NAVIGANT

HEALTHCARE

NAVIGANT'S 2018 CLINICAL INTEGRATION SUMMIT

September 2018

Foreword from Dennis Butts

Many original assumptions for the value-based care movement have been replaced with new and stark realities. Chief among those assumptions is the expectation that more is better regarding investments in technology, physician practices, and population health expenditures. We now know that such investments will just add costs if an underlying model for clinical integration is not in place.

It was against this backdrop that population health executives representing hospitals, clinically integrated networks (CINs), and accountable care organizations (ACOs) nationwide convened in the summer of 2018 in Chicago for Navigant Consulting, Inc.'s 2018 Clinical Integration (CI) Summit. While all markets are different, this paper documents the key issues impacting organizations and proven strategies around how to overcome them.

DENNIS BUTTS
Managing Director, Navigant

5 STEPS TO ENHANCE MARGINS IN A VOLUME OR VALUE WORLD

With expenses rising faster than revenue even for high-performing systems — all at the top of a strong economic cycle — providers have a minimal margin of error to make value-based investments that don't yield a positive return, or even increase top-line revenue. Now more than ever, it's critical for providers to both drive revenue and margin growth, while also preparing for an uncertain value-based payment future.

Following are no-regret strategies discussed at the CI Summit that providers can pursue now to help achieve these dual purposes.

I. Emphasize In-Network Customer Keepage

As with any other consumer-centric industry, retaining existing customers is essential to driving revenue capture. Studies suggest a 5% increase in customer retention[1] can

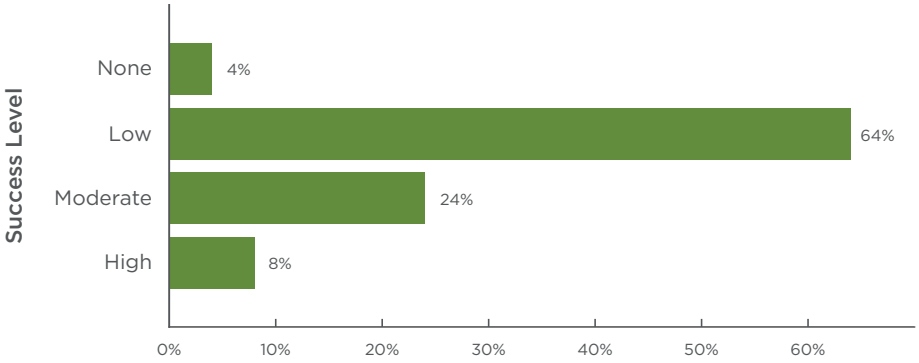
1. Forbes, "Five Customer Retention Tips for Entrepreneurs," Nov. 1, 2012: https://www.forbes.com/sites/alexlawrence/2012/11/01/five-customer-retention-tips-for-entrepreneurs/#21f30a745e8d

increase an organization's profits by 25% to 95%, while acquiring a new customer is anywhere from five to 25 times more expensive[2] than retaining an existing one.

Yet, according to a poll of CI Summit attendees, just one-third believe their organizations have successfully focused on improving their keepage rates (Figure 1).

Figure 1: In-Network Customer Keepage Rates

To what extent has your organization successfully focused on and improved your keepage rates?



Realizing that customer satisfaction is built through relationships and not episodes of disparate transactions, innovative health systems are focusing on retaining customers by building tighter provider network relationships focused on a consistent, high-quality care experience. Key tenets of this approach include:

- Technical connectivity, including automated appointment reminders, web portals with mobile availability, and telemedicine.
- A shared referral management infrastructure.
- Common standards for access, quality, and cost.

These approaches both support a patient's ability to easily access services, and systemwide reductions in handoffs between functions.

Already one of the largest Medicare Shared Savings Program (MSSP) ACOs with over 70,000 attributable lives and $630 million in medical costs under management, **Bon Secours Health System's Good Help** ACO was struggling with network keepage in 2013. Almost 50% of claims, or $300 million in MSSP claims, were heading out-of-network.

Good Help undertook an extensive campaign to improve network keepage, with the first step being to identify where the leakage was occurring, according to its former CEO Ken Petronis, now a Navigant senior advisor.

The system's analytics team built a tool to drill down into each of the ACO's primary care physician's (PCP's) attributed patient panels in- and out-of-network claims volume to identify potential opportunities. ACO and service line leadership then shared the data with PCPs and engaged those physicians who represented the greatest outliers. The process helped identify reasons for the leakage, the majority of which were access- and communications-related, not clinical in nature. These issues were logged, followed up on, and ultimately fixed.

2. Harvard Business Review, "The Value of Keeping the Right Customers," Oct. 29, 2014: https://hbr.org/2014/10/the-value-of-keeping-the-right-customers

The result: Good Help increased its in-network business by 4%, leading to an additional $12 million in new system revenue.

> "It was a classic example of the Hawthorne Effect in full bloom, but also emphasized the physicians' desire to improve outcomes once they understood where their performance stood."

KEN PETRONIS
Good Help

II. Consider Medicare Advantage Partnerships

Rather than focusing on fee-for-service (FFS) through standard Medicare ACO arrangements, many providers are turning to Medicare Advantage (MA) to achieve network objectives. Among the reasons, MA plan benefit design:

- Aligns with providers' value-based strategies with the focus on care quality and in-network utilization.
- Creates revenue opportunities above traditional Medicare and other commercial sources, without compromising FFS revenue.
- Offers providers flexibility in building a pathway from value-based upside contracts to those with partial and full capitation.

As MA increases in popularity, plans must implement strategies that enhance their value to beneficiaries and Medicare, and preserve enrollment. According to a Navigant analysis,[3] increasing a plan's MA star ratings is key to attracting new enrollees and increasing revenue.

Improving star ratings requires enhanced payer-provider collaboration through value-based MA arrangements. Such partnerships offer opportunities to increase plan satisfaction and quality, and share the financial benefits of such improvements.

III. Engage Physicians

Since physicians are data-driven by nature, demonstrating impact through quantitative outcomes is essential to effectively engaging physicians and making them more accountable for outcomes.

Founded in 2012, **Premier Management Company** realized early-on that the technology needed to better engage with physicians did not exist in the current market.

3. Navigant, "The Impact of Star Ratings on Rapidly Growing Medicare Advantage Market," Feb. 27, 2018: https://www.navigant.com/insights/healthcare/2018/medicare-advantage-star-ratings-analysis

"We wanted to emphasize outcomes and value, rather than volume. We knew we needed IT that connected across all of our provider sites, was actionable, and didn't require a steep learning curve."

ANWAR KAZI
CEO,
Premier Management Company

Premier set out to build the solution through **Premier Patient Healthcare** (PPHC), a physician-led MSSP ACO now composed of more than 500 PCPs caring for 45,000 beneficiaries across North Texas and Oklahoma.

"Our goal was to create enhanced workflows for PCPs that integrate seamlessly with their electronic health records (EHRs), and give them access to the right information when they need it — at the point of care."

SOHAIL MOHAMMAD
Chief Information Officer,
Premier Management Company

In 2017, PPHC launched Wiseman 360°, a real-time, predictive performance-monitoring solution that empowers physicians to coordinate preventive services, care, and intervention for patients who need it most. The EHR and payer-agnostic technology combines post-adjudicated claims, clinical, and other data sources to fuel the ACO's quality and efficiency enhancements. This includes:

- Enabling management oversight with performance dashboards that show monthly progress toward shared savings at the ACO, practice, and provider levels.
- Prioritizing actionable opportunities so it only displays those that are most salient to providers, such as:
  - Patients requiring an annual wellness visit or having an opportunity to be assigned.
  - Patients at risk of being de-assigned to the provider.
  - Patients with the most opportunity for clinical and/or savings opportunities.
  - Actions care managers would like providers to take, and vice versa.
- Creating enhanced workflow for primary care physicians that works seamlessly with their EHRs and gives them access to the right information when they need it at the point of care, including:
  - Closure of gaps in care and HCC coding.
  - Hospitalization alerts.
  - Specialist referral initiation and tracking.
  - Secure messaging (care manager, referral manager, patient).

The technology has helped PPHC become one of the top MSSP ACOs, earning shared savings in all three years of operation for a total of $51 million. This includes $26 million in 2016, ranked among the top 5% of all MSSP ACOs. Premier has observed that its top 20% adopters of the Wiseman 360° technology have generated two to three times the amount of shared savings as the remaining 80% of its physician participants.

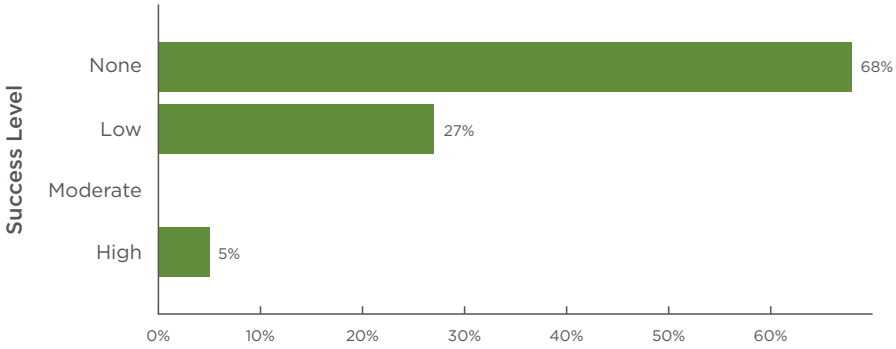
IV. Focus Care Coordination on Patient Populations Driving Negative Margins

Another use — and higher purpose — for existing value-based infrastructures is to improve outcomes for Medicaid and uninsured patients, populations for which providers are already at risk due to negative margins from low unit reimbursements and where community need is the greatest.

Few CI Summit attendees felt their organizations have been successful in managing total cost of care for Medicaid and uninsured patients (Figure 2), but there are exceptions.

Figure 2: Managing Medicaid, Uninsured Patient Costs

To what extent has your organization successfully focused on and managed total cost of care for Medicaid, uninsured, or other at-risk populations?



Cheryl Lulias, president and executive director of the **Medical Home Network (MHN)** and CEO of MHN's ACO, and Anthony Perry, MD, vice president of ambulatory transformation at **Rush University Medical Center** and MHN ACO board of managers chair, discussed how their organizations have helped hospitals across Chicago improve the health of more than 180,000 safety-net patients through reductions in emergency department use and patient length of stay.

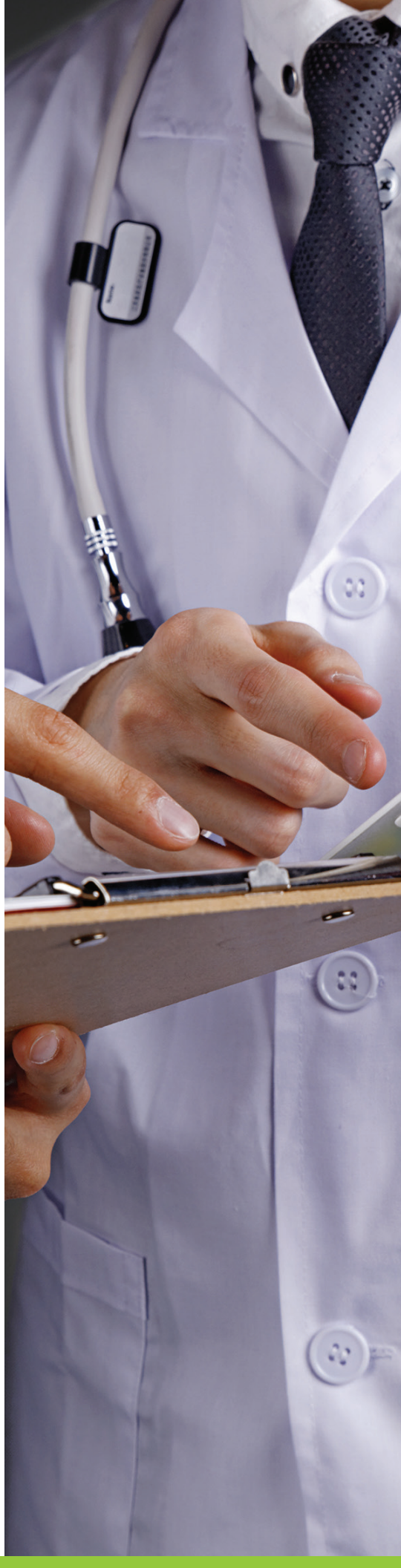
A regional catalyst for collaboration, MHN virtually integrates more than 28 academic medical centers and community hospitals with more than 300 PCPs through patient-centered care and real-time data sharing. The first Medicaid ACO in Illinois, the **MHN ACO** is owned and governed by leaders from nine federally qualified health centers and three health systems.

"Our unifying goal is to reduce healthcare disparities in Chicago. We're doing so by strengthening relationships between patients and their primary care providers by driving change at the point of care."

CHERYL LULIAS
Medical Home Network

An integral aspect of MHN's approach is fully integrating care managers and coordinators into physician practice clinical care teams. These care navigators provide coordination and management for patients' care, to include:

- Facilitating transitions of care as both a hospital partner and medical home.
- Supporting care management for complex patients across the ACO.



- Enabling care transitions for patients discharged to and from skilled nursing, long-term acute care, and rehab facilities.

"Our care navigators act as both hospital partners and medical homes, and they're vital to facilitating care transitions. They also come from the communities they're serving, which helps to overcome barriers to providing the required resources."

ANTHONY PERRY, MD
Rush University Medical Center

Technology plays a pivotal role in MHN's approach. The MHNConnect™ virtual portal connects hospitals, PCPs, and medical homes, helping them address whole-person care needs by accessing and structuring disparate data, assessing longitudinal patient records, and measuring outcomes. MHNConnect also features real-time alerts in context of claims and care management data to let providers know when a patient is back in the hospital, as well as provide information on the patient's health issues and conditions, medications taken, and previous admissions.

The model has helped MHN ACO members reduce readmissions by 35% and emergency room visits by 12.9%, and save more than $30 million over two years.

Figure 3: Driving Effective Care Management and Improving Health Outcomes — Medical Home Network

- ☑ Innovative **patient-centered, team-based** model of care
- ☑ **Identifying risk** through addressable medical, social, and behavioral barriers to compliance
- ☑ **Virtual connectivity** across provider settings
- ☑ Robust **care management and patient engagement platform** with integrated analytics to optimize interventions
- ☑ **Value-based** financing and shared incentives

V. Reduce Total Cost of Care in Targeted Areas

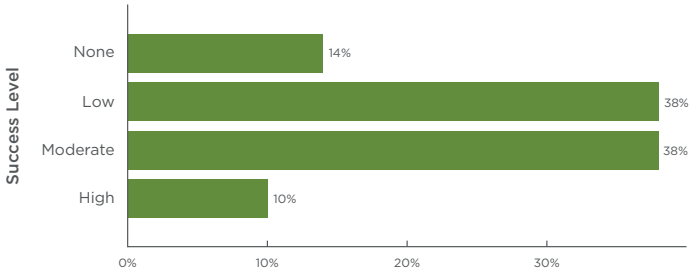
Though providers should not deconstruct their business models while still being paid on an FFS basis, it is possible to reduce total cost of care to: 1) deliver on community missions, 2) ward off competitive threats, 3) capture benefit from value-based contracts, and 4) create a mutually beneficial relationship with payers.

Focusing efforts on such areas as pharmacy care is essential to clinical and financial outcomes. The impact of medication nonadherence on providers and patients in the United States has reached epidemic proportions. Experts suggest[4] 20% to 30% of medication prescriptions are never filled, with about 50% of chronic disease medications not taken as prescribed. This lack of adherence leads to nearly 125,000 deaths, 10% of hospitalizations, and between $100 billion and $289 billion in added costs a year, studies show.[5]

Progress is being made, with approximately half of CI Summit attendees believing their organizations have successfully reduced pharmacy total cost of care (Figure 4).

Figure 4: Managing Pharmacy Care Costs

To what extent has your organization successfully focused on and reduced Pharmacy total cost of care?



Through a combination of research, strategic thinking, and early adoption of national best practices, **Summit Health Management** (SHM) has developed a highly effective model that can be scaled and customized for other independent groups looking to adapt to the changing healthcare landscape. Founded in 2014, SHM was developed by multispecialty group physicians who wanted to share their best practices transitioning to value-based care.

A key aspect of SHM's model is driving meaningful collaboration between physicians and clinical pharmacists by integrating pharmacists into primary care, according to SHM Chief of Population Health Jamie Reedy, MD, MPH.

4. NACDS, "The Cost of Medication Non-Adherence," Apr 20, 2017: https://www.nacds.org/news/the-cost-of-medication-non-adherence/
5. Annals of Internal Medicine, "Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States," Dec. 12, 2012: http://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states

"As medication usage rises, so does the opportunity for medication errors, such as incorrect dosages, drug interactions, and serious side effects. Clinical pharmacists are uniquely skilled at identifying and correcting such medication issues."

JAMIE REEDY, MD
Summit Heath Management

Through SHM's program, pharmacists work alongside PCPs, care management, and social workers to improve medication adherence, increase generic drug use, and reduce use of high-risk drugs through medication reconciliation and patient education. Pharmacists perform comprehensive medication management consultations with patients, both via in-office visits and by phone, and have the authority to make clinical decisions based on reports from EHR systems. The model also places pharmacists in offices where physicians are struggling with certain conditions, such as hypertension.

Among the results: an 84% reduction in high-risk medication use among the elderly, and diabetes, statin, and ACE-inhibitor medication adherence, well above top-tier performance among MA patients.

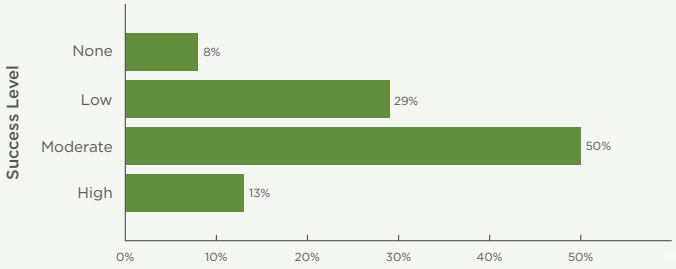
Finally, SHM implemented a strict vendor relationship policy, requiring all pharmaceutical reps to be vetted by the pharmacy services department. A list of approved reps is posted on the organization's intranet for clinical staff to view. The program also prohibits pharma company-provided lunches and use of reps for medication education, which is now conducted by pharmacists to ensure unbiased academic detailing. Moreover, SHM's sample medication policy restricts contents to evidence-based, cost-effective, and single-sourced products.

PROVIDER, PATIENT BENEFIT OF ANNUAL WELLNESS VISITS

Added as an Affordable Care Act benefit free of charge to Medicare patients, annual wellness visits (AWVs) have been associated with such benefits as stronger patient-physician relationships, promoting team-based care, and increased provider revenue potential.

Figure 5: Annual Wellness Visit Rates

To what extent has your organization successfully focused on and improved your Annual Wellness Visit completion rate?



When Bon Secours Health System's Good Help ACO initiated its AWV campaign in 2013, just 11% of Medicare patients were receiving AWVs. The ACO initiated an intensive, multifaceted strategy with a goal of significantly increasing AWV rates, according to former Good Help CEO Ken Petronis.

A major provider education campaign was launched, touting the cost and quality benefits of AWVs for Medicare patients. Within the health system, the ACO:

- Used a Lean Six Sigma approach to improve the process flow for an AWV, leveraging their EHR to streamline the process.
- Heavily utilized physician extenders and nurses.
- Developed a standard, systemwide AWV scheduling process.

While Good Help initially faced some resistance from physicians, the campaign was a major success. By 2017, AWVs were conducted among 65% of Medicare primary care patients across six Bon Secours markets, amounting to 60,000 additional annual visits and $9 million in additional incremental annual revenue.

navigant.com

About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage, and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the firm primarily serves clients in the healthcare, energy, and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

healthcare@navigant.com
linkedin.com/company/navigant-healthcare
twitter.com/naviganthealth