NAVIGANT

On Healthcare

HEALTHCARE

DEVELOPING A SUCCESSFUL MEDICARE ROADMAP

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Dennis Butts: We have Blake Allison, who is the chief executive officer of Southeastern Health Partners, which is a joint venture between AnMed Health, Bon Secours St. Francis and Spartanburg Regional Healthcare System.

We notice that the Medicare population is aging—aging rapidly. We know that each day thousands of people across the country become Medicare-eligible and the ability to kind of cross-subsidize the Medicare book of business with a commercial rate is becoming more and more difficult as a greater percentage of the population are reaching 65 and above.

That's becoming even more challenging as providers that we think about risk-shifting from payers to providers to be accountable, not only for the health outcomes, but to deliver improved health outcomes at a lower cost point. CMS is doubling down on the movement towards risk assumption by providers.

The length of time that we can stay in upside-only savings arrangements are decreasing pretty rapidly from the six-year maximum that we had with the traditional MSSP program, which has now been reduced to one to three-and-a-half years in a pathway program that has just been released.

As we at Navigant work across the country, some providers, dependent upon what market you're in, know that your market may not necessarily be progressing towards risk as quickly as other parts of the country. And some are saying that they just are going to double down on fee-for-service and ride that train until they are forced to move into value.

As we look at the escalating cost structures of healthcare systems, more and more patients moving from commercial to Medicare, margin compression and revenue degradation is a serious concern for healthcare providers.

We at Navigant just published a paper on the viability of rural health systems and systems are becoming that much more challenged to think about the sustainability of their future considering the compression of the margins that are happening across the country.

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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.

As we think about increasing populations of Medicare age, increased pressure to move towards risk, increasing financial pressures due to fee-for-service rates that aren't sustainable, organizations must think kind of holistically on what is our sustainable path moving forward.

Figuring out that sustainable path becomes challenging with the alphabet soup of different ways that we can participate in CMS programs from BCPI Advanced next-gen ACO. Do we do next-gen ACO or do we stay traditional MSSP? Should we be fee-for-service, or should we go down the Medicare Advantage path?

With the escalation towards Pathways and some of the corrections to the program, doesn't it make sense to jump from MSSP directly into Pathways, regardless of the timeline for risk assumption? So, that's a lot of the questions and dialogue that's happening across the country.

What we're going to do now is pass it over to Blake, again from Southeastern Health Partners, who will begin to share some of their stories, their pathway toward risk assumption through Medicare and other programs, so that we can understand more from a provider perspective what are some of the challenges, but probably more importantly for you as an audience, what are some of the solutions.

So, Blake, I'll pass it over to you to hear more about your organization.

Blake Allison: We are a joint-venture company that is three partners across the Upstate of South Carolina. So, if you know the state of South Carolina, the I-85 corridor cuts across the upper part of the state and we have three health systems that sort of stake areas along that map. It's AnMed Health, which is south and west part of the upstate and close to the Georgia border, Bon Secours St. Francis, which anchors the middle part in Greenville and Greenville county, and Spartanburg Regional Healthcare System, which is to the north and east and takes us up to the North Carolina border. The three systems came together, each own the company, a third-a third-a third, and put the company together for the purpose of doing value-based care.

The first contract was MSSP. We put those systems together, we came to attribute the lives about 58,000 members, which represents about half a billion dollars of spend that we've been managing for the last couple of years.

We have also recently launched into a UHC agreement on the commercial side. We're discussing Medicare Advantage with them, but wanted to get the commercial going and have approximately 18,000 lives sitting in that contract.

As we sit here today, our contracts are all upside-only. That said, we certainly are looking for and have the ability to look for the right opportunities for risk, both in the commercial on a limited basis, and certainly in the Medicare space. We feel that our size and some of our scale allows us to position ourselves for risk a little bit better.

Today, where we sit with Medicare and, as I mentioned, MSSP, we only do the MSSP. We do not get involved with the bundles at this point or other value-based programs. Some of the local systems do that directly, but we are not doing that out of SCHP. But we are looking at a number of Medicare Advantage plans for 2019 and beyond. I'll talk a little more about that as we get into some of the Medicare Advantage specifics.

Moving forward to a little more detail on the Medicare shared savings program… As I mentioned, we're a track one. One of the items that was very interesting for us, when we came together, we felt that we were a high-efficient beneficent provider. When we got together, looked at our benchmark, we had a historical benchmark that was very low, in the low 8000s on a per-beneficiary per-year basis, so that certainly created a challenge for us to generate savings. The good news is, in 2017, we actually did generate some savings against our updated benchmark, but we did not overcome our rate, so we got to give free money back to the government.

That's something that is certainly weighing heavily on our Medicare strategy going forward, as we feel like we've done some things to impact performance and yet not positioned the right program to realize those savings.

Just as a side note, one of the things that SCHP does, in addition to the contracts and the contract negotiation, we, through the home of the analytics shops, collect all of the claims data for our United Health population as well as MSSP and we utilize the Milliman Medical Insights tool to help us with our claims-based analytics.

Some of the things I wanted to talk through as we go deeper into this discussion with some of the lessons we've learned—you could probably fill a whole hour on just lessons learned. One of the things, I mentioned the Milliman tool, that really took us some time is how to optimize analytics and where would we spend the most of our time using a tool that would help deliver the insights we need. We had a couple different tools that we'd put into place that caused some confusion and lost some time, frankly, in trying to standardize our analytics approach. So, that was something that we corrected going forward and we sort of live in the world of always trying to be focused on, if anything else were to come up from a tool perspective, does it add to, enhance, or cause confusion to the tools we already have today.

We usually have a lot of different partners and vendors that want to talk to us about analytics and how to do better insights.

We struggled, I think, initially, to figure out our funding model for both the company as well as how we deploy our resources. MSSP, in all its glory, certainly has a challenge with how to put together the resources you need to go be successful in the program. We've moved through that a little bit, but don't believe we did as good a job up front talking through what are the real needs of both Southeastern Health Partners as well as the local systems and how do we fund those over time.

I think the other thing that, had we probably known a little bit more now, I think we would have evaluated different programs with a low benchmark. As I mentioned, we've sort of fallen into that nice category of saving money for the federal government and not getting any part of that. Hindsight's always 20-20, but looking at other programs had we been able to set some structure on how we wanted to save and how much risk we might have been willing to take on, there could have been a year or two of actual savings and payment to SCHP.

I think if you're a low benchmark, and you may already be looking at it, it certainly is impacting the way we view risk going forward and the way we view the program.

Speaking of the program, just to give a little bit about what we're doing. It's going to be no different, I'm sure, than all of you all, but because of this low benchmark, we really want to look at each of the programs. The easy answer might be to jump to the basic and just do the initial program, do B and then right into C and sort of stay there for a while, but because of this issue of giving back money, if you will, or how we perceive it, we're going to be pretty thoughtful on how we approach the breadth of the program and how can we set that up. Our board's going to be very involved in that. Our board is predominantly physicians, so this is always an interesting dialogue to have with them as they look to how they can achieve more margin, more performance in the program.

We have to wrestle with downside risk repayment. We'll talk about that again as we get through, but obviously it's very easy to be partners when you're upside only. It becomes much more challenging from a partnership perspective when you start to deal with downside. Then, obviously how do we continue to infuse performance.

Jumping ahead to the strategy and portfolio, that kind of level sets on the Medicare Shared Savings Program, but going to where we think we're going to go forward. I mentioned a lot about the Medicare fee-for-service and how we're going to approach that, but really, let's talk about Medicare Advantage, because of the fact that we know what we have in Medicare fee-for-service, we started to see a lot of increase in Medicare Advantage. The state of South Carolina had traditionally been behind on penetration. The upstate of South Carolina was in the low 30s, but it's already moved up into the 35 percent, or so, range of MA penetration, so it is here to stay. The interesting, you mentioned on the slides previously from Navigant, one of the constant conversations we hear from our systems is about the yield even now in Medicare Advantage. Even if they're able to negotiate a premium on their fee schedule, they are struggling with different aspects of utilization management and utilization review that they believe is causing

fee-for-service issues and is causing the yield of those payer relationships to be less than optimal. That has led us two directions. One, a question of whether we do MA at all, but number two, how do we then get them into the right programs, because the fee-for-service underpinning is no longer viable.

That's really what is leading us through SCHP to get heavier into MA plans. We're evaluating the traditional MA relationships. We have contemplated GlidePath to risk over time, as long as there's the appropriate structure that allows us, we feel like, to maximize some of those opportunities we have.

Really what we also wanted to do was—I mentioned earlier we don't have a formal provider sponsor plan—none of our three systems have a health plan, but we wanted to create a scenario where we were closer to a specific MA plan that we could feel as if it was provider-sponsored and begin to really drive transformation. We have opened up a discussion, actually have a discussion with one of the new insurances in the market, one of the new MA plans. We're putting together a high-performing network HMO product with a new MA provider. We're going to launch that. That really is going to help us, we believe, A, drive some transformation, but B, also create a little bit of disruption and allow us to have a provider-sponsored feel, without having to underwrite the risk fully. That's a new development for us from the middle. That implementation's going to be a big part of our strategic plan for 2021 and beyond.

The last thing we spent a lot of time on is how do we handle the portfolios. The system's going out and signed up with everybody on the MA side and that's fine, but when we think about value-based care and maximizing the programs we've really started to talk through, we've got to have a portfolio approach here. We've going to have MSSP, so how many value-based programs, and then I think eventually how many underlying fee-for-service agreements do we have and how do we grow the plans we want to grow to have the right structure in place that gives us the benefit of our performance of our network, also gives the plan the opportunity to grow and not have small buckets of lives across multiple fronts. We have set in ours that we'd like to have no more than three in our portfolio on the value-based side for Medicare Advantage. One of those is absolutely going to be what we call this provider-sponsored.

That took a little bit of us to walk through, because that's not exactly how the systems think. If somebody has lives, you want to go get a contract with them to get access to those lives, but we're taking that different approach. We actually want good, solid plans.

Dennis: Thank you so much for that, Blake. Maybe one last question. What is just one key lesson learned that you would maybe encourage the audience to consider as they go down this path?

Blake: We have to realize that the medical staff structure we've had traditionally does not work in value-based care. The physicians that have typically had the airtime are not, most likely, the ones that are going to be the leaders going forward. So, how you find, elevate and empower the physician leadership to engage in this is going to be mission critical. This has got to happen with engaged, activated and empowered physician leaders.

Announcer: That concludes today's episode. Be sure to check in with us for future installments on the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.