very few independent practices are able to achieve the transformation at scale necessary to create economic value – make sure yours can • Very complex, often fragmented model to pull off • The challenge is having the right providers in exactly the right geography to do anything at scale with the solution (e.g., productize) • Market is flooded with mediocre first-generation enablement solutions being shopped by independent providers and plans, many do not provide economic impact at scale	Independence Blue Cross / tandigm health BlueCross BlueShield of North Carolina / Aledade
Everything but the System *Acquire and aggregate non-system assets (e.g., ancillaries, physicians)*	• Key play that enables revenue diversification and ability to control downstream spend by controlling physician decision-making. Forces provider cost transparency • Two-pronged value creation: arbitraging the difference between system rates and the rest of the market – lower payer's cost while generating margin • Highly targeted strategy applicable to certain markets only given investment required and ability to create critical local mass • This is also a tricky play for a more dominant share health plan to pull off because of the conflicts created	OPTUM

13

Commercial

Emerging commercial strategies are aiming to offer differentiated experience AND lower costs through strategic steerage

Make Narrow Look Big *Proactive steerage to owned providers, on top of a broader network*	• Kaiser's model highly successful in markets accustomed to HMO. Historic attempts to grow outside of CA often failed because markets reject HMO model---proposition perceived as constraining choice and adding referrals burden • More recent strategies use core owned Kaiser assets supplemented by a rented PPO network • Creates perception of choice, with Kaiser experience on the front but enables active steerage by Kaiser docs to Kaiser services and the best cost/quality docs, imaging, etc. within the broader PPO network	KAISER PERMANENTE thrive *(Georgia)*
Community Health Hub *Ultimate convenience play--multichannel access points of care*	• Based on concept of convenience drives usage, and whomever controls the front door to health controls the downstream costs – More extensive retail health locations than any provider can match, benefit design synergy and a growing suite of services being built – Betting on ability to manage drug costs and leveraging Aetna insights on how to steer downstream care to local high-performing providers within PPO network • Prior efforts on Minute clinic model were moderate, but will benefit from recent acceleration of COVID testing model and hybrid in-person/digital approach to care	CVSHealth Health HUB
Digital-first Health Plans *Virtual first primary care health plans offering 24/7 access to providers on demand, any time Super low-cost*	• Digital first concierge or triage model is convenient and enables plan to direct or divert care – Unlimited text or virtual access, alternative cost-share on traditional care gets to much lower price for customer • Nascent/evolving (e.g., not fully integrated/controlling downstream care yet) but showing promise; running to its full extent has the potential to steer across the continuum • Health plan owns patient record and all encounter data which, in theory allows for greater control and ability to manage total cost of care	PREMERA / 98point6 Humana / On Hand / dr. on demand

14

LESSONS LEARNED FROM PROVIDER/PAYER PARTNERSHIPS

Have a clear value proposition aligned to the market

- Must add differential value to consumers
  - Too many provider/payer initiatives do not create enough NET NEW value to make a difference or move share
  - Narrow network ACOs and some versions of PCMH are trends many followed blindly with varied success
- Market first, ALWAYS market first – seek leverage and fit
  - What works in one context does not always work in another
    - Kaiser model thrives in CA, had struggled in other geos
    - Sanitas works in FL, but struggles in CT
- Avoid over-reacting to competitor/latest "shiny object"
  - Too many partnerships/acquisitions driven by existing partner relations or target-first thinking

Follow the money

- Know your partner/target's economics as well or better than they do
  - Too many partnerships/fail to align incentives to be mutually beneficial (e.g., many Commercial ACOs/JVs struggled, early CMS ACOs under-performed)
- Significant value transfer can occur, make sure you are getting your fair share (e.g., MLR floors limiting payers' MA value capture)
- Partnerships always more complicated than they seem, scale must be worth it, with reasonable feasibility
  - e.g., aggregating fragmented, independent provider assets using tools and goodwill alone is MUCH harder than a single partner

Explicitly align on ambition and risk tolerance

- Transformational offerings or resetting the basis of competition requires "breaking eggs"
- Incremental improvement may be right for dominant share players
- Over-designing solutions that don't solve the underlying problem – for example contract conflict on tiering or steerage results in big deals getting neutered
- Bold acquisitions often deferred in favor of partial investment/pilot
  - Often get "stuck in the middle" with sub-optimal funding to drive investments and innovation due to future ownership concerns

It is all about the execution

- The strategy/deal is only the first part, execution is much harder
- Ensure you have the right talent and expertise to pull it off
- Don't let legacy operating model constraints get in way of unlocking value – eliminate siloes and turf wars (e.g., Commercial/MA siloes)

15

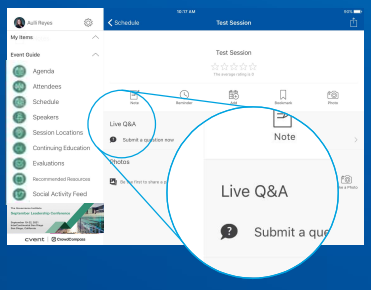
Questions?

Virtual

Please enter your questions in the Ask a Question Box

Ask a question…

In-Person



Click "Live Q&A" in the session on the mobile app

The Governance Institute® | A SERVICE OF nrc HEALTH

16

QUESTIONS

17

Contact Information

Deirdre Baggot, PhD
Deirdre.Baggot@oliverwyman.com

Craig Samitt, MD
Craig.Samitt@gmail.com

Barbara Price
Price.Barbara@scrippshealth.org

The Governance Institute
1245 Q Street
Lincoln, NE 68508
Toll Free (800) 388-4264
Info@GovernanceInstitute.com

18