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System Focus

A Peek Behind the Payer Curtain at Banner Health

A fireside chat with Chuck Lehn, Insurance Division President of Banner Health Network, and Brian Silverstein, M.D., Chief Population Health Officer at Innovaccer.

It's not often that healthcare leaders and board members are afforded a candid glimpse of payer operations and priorities from an expert who operates in both the insurance and healthcare provider realms. At The Governance Institute's April Leadership Conference in Scottsdale, AZ, Governance Advisor Brian Silverstein, M.D., Chief Population Health Officer of Innovaccer, was joined by Chuck Lehn, Insurance Division President of Banner Health Network, one of the largest secular non-profit healthcare systems in the country. Lehn's unique perspective from the intersection of payers and providers offers insight into the evolving payer–provider dynamic, and how all stakeholders can improve performance in the era of patient-centric, value-based care. Below are some highlights from the discussion.

Silverstein: You wanted to start with a patient story, and I think that's really important as we start thinking about what's happening in the world, and what this means for patients.

Lehn: We always start our discussions with a patient story. We use a patient representative, who we have named "Sofia," and we call it Sofia Stories. We try to begin and end a lot of our meetings with Sofia Stories to determine if we are really using our integrated delivery model, payer and provider, to deliver a great experience and a great outcome for Sofia.

Our mission is about healthcare made easier so life can be better. That's what we are trying to do at the end of the day with our payer–provider integration.

Silverstein: It would be useful to describe Banner Health as an organization and also appreciating that the insurance division is a separate entity under that Banner Health umbrella.

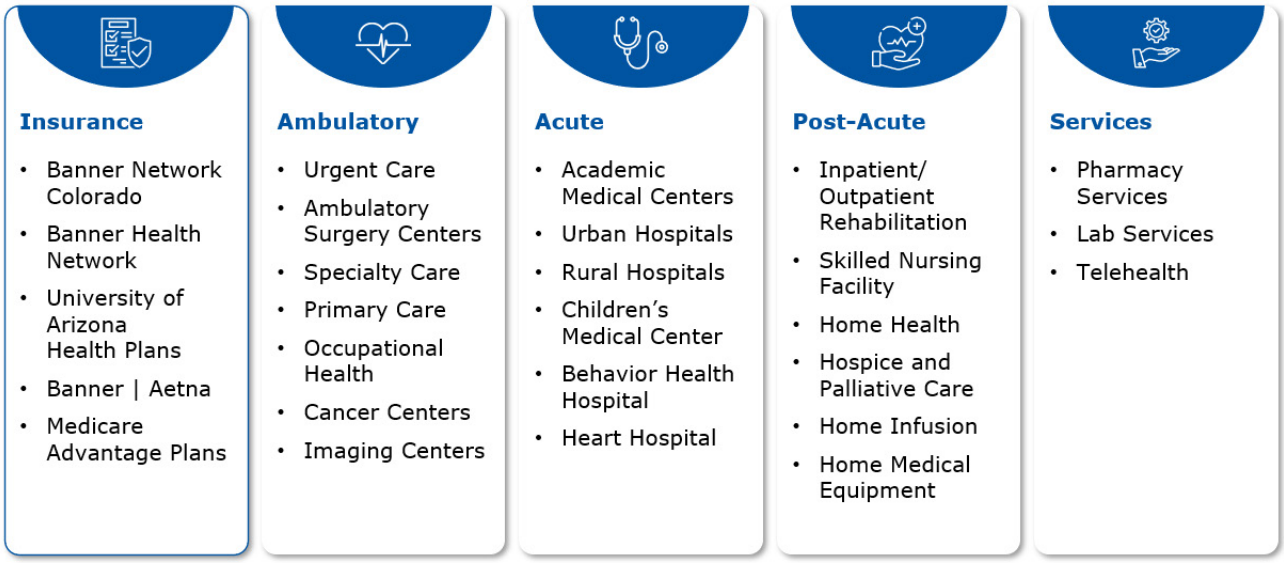
Lehn: I have responsibility for the insurance plans. We have licensed insurance plans, Medicare, Medicaid, and commercial, and I also have responsibility for the managed

care negotiations. We contract with pretty much all the plans in the market on value-based arrangements.

On the insurance side, we have networks that serve both our own insurance products and BlueCross, United, Cigna, and Aetna. Banner|Aetna is a joint venture started in 2016 and owned 50 percent by CVS and 50 percent by Banner. We launched wholly-owned Medicare Advantage plans in 2021, and we have had a Medicaid plan since 2015. We have also invested heavily in the ambulatory arena because we needed lower-cost care settings.

Our acute-care footprint is probably what most people know us for, including our academic affiliation with the University of Arizona. We have also invested in the post-acute environment. We believe that a lot more care will be delivered in the home, so we are focusing on how we can enable that, including virtual capabilities.

Exhibit 1: Banner Health Portfolio of Services



Silverstein: Organizations are grappling with how to partner with insurance companies. Do we want to build something ourselves? How long is that going to take? Should we partner with someone instead? What's happened with Banner's insurance division? Banner overall is $12 billion in revenue, and the insurance division is about three of the 12 billion, so you make up a substantial component, but that wasn't always the case.

Lehn: That's happened over a period of time. We started probably in earnest somewhere in the 2010–2011 range. We were a Pioneer ACO with CMS. That was

really the springboard of developing the infrastructure. Through acquisition of a health system called Sun Health, we had a small Medicare Advantage plan. That's how we got into the government payer business.

We have a big footprint in the government payer area just as a delivery system. We call them the bookends of our markets where there's higher concentrations of Medicare and Medicaid individuals. We joint-ventured with Blue Cross Blue Shield. We ended up selling our interest in the joint venture back to BCBS of Arizona. We still have value-based arrangements with them but decided that we didn't have the right chemistry for the joint venture.

We acquired a Medicaid plan through that acquisition, and then we started talking to Aetna in about 2015. We were in the accountable care model with them. They were one of the smallest plans in the market, and we were the largest delivery system. We knew that we needed a national presence. This has especially been accelerated with the pandemic—people work and live in lots of different places now, so you need to be able to sell nationwide.

We were going to focus on the small group and individual market. We are closing in on half a million members now, and we have had our most significant success upmarket working with large national employers. They were looking for something different, and we offered a model of a performance network and a broad network and more affordable coverage.

One thing that makes our joint venture unique is the delivery system does all the medical management. We have to be really focused on the right care, right patient, right place, right time, and right provider. We focused on building those capabilities with the joint venture, and then the Aetna (now CVS) team focused on helping us grow the market. Now we have a full portfolio. We sell everything from individual one sale at a time all the way to jumbo accounts.

We needed a national partner for the commercial insurance because of the nature of self-funding. Probably 80 percent of our business is self-funded and about 20 percent is fully insured. But on the government programs, we decided we could do that ourselves.

Silverstein: On one hand, you're the insurance company—you are negotiating rates internally as well as externally. On the other hand, you're acting for Banner. When Banner takes a risk-based or value-based contract, you're helping the health system deliver on those contracts. Will you share how you think about the health plan side versus the delivery side?

Lehn: It is an interesting dynamic. We try to use the networks to drive the performance of the medical management. Things that a health plan would do, we do through our networks. We get the health plans to delegate that core medical management to us. Then we have a single solution for the providers so they can do most of their Medicare, Medicaid, and commercial with us, and have one payer-agnostic process.

We do have our own arrangements with ourselves. Sometimes, I'll sign both sides of the contract. We try to be fair and equitable. Being on both sides of that equation was really helpful during the pandemic.

Exhibit 2: History of Growth and Transformation of Banner's Insurance Division

Silverstein: What's the best way for me to approach an insurance company and say that I need more money?

Lehn: If you want to get paid more, is there a way that you can create value? In the government programs, the value drivers are utilization management, care management, accurate coding and documentation, and STAR, which has now pivoted mostly towards member engagement and member satisfaction.

On the commercial market, if you're working with large employers, our scorecards aren't that different. The measures underneath might be a bit different, but the scorecard is still utilization, place of service, and quality. Risk adjustment applies in lots of different populations now. You know what the levers are, so approach them and say, "Hey, here are the places where we can add value."

> "I know I must get my networks to perform. We must have the right incentives, the right data and analytics, and the right structures for them to view their performance. If they keep improving in any of those areas—quality, utilization, member satisfaction—it's going to create value for the plan, and I should get some of that back."—Chuck Lehn

Silverstein: Governance can apply at different levels, at the health system level as well as for your clinically integrated network. Share a little bit about what you're telling the network providers to do to create value that will ultimately then result in more economic value.

Lehn: We typically contract on a percent of premium or shared savings model. We have governance processes at the plan level and at the network level. With the providers, we have clinically integrated networks and really try to focus on those performance levers—quality, utilization, and member engagement.

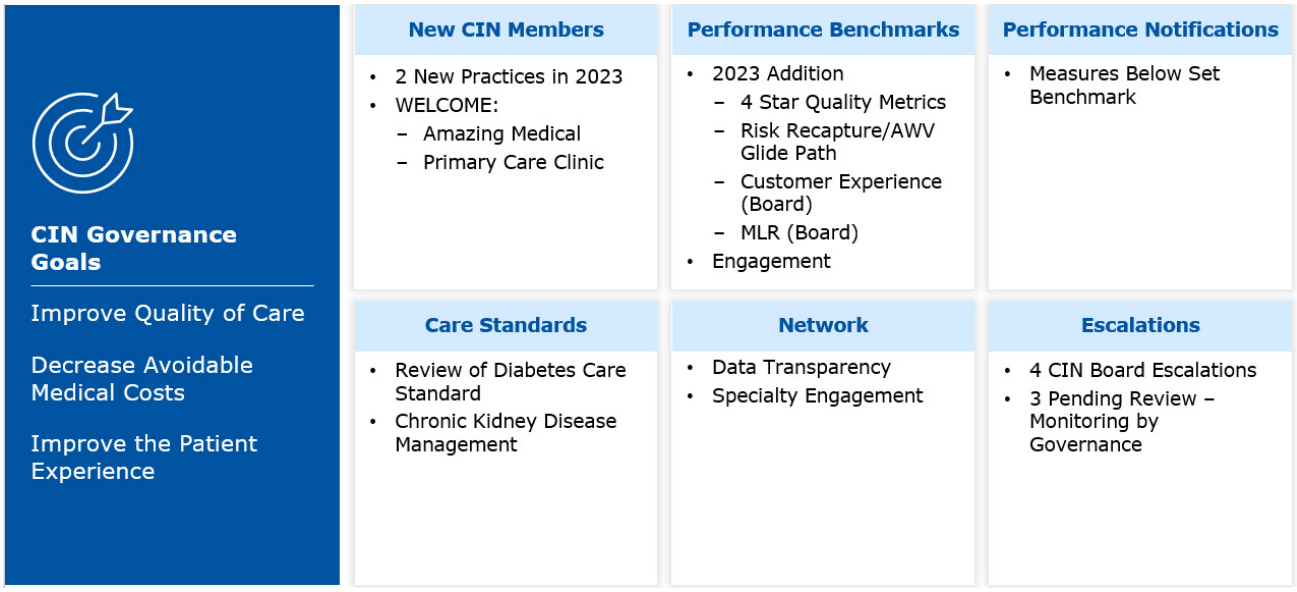
Don't underestimate member engagement/patient satisfaction. It's becoming the biggest part of the STAR measures. Retaining members is just so valuable to a plan. If you're really good at member retention and member satisfaction, that creates a lot of long-term value for the plan, so we try to align the governance processes of our networks to those value drivers and make sure we have those in place.

We have a big Medicare shared savings book in all our markets. We focus on all lines of business—Medicare, Medicare Advantage, commercial, and Medicaid—and try to get consistent processes and governance to focus on all of them. The measures might be a little different, but everyone's trying to achieve similar overall outcomes.

It's a long journey, and it takes time to get everybody engaged. We are in full transparency mode. We publish everybody's data about performance and the clinically integrated networks talk about things that they can do to improve.

Silverstein: Highlight what you're doing with member experience from both the plan perspective as well as the provider perspective. How do you approach this in an integrated way?

Exhibit 3: BHN PCP Governance Committee Activity



Lehn: We must walk in each other's shoes. What are the plans' obligations? Understanding the expectations and what really drives performance for the plans—that's table stakes.

For example, in Arizona, there are withholds for quality and member satisfaction. The plans that do the best can achieve more than 100 percent of the withhold back. We had to start putting member satisfaction measures in each practice with simple tools. I was pleasantly surprised at how practices embraced it. People can click on a QR code and complete a short survey. I had several physicians say, "I never knew that patients didn't like X." Getting the physicians to see opportunities for improvement and then having tools to help them is key. This is a journey. Have good, simple tools for them to use in their practice every day. We use practice transformation consultants to help the practices deploy those tools. Then you can start measuring and celebrate when things start to improve.

We have maintained our rate position or rate increases by doing more value-based care. We are trying to give the members and the providers a consistent experience, so we don't differentiate the way we work with providers for our plans versus any other plan.

Silverstein: What's required to create a payer pathway to whole-person coverage—a comprehensive offering that's not just medical, but also has dental, vision, mental health, and be able to offer a full service?

Lehn: You have to do an honest assessment of your capabilities. What are you good at? It's a build-or-buy decision. We use dental networks for our dental benefits. We use vision networks for our vision benefits. We have a mixture of our own delivery assets and some network assets that we use on the behavioral health side. We have a big capabilities grid—everything that we need to be successful. Do we have those capabilities? What does it cost to build those capabilities? Is there somebody that is better at it who we should partner with?

There's a fine line between partner and competitor. If they can help me more than they can hurt me, then it's probably a good deal. We have our traditional health system competitors in our network—they can help us grow. It's better to leverage the investments they have already made. You must think about how to grow and perform and who can help you do that.

→ Key Board Takeaways

- Evaluate the options in your market for building, buying, or partnering with payers.
- Revisit your current strategies for moving into risk-based contracts.
- Build a solid relationship with payers with clearly defined incentives.
- When working with insurance companies, articulate ways that you can add value (e.g., member engagement, utilization or care management, quality).
- Broad physician networks are needed to succeed with value-based care arrangements. Assess your physician network integration status to determine where there may be gaps or areas of opportunity to partner with other providers to expand your network.
- Data infrastructure is critical, and physician groups are looking for health system support. Leverage your payer relationships to include infrastructure development and support.

Silverstein: Do Banner Health plan members need to get their care from a Banner facility to get preferred rates?

Lehn: It's not universal for every single plan, but we generally have what we call a performance network, and that's a higher benefit option. If you choose the

performance plan or the performance network, you get a higher level of benefit if you're an individual. If you choose the broad network, you have a lower level of benefit. Members get to make the choice.

On the commercial side, employers typically want a broad network, so you must have everybody in—all your competitors. That gets your foot in the door. You must have that broad network to respond to an RFP.

Our goal is to try to use different tools and techniques and approaches to get as many people as possible moving towards that performance network, because they will disproportionately use your own delivery system.

Silverstein: When you're thinking about that performance network, what are some of the things you look at?

Lehn: First, you want network providers who will align and be engaged. They must have professional interest in improving, and they must be willing to work with you so that when you start talking about practice transformation and driving those levers of performance, they are willing to engage.

We un-blind all of that, and then in our governance processes, the physicians look at each other and say, "You're not doing a good job with diabetics. Your A1C management is terrible." We really look at engagement. Even if they're a low performer, you can help them get there. Most of the time, it's the processes and technology adoption [that are lacking].

Silverstein: When you think about your providers, what do you consider to be a low-maintenance provider and what is high-maintenance, and how does that impact how you contract with them?

Lehn: The low-maintenance providers have some capabilities in their practice, the right mindset of improvement, will embrace the incentives that you're offering, and will use those to keep investing in their practice to improve. They will rely on us for some data and information support, but they have a culture of improvement built into their practice already.

Low performers aren't engaged. This is not for them. They're not interested. You can't get through their practice manager. Everything is a problem. They can't adopt the things that you're trying to get them to adopt. Sometimes you need them because you need network coverage. We have a lot of variation in performance, but we are starting to flatten and get it more towards the center.

Silverstein: If you're contracting with a health system that has its own practices, are you then communicating with the system or are you communicating with the practices or both?

Lehn: Both. We have dedicated leadership to our medical groups. We have a joint operating committee. We meet every month and go over all of the practices for our employed medical groups. We have about 3,000 physicians in our academic and community medical groups. There's variation in performance but through those joint operating committees we share common incentives. It's about performance and listening. What do they need to be successful? It's always more data. There's never enough data. The data needs to be more accurate.

Ten years ago, I would have thought we were all much further along in this, but it has just taken time. We are now getting towards 60th or 70th percentile performance on the data side. We ingest data from all our payers, claims data, supplemental data, lab, pharmacy—all of it. Then we have tools to aggregate that information and feed it into point-of-care tools and tools that can look across the population.

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