Louisiana Health Care Commission
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Volume to Value

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Universal Belief

The current cost of acute, post-acute, outpatient, and ambulatory healthcare is not sustainable for patients, employers and payers. Healthcare value is being questioned by all.

*Providers must compete on their ability to deliver predictable, high quality care at predictable costs and with a better patient experience.*
Population Health Future State

Insurers

Providers/Physicians

Institution

Ambulatory

Home

Population

Shared Risk
Managing risks for the health of a population
Clinical Integration is a Defined Program by the FTC to Allow Joint Contracting Without Financial Risk

The Building Blocks of Clinical Integration

- Enhanced Accountability
- Quality Data Aggregation and Reporting
- Performance Measurement and Incentives
- Evidence-Based Best Practice Utilization
- Legal Entity and Governance Structure

Clinical Integration is “an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”

-Federal Trade Commission (FTC) Definition
Clinical Integration - Foundation for Risk Capabilities

Network Development
- Stakeholder Engagement
- Value Proposition
- Participation Criteria
- Physician Leadership
- Incentive Design

Organizational Structure & Planning
- Payor Contracting Strategy
- Physician Governance
- Committees and Decision-Making
- Financial Structure
- Organizational Incentive Alignment

IT Infrastructure and Capability
- EMR and EHR
- Clinical and Financial
- Patient Engagement Tools
- Integration with Existing Systems

Analytics
- Clinical Metrics and Results
- Cost Analytics
- Standard vs. Ad-hoc Reporting
- Risk Identification
- Regulatory vs. Operational

Cross-continuum Coordination
- Strong Primary Care
- Communication
- Referral Management
- Population-Based Programs
- Shift to Ambulatory Management
- Transitions of Care

Collaboration Platform
- Common Protocols
- Physician-Guided Quality Best Practice Dissemination
- Clinical Metric Selection
- Peer Review; Transparency
- Build Network Culture
Increasing risk allows clinical/financial benefits

- Fee For Service
- P4P
- Clinical Integration
- Population Health Management
- Bundled Payments
- Shared Risk
- Full Risk
- Health Plan

Clinical and Economic Opportunity
What is the currency of value based contracts?

Attributed lives are the currency for value based contracts. Primary care providers, not specialists, determine attributed lives.

Primary care defined by payers: Peds, Family Medicine, Internal Medicine, Med/Peds
Value based Contracting Steps - Financial

1. Clinically Integrated Network (CIN) determines which Primary Care Providers will participate in contract
2. Payer applies *attributeion methodology* to define CIN population under contract
3. Actuaries project total costs for medical care and Rx and assign benchmarks for each
4. CIN negotiates shared savings/shared loss tiers based on degree below or above cost targets
# Success In CMS Risk Contracts Is Driven By 5 Value Levers

## Value Levers

<table>
<thead>
<tr>
<th>Risk Adjustment</th>
<th>Increase benchmark by up to 3% by accurately capturing patient acuity through ICD10 coding</th>
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<tbody>
<tr>
<td>Quality</td>
<td>Achieve 30 Centers for Medicare &amp; Medicaid Services (CMS) established quality metric thresholds to improve benchmark by up to 1%</td>
</tr>
<tr>
<td>Clinical Programs</td>
<td>Drive medical savings through clinical interventions to drive down total medical expense – <em>Transitions, Complex Care, and Advanced Illness Programs</em></td>
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<tr>
<td>Network</td>
<td>Align process and strategic goals across the network by bringing together primary care and specialties, and leverage provider networks to achieve savings – <em>Pharmacy, Post-acute</em></td>
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<tr>
<td>Technology</td>
<td>Technology solutions that aggregate data and identify impactable opportunities, drive engagement and management of high risk populations, and support robust tracking and measuring of performance</td>
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Who We Are

Health Leaders Network (HLN) is a physician-led organization of providers, committed to advancing the Triple AIM of improving population health outcomes, improving patient experience and controlling costs. HLN is governed in such a way to drive continuous improvement.

Vision

Health Leaders Network’s vision is to be the regional leader in population health by partnering to provide a continuum of care focused on quality, efficiency and value.
PARTICIPATING PROVIDERS

- Total: 1105
  - Employed: 436
  - Independent: 321
  - AHP: 348

- Adult Primary Care: 131
- Pediatrics: 72
- Specialists: 554

COVERED LIVES

- Total: 119,273
- Commercial: 80,551
- Next Gen: ~22,000
- MA: 14,294

CONTRACT PIPELINE and CURRENT CONTRACTS

- Negotiating: 0
- Finalizing: 1
- Signed: 6

Blue Cross/Blue Shield
- Covered Lives: 50,571
- Providers: FMOLHS only
- Contract Type: Shared Savings/Risk

FMOLHS Health Plan
- Covered Lives: 16,477
- Providers: HLN
- Contract Type: Shared Savings

Humana MA
- Covered Lives: 14,294
- Providers: FMOLHS only
- Contract Type: Shared Savings/Risk

United ACO
- Covered Lives: 13,503
- Providers: HLN
- Contract Type: Shared Savings

Next Generation ACO
- Covered Lives: ~22,000
- Providers: FMOLHS/BRC
- Contract Type: Full Risk

Updated: January 2018

03/23/18

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Health Leaders Network Clinical Results

• Wellness and Prevention Adult
  • Pneumococcal vaccine 77%
  • Depression screening increased to 72%
  • Statins for CV Disease 77%

• Pediatrics care
  • Combo 7 immunization rate 80-84%
  • Well child visits ages 3-7 increased to 71%

• Hypertension (38,000 patients) – 76% with BP at target
Health Leaders Network Cost Reduction

**BCBS total cost of care**
- 2016 $12M saved caring for 32,000 lives
- 2017 $30M saved caring for 43,000 lives
Questions