The MetroHealth System
Creating Value through Collaboration

NEO HFMA – Payer, Provider Relations
July 28, 2016
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I. View of the Healthcare Landscape

II. Market Forces Encouraging a Different Approach

III. Provider/Payer Collaboration Models

IV. Closing
Who is Caught in the Middle?

Source: www.thebackofthenapkin.org
The U.S. health market requires greater flexibility and insight than ever before.
Various economic, technological, regulatory and social factors are pushing the industry in new directions, creating opportunities and challenges that never before existed.

<table>
<thead>
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<th>Key Drivers</th>
<th>Demographics</th>
<th>Economic Pressure</th>
<th>Healthcare Reform</th>
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<td></td>
<td>Population Growth</td>
<td>Governments</td>
<td>PPACA (US)</td>
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<td></td>
<td>Population Ageing</td>
<td>Employers</td>
<td>Other global reform</td>
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<tr>
<td></td>
<td>Chronic Conditions</td>
<td>Market Competition</td>
<td>ARRA, HITECH for EHR</td>
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<thead>
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<th>Business Model Enablers</th>
<th>Convergence</th>
<th>Consumerism</th>
<th>Care Model Redesign</th>
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<td>Payer-Provider Integration</td>
<td>Consumer Engagement</td>
<td>Population Models (e.g., PCMHs, ACOs)</td>
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<td>Incentive Alignment</td>
<td>Value Based Benefits</td>
<td>Condition Oriented Models (COEs, DM programs)</td>
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<td></td>
<td>Risk Shifting</td>
<td>Wellness/Preventative Programs</td>
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<table>
<thead>
<tr>
<th>Technologic Enablers</th>
<th>‘Big Data’</th>
<th>Mobility</th>
<th>Personalized Medicine</th>
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<tr>
<td></td>
<td>Aggregation, Storage and Analytics</td>
<td>Telemedicine</td>
<td>Genomics</td>
</tr>
<tr>
<td></td>
<td>Pooling/Open Data</td>
<td>Wireless Sensors</td>
<td>Targeted Therapeutics</td>
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<td></td>
<td>Data Center Capacity</td>
<td>Remote Patient Monitoring</td>
<td>Personalized Treatments</td>
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<tr>
<td></td>
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<td>Apps/Social Media</td>
<td>Pharma Firms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Competing to ‘Own The Disease’</td>
</tr>
</tbody>
</table>

Source: FTI Consulting
View of the Healthcare Landscape
Moving Forward

The Past

Risk
Employers, payers

Reimbursement
Service/volume-based

Information
Siloed, static, paper-based

Treatment
One-size-fits-all, volume-based

Delivery
Hospital-based, expert/specialist driven

The Future

Providers, patients

Performance/value-based

Networked, dynamic, digitally-based

Personalized, value-based

Community/retail-based, team driven


Providers and Payers are in the unique position to help shape the industry’s future.

Source: FTI Consulting
Health Impact Pyramid (CDC)
Factors that Affect Health

Source: Georgia Department of Public Health; Centers for Disease Control and Prevention
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Triple Aim: Catalyst for Change

Improving the patient’s experience of care
- Quality, access, reliability

Better care

Improving the health of populations
- Healthy life expectancy

Better health

Lower cost

Reducing the per capita cost of health care
- Or at least controlling or slowing cost growth

Source: Summit Leadership Strategies
Triple Aim: Alternative View

Source: David A. Kindig, MD, PHD
Health Reform Continues Full Steam Ahead

Affordable Care Act Remains (Mostly) Intact After Legal, Political Challenges

Major Milestones of ACA Rollout
2012–2018

2012
Rise of Accountable Payment Models

- Medicare Advantage bonuses
- Hospital Value-Based Purchasing Program
- Medicare Shared Savings Programs
- Hospital Readmission Reduction Program
- Center for Medicare and Medicaid Innovation (CMMI)

2013
Implementation of New Financing Mechanisms

- Medicare tax increase
- Excise tax on medical devices
- Disproportionate Share Hospital (DSH) payment reductions

2014
Launch of Coverage Expansion

- Guaranteed issue
- Community rating
- Health insurance exchanges
- Individual, employer mandates
- Optional Medicaid expansion to 133% of the Federal Poverty Level (FPL)

2015-2018
Elevated Penalties for Drivers of Excess Cost

- Hospital-acquired condition penalties
- Independent Payment Advisory Board (IPAB) recommendations
- Individual, employer penalty increases

Source: Advisory Board Company
Payment Cuts have Become the Norm

Hospitals Bearing the Brunt of Payment Cuts
Reductions to Medicare Fee-for-Service Payments

<table>
<thead>
<tr>
<th>Year</th>
<th>ACA IPPS(^1) Update Adjustments</th>
<th>ACA DSH(^2) Payment Cuts</th>
<th>MACRA(^3) IPPS Update Adjustments</th>
<th>Total Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($4B)</td>
<td></td>
<td></td>
<td>($4B)</td>
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<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td>($14B)</td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>$24B</td>
<td></td>
<td>($24B)</td>
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<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td>($29B)</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td>($38B)</td>
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<tr>
<td>2018</td>
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<td></td>
<td></td>
<td>($54B)</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
<td></td>
<td>($67B)</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td></td>
<td>($76B)</td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td>($86B)</td>
</tr>
<tr>
<td>2022</td>
<td></td>
<td></td>
<td></td>
<td>($94B)</td>
</tr>
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New Proposals Continue to Emerge
President’s FY2016 Budget Proposal Includes Significant Cuts to Providers

- **$30.8B** Reduction in Medicare bad debt payments
- **$29.5B** Savings from moving to site-neutral payments
- **$14.6B** Cuts to teaching hospitals and GME payments
- **$720M** Cuts to critical access hospitals

1) Inpatient Prospective Payment System.
2) Disproportionate Share Hospital.

Source: Advisory Board Company
Shift Towards Risk-Based Payments

Aggressive Targets for Transition to Risk
Percent of Medicare Payments Tied to Risk Models

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
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<tbody>
<tr>
<td>20%</td>
<td>30%</td>
<td>50%</td>
<td></td>
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</table>

FFS Increasingly Tied to Value
Percent of Medicare Payments Tied to Quality

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>85%</td>
<td>90%</td>
<td></td>
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</table>

Examples of Qualifying Risk Models:
- Medicare Shared Savings Program
- Bundled Payments for Care Improvement Initiative
- Patient-Centered Medical Home

Examples of Quality/Value Programs:
- Hospital-Acquired Condition Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital Readmissions Reduction Program
- Merit-Based Incentive Payment System

Source: Advisory Board Company

1) Fee-for-Service.
More Providers Taking the Hint

Dismal Outlook for Fee-for-Service Motivating a Look at Risk-Based Options

89 ACOs Join in 2015, Few Generating Shared Savings in First Year

### Medicare ACO Program Growth Continues

*As of April 2015*

<table>
<thead>
<tr>
<th>ACO Type</th>
<th>Total ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pioneer ACO</td>
<td>19</td>
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<tr>
<td>MSSP ACO</td>
<td>404</td>
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<tr>
<td>Total ACOs</td>
<td>423</td>
</tr>
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### One-Quarter of MSSP ACOs Share in Savings

*First Performance Year*

- **26%** Held Spending Below Benchmark, Earned Shared Savings
- **46%** Did Not Hold Spending Below Benchmark
- **27%** Reduced Spending, Did Not Qualify for Shared Savings

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1) Medicare Shared Savings Program.
2) For the 2012 and 2013 cohorts; percentages may not add to 100 due to rounding.

Source: Advisory Board Company
Market Demand for Alternative Solutions
Patient Cost-Sharing Continues to Accelerate

Percent of Covered Workers Enrolled in a Plan with a $1,000+ Deductible by Firm Size

*Single Coverage*

<table>
<thead>
<tr>
<th>Year</th>
<th>Small Firms (3-199 Workers)</th>
<th>Large Firms (200+ Workers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>40%</td>
<td>13%</td>
</tr>
<tr>
<td>2010</td>
<td>46%</td>
<td>17%</td>
</tr>
<tr>
<td>2011</td>
<td>50%</td>
<td>22%</td>
</tr>
<tr>
<td>2012</td>
<td>49%</td>
<td>26%</td>
</tr>
<tr>
<td>2013</td>
<td>58%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Average In- and Out-of-Network Deductibles for Group Plans

*n = 1,100 employers*

<table>
<thead>
<tr>
<th>Year</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$680</td>
<td>$1,000</td>
</tr>
<tr>
<td>2010</td>
<td>$760</td>
<td>$1,380</td>
</tr>
<tr>
<td>2011</td>
<td>$1,010</td>
<td>$1,750</td>
</tr>
<tr>
<td>2012</td>
<td>$940</td>
<td>$1,570</td>
</tr>
<tr>
<td>2013</td>
<td>$1,230</td>
<td>$2,110</td>
</tr>
</tbody>
</table>

Source: Advisory Board Company
Characteristics of a Traditional vs. Retail Market

**Traditional Market**
- Passive employer, price-insulated employee
- Broad, open networks
- No platform for apples-to-apples plan comparison
- Disruptive for employers to change benefit options
- Constant employee premium contribution, low deductibles

**Retail Market**
- Activist employer, price-sensitive individual
- Narrow, custom networks
- Clear plan comparison on exchange platforms
- Easy for individuals to switch plans annually
- Variable individual premium contribution, high deductibles

**1. Growing number of buyers**

**2. Proliferation of product options**

**3. Increased transparency**

**4. Reduced switching costs**

**5. Greater consumer cost exposure**

Source: Advisory Board Company
Market Demand for Alternative Solutions

**Consumerism**
- Ever-increasing cost of health care
  resulting in
- Increasing personal responsibility for cost of health care
  resulting in
- Increasing consumerism in health care
  resulting in
- Demand for pricing and quality transparency

**New Model**
- Market for health insurance moving towards “retail model”
  resulting in
- Reduced demand for expansive provider networks
  resulting in
- Creation of narrow and tiered network products
  resulting in
- Steeper discounting in exchange for steerage/volume
A Call to Action

Status Quo

1.

“Not my problem”

Visionary

2.

“We will find a way”
Emerging Themes on Provider and Payer Side

Outcomes of Market Disruptions

1. End of Traditional Growth Model
   - Heightened regulatory scrutiny
   - Limitations on pricing increases
   - Reimbursement cuts
   - Long-term deficit reduction plans

2. Increased Partnerships, New Identities
   - Provider-health plan joint contracts, ventures
   - Provider-provider mergers and affiliations

3. Rise of Consumerism
   - Employer cost-shifting
   - Growing popularity of high deductibles
   - Patient engagement measures

Source: Advisory Board Company
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AHA Board CPI: Must-Do Strategies

Adoption of Must-Do Strategies

1. Clinician-hospital alignment
2. Quality and patient safety
3. Efficiency through productivity and financial management
4. Integrated information systems
5. Integrated provider networks
6. Engaged employees & physicians
7. Strengthening finances
8. **Payer-provider partnerships**
9. Scenario-based planning
10. Population health improvement

Organizational culture enables strategy execution

Establish partnerships with payers to align the risk and rewards of new projects and payment systems.

Source: AHA
Private Payer ACOs Emerging Nationwide

- **Providence Health & Services**: $30 M, two-year contract with public employee benefits board
- **Blue Shield California**: Two ACOs in Northern California
- **Anthem Blue Cross**: ACO pilot with Sharp HealthCare medical groups
- **BCBS Minnesota**: Shared savings contract with five providers
- **BCBS Illinois**: Shared savings contract with Advocate Health Care
- **Humana**: ACO pilot with Norton Healthcare
- **UnitedHealthcare**: ACO with Tucson Medical Center
- **CIGNA**: Medical home contract with Piedmont Physicians Group
- **Maine Health Management Coalition**: Multi-stakeholder group supporting ACO pilots
- **BCBS Massachusetts’s Alternative Quality Contract**: Annual global budget, quality incentives for participating providers
- **Aetna**: ACO pilot with Carilion Clinic
- **Source**: Advisory Board Company
Cooperating to Deliver Distinctive Offerings

Newly Formed Payer-Provider Partnerships

- **Blue Shield, Hill Physicians Medical Group, AllCare IPA**
  - *Blue Groove*
  - Premium reduction: 10%

- **Steward Health System, Tufts Health Plan**
  - *Steward Community Choice*
  - Premium reduction: 15-30%

- **Banner Health, Health Net**
  - *ExcelCare*
  - Premium reduction: 20%

- **Fairview Health, Medica**
  - *Fairview Health Advantage with Medica*
  - *(defined contribution plan for businesses)*
  - *Harmony with Medica and Fairview*
  - *(individuals)*

- **MedStar Health, Evolent Health**
  - Supporting population management strategies

- **Carilion Clinic, Aetna**
  - *Banner Health, Aetna*
  - *Aetna Whole Health*
  - Premium reduction: 30%

Source: Advisory Board Company
Incenting Success by Placing Support at Risk

Process for Prospective Quality Payments at Spurlock Health

Health plan pays out PMPQ² care coordination fees at beginning of quarter

First Quarter

Spurlock Health uses funds to hire care coordinators, improve disease registry

• Spurlock Health achieves all quality metrics during quarter
  • Keeps entire care coordination fee payment

• Spurlock Health does not achieve all quality metrics
  • Required to pay back PMPQ received for each metric missed

Case in Brief: Spurlock Health

• Large health system located in the West
• Care coordination fees paid by health plan at beginning of each quarter, receives $1 PMPQ² for each quality metric included in contract, up to $8 total PMPQ
• Spurlock must pay back fees received for any metrics missed at end of performance period
• Funds investments necessary for success under population health contracts

1) Pseudonym.
2) Per-member, per quarter.

Source: Advisory Board Company
Population Care Coordinator Connects with High Risk

- Practices required to hire a population care coordinator (PCC) to follow up with at-risk members
- Horizon offers 2-day training for PCCs to share best practices, update clinical knowledge

Member Management Through Education and Benefits

- Select products offer access to PCMH without patient obligation
- Practices receive scripting on how to discuss PCMH benefits

Case in Brief: Horizon Blue Cross Patient Centered Medical Home

- 3.8M member plan in NJ with 750,000 members cared for by a PCMH
- Participating providers earn upfront care coordination fee and opportunity to share in savings
- PCMH members had 9% lower total costs and 8% fewer admissions than non-PCMH members

Source: Advisory Board Company
**Case in Brief: CareFirst BlueCross BlueShield**

- **Not-for-profit health services company** serving 3.4 million members in Maryland, D.C., and northern Virginia.
- **In 2011**, launched PCMH program providing opportunities for virtual panels of 10-15 PCPs to earn bonuses based on quality and total cost metrics.
- **Provides PCPs** with color-coded rankings of specialists based on risk-adjusted PMPM costs.

**Members covered by PCMH program**

- **1M+**

**Eligible PCPs participating**

- **80%**

**Average pay increase for PCPs receiving bonuses**

- **59%**

Source: Advisory Board Company
Data Key to Total Cost Transparency

Specialists Color-Coded By Total Cost

PCP Virtual Panels

Employed Specialist A (Red)
Employed Specialist B (Yellow)
Independent Specialist C (Green)

Hospital A
Hospital B

27%
Difference in risk-adjusted PMPM cost between top- and bottom-quartile PCPs

40%
Percent of panels earning bonuses, 2014

$345M
Savings from PCMH program, 2014

“We’re seeing that [the data] changes the patterns. There’s a hubbub among the panels to see what their choices are, and what it costs them.”

Chet Burrell
President & CEO
CareFirst BlueCross BlueShield

Source: Advisory Board Company
Collaborative Provider Care

Targeting Primary Care Physicians

Key Elements of Cigna Collaborative Care

Eligible Provider Groups

Physician Groups
- Large primary care practices
- Multi-specialty groups
- Independent physician associations

Hospitals
- Fully integrated systems
- Physician-hospital organization

Collaborative care agreements as of January 2015

Source: Advisory Board Company
Achieving Success in Cost, Quality

Physicians Determine Best Route to Savings

**Physician Group Performance**,\(^1,2\) 2013

*Large Groups Participating for 2+ Years*

![Bar chart showing 91%, 78%, and 74%](chart.png)

- **91%** Total Medical Cost
- **78%** Quality
- **74%** Cost and Quality

“Strong partnerships with ancillary facilities as well as our providers’ commitment to decrease avoidable emergency room visits by providing easy access to primary care services.”

Andrew Snyder, MD
Brown & Towland CMO

“Opening urgent care clinics in areas where people with high ER use lived, making it easier for them to get the right care at the right time in the right setting.”


Source: Advisory Board Company
National Payers Pursing a Different Strategy

Designing Narrow or Co-Branded Networks at a Lower Price to Consumers

Aetna’s Spectrum of “Accountable Care Solutions”

- Pay-for-performance incentives
- Delegated risk through commercial ACOs
- Co-branded “Whole Health” insurance products
- Consulting support for providers launching health plans

Greater risk shifting to providers

Notable Provider Partners

- Banner Health
- INOVA
- Mount Sinai
- Memorial Hermann
- Meridian Health

77 ACO agreements as of Q1 2016

“We’re comfortable being known as the health plan that wants to put health systems in the business of selling insurance.”

Daniel Finke, CEO
Aetna Accountable Care Solutions

Source: Advisory Board Company
Aetna and Banner Health Collaboration

ACO Product Increases Banner’s Ability to Manage Care

Key Elements

- **Enhanced Analytics**
  Banner relies on Aetna’s data exchange and member engagement tools

- **Care Management**
  Aetna proactively identifies care gaps that Banner physicians are able to close

- **Product Design**
  Insurance product built around Banner helps them maintain coordinated care

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**Case in Brief: Aetna Banner Health**

- ACO-based insurance product designed around the Banner Network in Phoenix, AZ
- **$5 million saved in 2013** for fully insured commercial membership correlating with a 5 percent decline in medical costs

Source: Advisory Board Company
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Imagine the Possibilities by Collaborating

Logic will get you from A to B

Imagination will take you everywhere

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- Albert Einstein