TRENDWATCH

Compendium: Hospitals and Health Systems Prepare for a Value-driven Future

Profiles of Interviewed Health Systems

Seven health systems were interviewed to inform the AHA TrendWatch *Hospitals and Health Systems Prepare for a Value-driven Future*. Profiles of each of these organization's value-based payment (VBP) activities follow.

Aurora Health Care (Milwaukee)

Aurora Health Care is an integrated delivery system of 15 hospitals, more than 150 clinics, 70 pharmacies and a visiting nurse agency that serves patients across eastern Wisconsin and northern Illinois with approximately a fifth of its patient population in risk-related arrangements. Aurora gained experience with value-based payments in 1998 by directly contracting with nearly 40 employers under a capped total cost of care arrangement and later pursued upside-only risk in accountable care organizations (ACOs) with multiple health plans. Aurora and Anthem announced a shared savings and care coordination agreement in June 2015 and then in 2016, they created the Wisconsin Collaborative Insurance Company. It offers commercial health insurance products with a network of physicians and hospitals that routinely rank as some of the most efficient and high quality in

Wisconsin. Also in 2016, Aurora and UnitedHealthcare partnered to launch an ACO for United's Medicare Advantage members in the Milwaukee area.

Aurora first experimented with population health management and plan design via its self-insured plan. Today, it has an integrated medical group and is in the early stages of integrating other services — including visiting nursing, behavioral health, family support and pharmacy — with the goal of further optimizing these as the system expands its adoption of risk. The integrated medical group continuously develops clinical pathways via Epic Systems as a normal course of business; however, Aurora has opted to not establish prior authorization and pre-certification requirements for it's employees in these pathways as the system believes these practices yield inefficient care. Aurora is pursuing a more customer centric approach to meeting patient needs through its collaboration with Anthem as it brings strong risk management proficiency and leverages Anthem's predictive modeling and service center capabilities.

Seeking to ensure leadership alignment, Aurora established a dual reporting structure for Population Health

management in both its enterprise business group and medical group to engage clinical leaders in finance and risk decisions. As a result, contracting leaders have become well-versed in population health and value-based care topics, enabling them to negotiate quality performance metrics with payers that are actionable by clinicians and support better patient care.

Banner Health (Phoenix)

Banner Health operates 29 hospitals, including three academic medical centers and other related health entities and services in seven states. Building on experience with risk in its self-funded employee plan and Medicare Advantage plans, Banner Health began pursuing other value-based arrangements five years ago and now has ACO partnerships with several national health plans across all market segments. With half a million lives in value-based arrangements — primarily in the northern Colorado, Phoenix and Tucson markets — the system receives approximately $1.5 billion of its $7.5 billion enterprise revenue via value-based payments.

Banner focuses on developing infrastructure to support these arrangements

American Hospital Association®

in three areas: care management, data analytics and registries. While most of the care management programs are primarily Banner-staffed, the system in recent years pursued partnerships to support technical capabilities. Although the basis of these partnerships varies depending on how partners' capabilities align with Banner's capabilities and needs in a particular market, the system is positioning to develop service platforms that can interface — and eventually be integrated — with its clinical platform to meet customer needs. In doing so, Banner found that strong partners support interoperable technologies. Some lessons learned through this process include building early alignment on a common EHR and integrating as much information as possible, establishing tight feedback loops between measurement and clinical change, and distributing timely information to providers.

One-third of Banner's affiliated physicians are employed by its medical group and the other two-thirds are in private practices. Banner anticipates that its employed physician ranks will grow in the coming years and is already observing rapid consolidation among specialists. While Banner has created a common physician scorecard to measure quality, service and efficiency scores, physicians' scores do not yet drive a substantial portion of their compensation. With its 2015 acquisition of the University of Arizona Health Network, the system aims to weave clinical research findings into its population health management capabilities and integrate the academic centers into its narrow networks.

Banner Medical Group leadership play the critical role of building care teams and focusing on the total cost of care. Network and medical staff collaborate to develop narrow networks, including both employed and contracted physicians, for six specialties, beginning with cardiology, oncology and orthopedics. Service line leaders were responsible for ensuring a consistent clinical approach, embedding technology to support care and managing financials, while participating in Medicare bundled payment initiatives. These efforts have required thoughtful consideration regarding physician participation in the Banner network. In conjunction, system leaders have been effective partners in building out ambulatory sites.

Banner anticipates that it will continue to focus on accountable care development, pursuing strategic partners in the Medicaid and commercial markets to focus on effective network and care management. Despite its commitment to improving how care and coverage work together, Banner does not anticipate launching its own insurance plan, given the level of plan consolidation in its markets. Instead, it will continue to concentrate on becoming an integrated delivery system, focusing on meeting and exceeding rising consumer expectations.

Billings Clinic (Billings, Mont.)

Montana's largest health care organization, Billings Clinic is an integrated multi-specialty group practice comprised of 350 physicians across 50 specialties, a hospital, a skilled nursing and assisted living facility and distributed clinics across the state. Billings' group practice integrated with Deaconess Medical Center in 1993 and has since developed a tightly integrated, physician-led and professionally-managed dyad model. Heavily involved in rural healthcare, Billings Clinic manages 11 critical access hospitals (CAHs), and is involved in the governance of five of those hospitals.

Billings Clinic has a longstanding commitment to managing population health and in doing so, has participated in alternative payment models; however, it perceives many of these programs to function more effectively in urban markets than rural ones and struggles to reconcile these arrangements with its commitment to serving rural health populations. In a number of initiatives — such as the Group Practice demonstrations and one-sided Medicare Shared Savings Program arrangements — the Clinic performed very well with regard to quality and cost, but did not generate sufficient levels of savings to exceed required thresholds. The Billing Clinic had a similar experience participating in Medicare's hip and knee bundled payment program. Billings owned a Medicare Advantage plan for over six years but is now in the process of divesting it; critical issues related to providing medical management across a widely distributed and rural membership and network, in addition to sharply rising specialty pharmacy costs, were primary factors driving that decision. Billings is now seeing other providers and payers in its market begin to position for value-based payments. It anticipates working with Blue Cross Blue Shield of Montana (BCBSM) on a statewide clinically integrated network via its critical access hospitals and will collaborate with BCBSM and Pacific Source in establishing ACO-like models for commercial lives. It also plans to participate in a state innovation-Comprehensive Primary Care Plus program, using telehealth to support Project ECHO-enhanced integrated behavioral and physical health services.

Using a single EHR across the hospital and clinic, Billings has developed effective care management capabilities and care teams to bridge historic care silos.

Nurse navigators and medical assistants are employed for primary care documentation and chronically ill patients can receive condition-specific nurse contact and support between appointments. After finding that half of its hospital patients come from outside of Yellowstone County and therefore receive much of their follow-up and primary care from other institutions, the Clinic is working to put in place a service model that extends these capabilities to rural clinics and critical access hospitals. The Clinic has a longstanding telemedicine program through which it provides approximately 100 telehealth appointments each month, with a focus on post-surgical follow up and behavioral health. The Clinic uses telehealth in correctional clinics and Native American schools, and is currently piloting a workplace virtual health program for relatively healthy populations at a local law firm. Billings Clinic anticipates further developing its virtual health capabilities, particularly at worksites, and pursuing retail medicine at large local grocery stores. It also expects to build on its nascent medical education programs to support alternative approaches to meeting rural needs.

Through its bundled payment program, the Billings Clinic found that its acute care costs were competitive but post-acute care costs were high. It has since sought to increase alignment of post-acute care partners, including through the development of a joint venture home health and hospice program with a local partner and the exploration of potential partnerships for inpatient rehabilitation services. Billings Clinic is also striving to be more coordinated with its critical access hospitals — particularly for discharged patients who utilize these hospitals' swing beds —

by connecting them to Billing's EHR and financial systems.

Billings Clinic is committed to its physician leadership; in addition to its physician CEO, physicians are represented on internal and community governing boards. The merger with Deaconess required the Clinic to define its future direction as a single organization; establishing a single budget was a key driver of the Clinic's cultural evolution to an integrated delivery system. Using a dyad model similar to that of the Mayo Clinic across most levels of the organization fosters collaboration across administrators and physicians. Since the Clinic revamped its vision in 2005 to be best in the nation in quality and service irrespective of payment model, physicians and executives have worked closely to drive this agenda. To support its vision, some physicians' compensation — particularly in primary care — has shifted to focus on quality outcomes and less on production.

Health First (Rockledge, Fla.)

Health First is developing a fully-integrated delivery system (IDS) comprised of four hospitals, outpatient centers, a multi-specialty physician practice and two health plans that manage over 150,000 lives. Seeking seamless integration between system and payer functions, Health First has committed the last four years to reorganizing its assets from a holding company into a system of care focused on achieving the Triple Aim and shifting from a "sick outlook to a health outlook" for patients and members. As Health First realizes this transformation, it has seen substantial financial growth, dramatically improved quality scores and reduced annual costs by nearly $140 million. While it is participating in Medicare bundles,

Health First has not engaged in any accountable care or clinically integrated networks. The integration of Health First's health plan has not noticeably impacted its relationships with other payers. However, it has begun to private label its plan for other systems.

Health First's board challenged its president and leadership team to shift their view of the organization as a health care company to a systems integration company that operates in health care. Influenced by its location on Florida's Space Coast, the system began a journey into integration science, applying lessons from the aerospace industry's shift from volume to value, while gleaning guidance from other IDSs about their own transitions. Health First utilized the Capability Maturity Model Integration (CMMI) approach to integrate the previously discrete goals and purposes of its hospitals, plans, medical group and outpatient services. Using the health plan as the organizer of care, all care management functions reside within the plan, managing population health for all Health First patients, regardless of whether they are plan members.

To compensate for the loss of immediate feedback that it experienced in its siloed model, Health First formed three governing councils: a strategic council including the CEOs of the IDS, health plans, medical center and community hospitals; an operating council comprised of the system's operational leaders who are responsible for creating a unified platform under the IDS COO; and, a clinical council that defines Health First's clinical imperative and pathways. These councils work together to define future initiatives and apply a systematized approach to ensure sufficient financial and human

capital resources are available to achieve them. The system also moved away from operating unit level budgeting to system-wide financial forecasting with key performance indicators that can inform predictions of the bottom line (e.g., third next available appointment, percent of pharmacy business from non-health plan members).

Health First's transformation challenged its traditional hiring practices. In recent years, the system has hired a CIO from the banking industry as well as data scientists to drive the CMMI process. In addition to this new expertise, the system focuses on hiring leaders who have track records of working together with peers — rather than independently — to drive change. The colocation of senior executives has helped to foster this level of collaboration.

Intermountain Healthcare (Salt Lake City)

Intermountain is a health system with 22 hospitals, a broad range of clinics and services, approximately 1,400 employed Intermountain Medical Group primary care and secondary care physicians practicing at more than 185 clinics, and health insurance plans from SelectHealth. The system represents approximately 45 percent of Utah's hospital beds and, as Utah's largest insurer, provides insurance to about 850,000 members, or 22 percent of the state. The system began adopting insurance risk in 1983 and now offers insurance products across all segments – including commercial, Medicare Advantage, Medicaid and insurance exchanges. The system has established upside-only shared savings arrangements with other payers but is now pursuing capitated risk-based opportunities with commercial payers.

Cultural and market factors influenced Intermountain's early decision to pursue VBP which now comprises nearly half of the delivery system's payments. Intermountain describes its payment approach as an outgrowth of its philosophy of caring for patients: "ethos rather than ethics." While Intermountain is not a traditional closed system, over 90 percent of members' care — including pharmacy — is delivered within the network; members comprise approximately 30 percent of the care delivered in Intermountain's clinics/hospitals. Because the system tends to have longer tenure with its members than most insurers across the country, it has greater incentive to invest in preventative care. With federal and state governments able to mandate care prices and rate pressure from employers, Intermountain utilizes all relevant tools to provide value and support ongoing financial performance; the system is focused on strategies that keep patients healthier and combat overutilization.

Intermountain's employed and affiliated physicians participating in narrow networks agree to a contract, or "citizen agreement," that defines 18 shared commitments, including but not limited to: complying with evidence-based practices, linking their EHRs to that of Intermountain, treating other clinicians with respect and providing equal access to all patients regardless of their payer source. Intermountain has sought to align the right clinical decisions with the right financial incentives. Physicians in the broadest networks are paid via a fee schedule while a quarter of compensation for those in narrower networks is based on achievement of metrics related to quality, customer service, and total cost of care for population in their practicing community.

Intermountain describes patients as "shareholders" to help ensure consistent patient care regardless of payment mechanism and reinforced by clinical standards that have been established across 10 services lines. These standards are based on best practices, reviewed, socialized and approved by physician leaders, formalized in practice models and reinforced by Intermountain's clinical information, scheduling and reporting systems. With these standards in place and a requirement for justification of care orders that fail to comply with care protocols, Intermountain is agnostic to the employment status of physicians that serve patients within its system.

Intermountain maintains five geographic committees which function as consolidated care management teams. These geography-based committees — comprised of four employed physicians, four affiliated physicians and four administrators — meet monthly to review patients' care, including outlier analyses. Using claims analytics, the committees take on the role of a utilization review panel within a health plan with a focus on rapid response, and are evolving to become a single channel for patient navigation. They focus on comparing current performance on patient satisfaction and quality metrics as well as per member per month expense to historical performance and other geographies, drilling down to trends related to service use rather than service costs. Supporting this, Intermountain has care management functions in its insurance plans, hospitals and medical group, and is currently in the process of consolidating these into a single one-stop-shop for consumers.

Despite finding the drumbeat for VBP to be quieter than expected — particularly within Medicare Advantage and among national payers — Intermountain anticipates continuing its pursuit of capitation in the coming years. It has started more robust

engagements with commercial payers in 2017 when it will receive a capitated rate for all medical and pharmacy expense, with 66 to 80 percent of risk going to the system based on medical spending, quality and satisfaction scores.

Nationwide Children's Hospital (Columbus, Ohio)

Because Nationwide Children's is the predominant provider of pediatric services in its region, these patients — ranging from age 0 to 18 — are attributed to PFK based on geography rather than physician. Under this arrangement, the health plans retain a portion of the state Medicaid fund ing for administrative functions (e.g., eligibility, marketing, member complaints, claims processing) and pass the remaining funding to PFK for care. PFK's capitation encompasses facility, physician, pharmacy and dental costs.

Nationwide Children's and affiliated physicians share equal ownership of PFK. Employed physicians have incentives balanced across the quality, productivity and academic domains. Nationwide Children's reports that these arrangements align with how the physicians want to practice medicine, focusing on distributing resources to provide the best care possible and emphasizing wellness. While the network includes employed and contracted behavioral health providers, their services are not part of Medicaid managed care capitation payments, and therefore comprise a separate revenue stream. Community physicians are aligned under a PHO model via a loosely affiliated network supported by messenger model contracting and data analytic collaboratives. These physicians are paid on a FFS basis with pay-for-performance incentives, which were originally based on improving access and now emphasize quality,

state-selected performance measures and pharmacy management.

PFK's management team also has quality-related performance metrics related to population wellness, infant mortality, asthma and well visits. However, the organization measures its overall success based on its ability to mitigate the projected Medicaid shortfall, in comparison to the traditional FFS model. Over the years of risk adoption, the board and management teams have been actively involved in establishing the organization's risk profile and approaches to measure it.

PFK employs robust care coordination models and receives formal delegation of these services from its health plan partners, particularly for higher risk patients. The PHO maintains several targeted quality initiatives for complex patients, including a pharmacy management program in which pediatric pharmacist staff develop formularies with health plans and determine how to manage certain patients. PFK also provides clinical services for 250 neonatal beds, split between its own campus and several adult hospitals in the region. To support these initiatives, PFK uses a population health management infrastructure that integrates claims data from the five participating managed care plans with EHR data to identify service gaps and utilization trends.

PFK has faced critical challenges in accessing data and structuring capitation rates. Accessing data from health plans is one of PFK's most challenging activities, specifically with regard to ensuring this activity remains a priority for payers, reconciling data across payers and providers, and utilizing lagging data to make population health decisions. An additional complexity has involved working with the state to establish future capitation rates based on utilization

patterns. Nationwide Children's is currently exploring an additional shared savings arrangement with the state and CMS beyond its capitated rate based on the hospital's ability to contain cost growth below general health care cost inflation and achievement of quality indicators.

In the future, Nationwide Children's anticipates evolving toward at-risk models in the commercial sector. While care efficiency improvements accrue to all patients, transitioning from a FFS model is more complicated with commercial populations. Still predominantly paid under FFS for commercial business today, Nationwide Children's has begun early discussions with commercial plans, several major health systems and large employers to move to at-risk models, exploring the possibilities of being a pediatric clinical solution for other large systems while maintaining direct contracting with payers, and adopting some risk for adult populations. The PHO is assessing commercial population utilization and economics in comparison to its Medicaid experiences and is finding limited potential upside to applying the complex case management practices — particularly related to social determinants — that it has employed for Medicaid populations.

Saint Luke's Health System (Kansas City, Mo.)

Saint Luke's Health System is comprised of 10 hospitals and campuses across the Kansas City region; an employed, integrated multi-specialty medical group; behavioral health care; and home care and hospice. In recent years, the system focused on containing costs and expanding access to its services. However, with over a third of its business currently contracted through Blue Cross Blue Shield of Kansas City, the system and its physicians entered into a patient-centered medical home arrangement with the

plan in 2012. The system now participates in the Medicare Comprehensive Care for Joint Replacement bundled payment and Comprehensive Primary Care Plus (CPC+) programs, in addition to the MACRA.

In preparation for greater risk adoption, Saint Luke's is developing its population health capabilities, making investments in care coordination personnel, quality reporting software and a post-acute care network. Employed Saint Luke's physicians are moving towards incentive-based compensation primarily driven by quality metrics, starting at 10 percent of anesthesiologists' salaries, with greater percentages of hospitalist and cardiologist salaries tied to performance. While Saint Luke's anticipates growth in the number of its employed physicians — and is currently encountering private practices seeking acquisition — it anticipates the need to be increasingly selective as it grows to meet the demands of value-based payment models.

The system established Saint Luke's Care, a physician-led organization, in 2003 to develop evidence-based protocols, order sets and standards, and is now considering using this entity to support clinical integration, as it has been successful in building alignment between employed and independent physicians in establishing best practices for patient care. With regard to broadening its hospital network, Saint Luke's will seek to strengthen its relationship with clinically affiliated hospitals by sharing infrastructure to assist these entities with the Merit-based Incentive Payment System under MACRA.

American Hospital Association

manatt

American Hospital Association
800 Tenth Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
202.638.1100
www.aha.org

Manatt Health
7 Times Square
New York, NY 10036
212.790.4500
www.manatt.com