HBCH CONFERENCE 2021

Navigating to Value

LINKING PRICE TO QUALITY & OUTCOMES

In Person December 8, 2021

HBCH Conference 2021
Rice University, BRC

December 8, 2021

7:00 am – 5:00 pm CDT

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LINKING PRICE TO QUALITY & OUTCOMES
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HBCH ORGANIZATION MEMBERS

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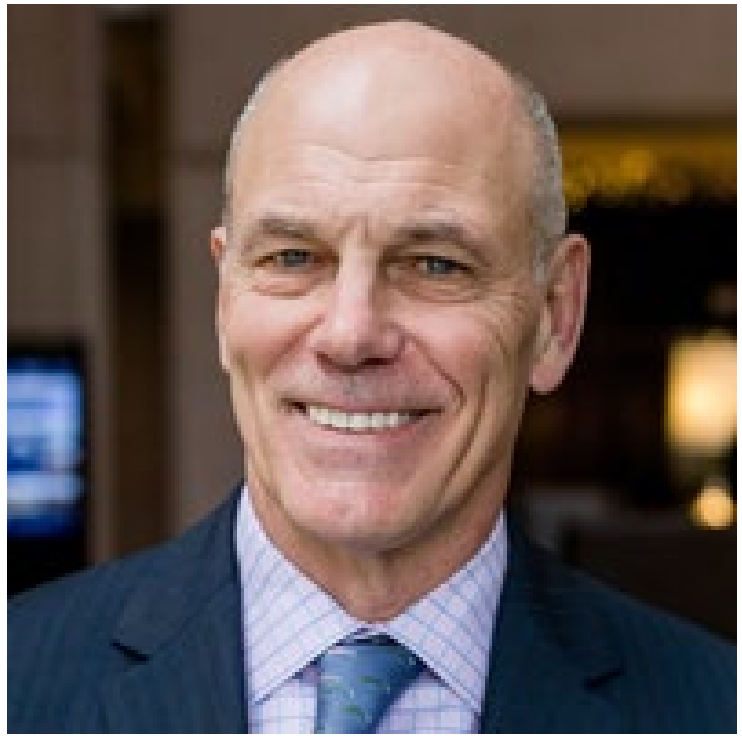
Introduction



Chris Skisak
Executive Director,
Houston Business
Coalition on Health

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HBCH Team

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Post Reception – Hilton Plaza Medical Center, 5 pm - 6 pm, 9th Floor Rooftop Bar

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HOTELS & RESORTS

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Survey Completion

Complete the emailed Conference Survey and submit to HBCH on or before Tuesday, Dec. 14, and be included in a drawing to win one of three $100 gift cards.

Mobile App

Paul Keckley

This week, more than 800 will assemble in San Diego for America's Physician Group's (APG) 2021 Annual Conference. The group's 335 member organizations seek to replace "the antiquated, dysfunctional fee-for-service reimbursement system with a clinically integrated, value-based healthcare system where physician groups are accountable for the coordination, cost, and quality of patient care."

The reality is that healthcare system is change resistant: it has rewarded its investors, suppliers, distributors, hospitals and physicians reasonably well for decades while managing the public's expectations. But at an unsustainable cost that's well documented but not easily solved.

The value agenda is key to the system's future.

Collective & Collaborative

HBCH NORTHSTAR

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Keynote Speaker

Elizabeth Mitchell

President & CEO, PBGH

Purchaser Business
Group on Health

December 8, 2021

Navigating to Value

What can we do?

Elizabeth Mitchell

President and CEO

Purchaser Business Group on Health

About PBGH

Purchaser Business Group on Health

- 40 members
- Private employers & public agencies
- $100B spend
- 15 Million Americans

Advancing Quality

Driving Affordability

Fostering Health Equity

EXPERTISE APPLIED ACROSS ALL STRATEGIES:

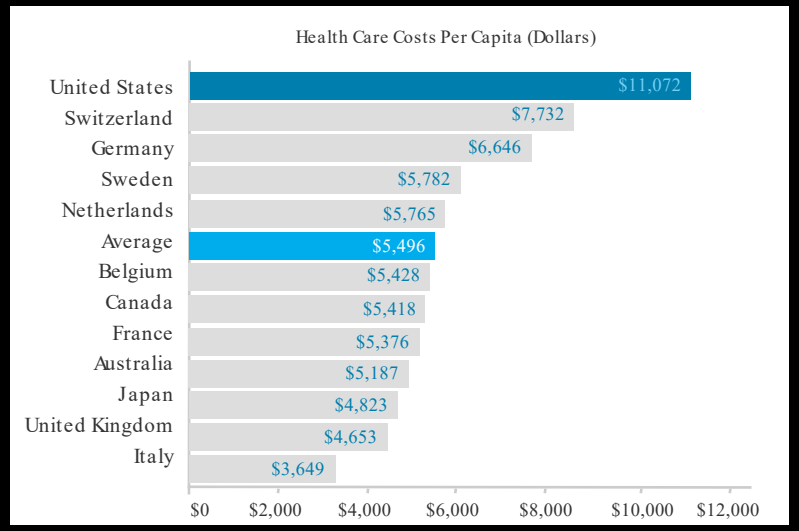
Measuring What Matters | Policy and Advocacy | Payment Reform | Care Redesign | Health Equity

Agents for Change – PBGH Members (partial list)

Health Care Costs and Their Impact on the U.S. Economy

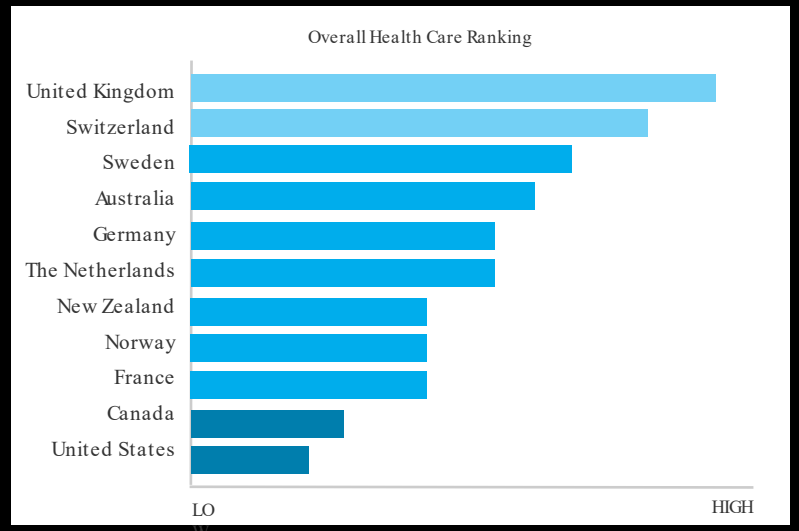
Rising health costs are not buying quality care. The problem is accelerating.

U.S. health care spending is almost **TWICE** the average of other wealthy countries



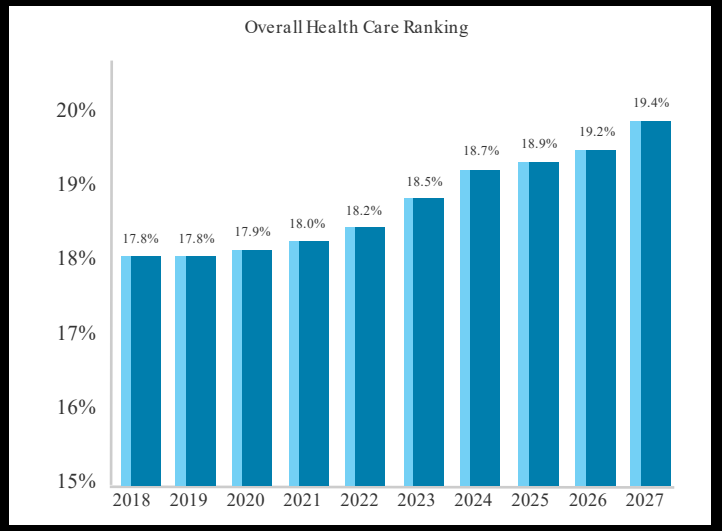
Organisation for Economic Co-operation and Development, OECD Health Statistics 2020, July 2020. pgpf.org ©2020 Peter G. Peterson Foundation.

U.S. health care quality ranks **LAST** among wealthy countries



K. Davis, K. Stremikis, D. Squires, and C. Schoen. Mirror, Mirror on the Wall: How the Performance of the U. S. Health Care System Compares Internationally, 2014 Updaye, The Commonwealth Fund, June 2014.

$1 in $5 will be spent on health care as a percentage of GDP



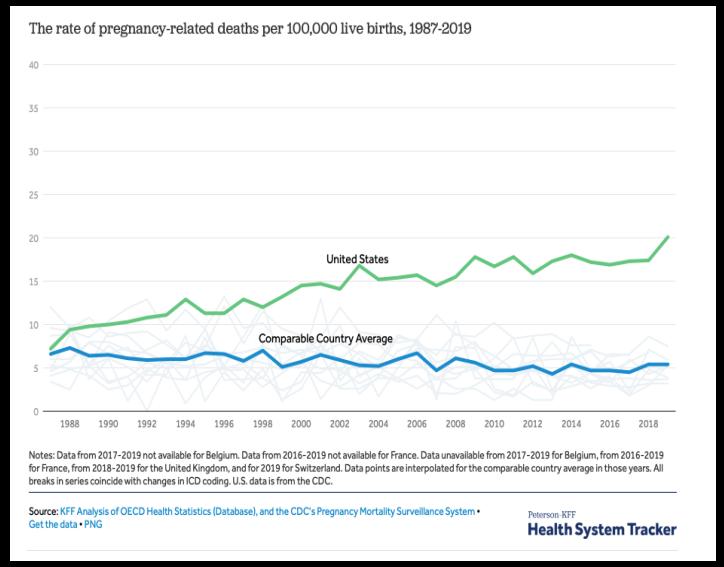
Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2018-2026. Forecast Summary and Selected Tables.

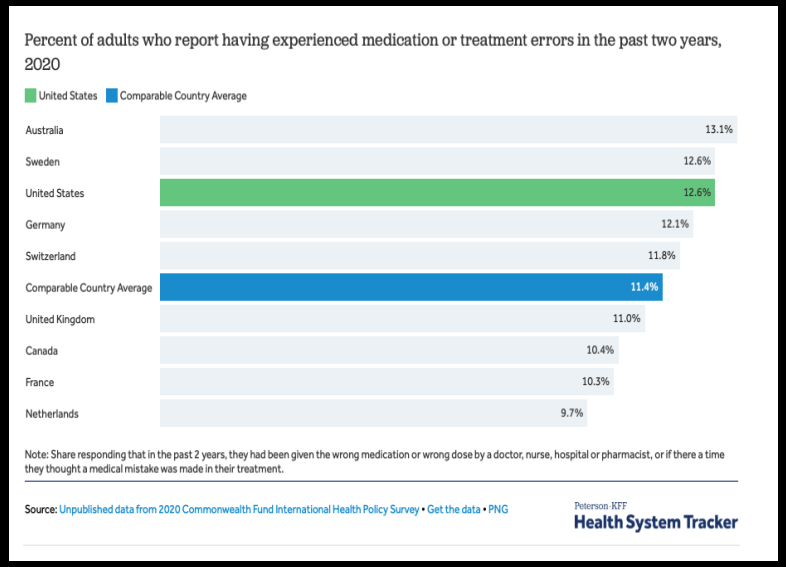
Health Care Quality in the U.S. Lags Other Nations

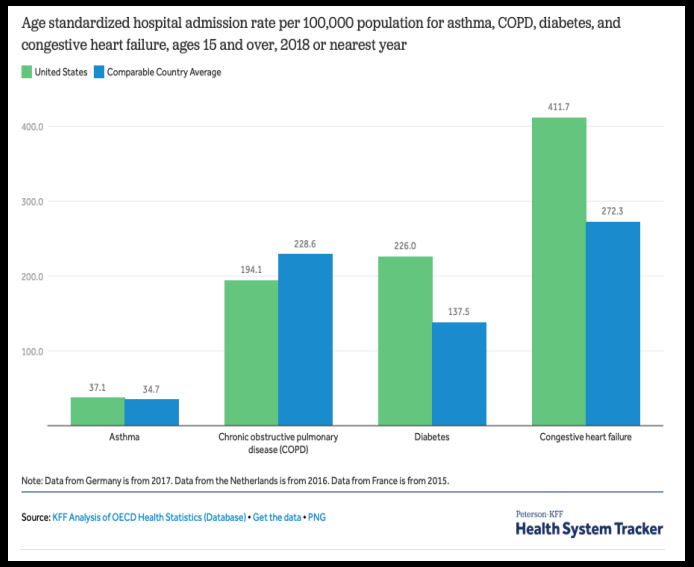
Maternal mortality rates in the U.S. **have risen** over time and are much higher than in peer countries

The U.S. has **higher rates of** reported medication and treatment **errors** than most comparable countries

Hospital admissions for diabetes and congestive heart failure were **more frequent** in the U.S. than in comparable countries







The Cost to Businesses and Families

Health care costs drag on both business growth and household income.

Every 10% increase
in health care costs results in about
120,800 fewer jobs and $28 billion in lost revenue.

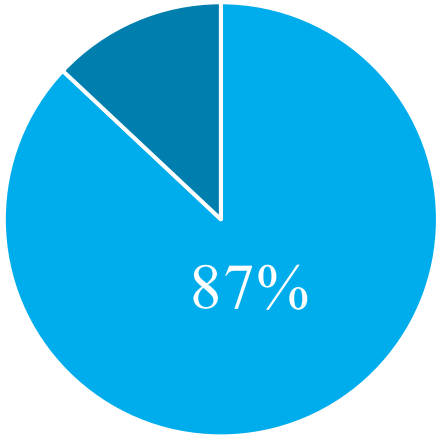
If health care costs merely tracked the rate of inflation between 1999 and 2009, instead of exceeding it, the average American family would have had an additional $450 per month to spend on other priorities.

Sood, Neeraj, Arkadipta Ghosh, and Jose J. Escarce, Health Care Cost Growth and the Economic Performance of U.S. Industries. Santa Monica, CA: RAND Corporation, 2009. https://www.rand.org/pubs/research_briefs/RB9465.html.

Auerbach, David I. and Arthur L. Kellermann, How Does Growth in Health Care Costs Affect the American Family?. Santa Monica, CA: RAND Corporation, 2011. https://www.rand.org/pubs/research_briefs/RB9605.html.

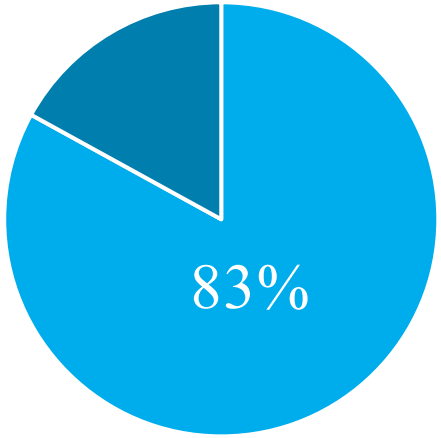
Remember. The C-Suite Wants This

The C-Suite is Taking Notice



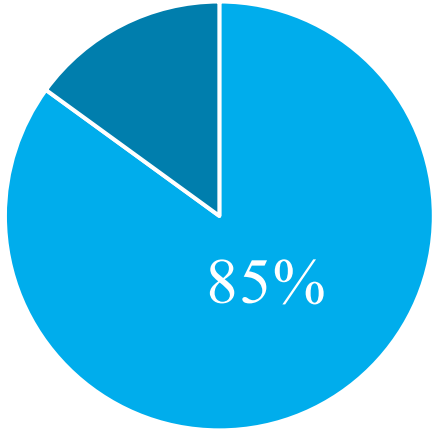
Believe that the cost of providing health benefits to employees will become unsustainable in the next five to 10 years.

They See a Failed Market



Believe a greater government role in providing coverage and containing costs would be better for their business.

They Also See Potential — But They Need Options



Agreed that employers collectively can change health care cost to a moderate or considerable extent.

Source: PBGH-KFF-West Health Survey

Relying on the Industry Hasn't Solved the Problem

Health Plans

Brokers

PBMs

Congress

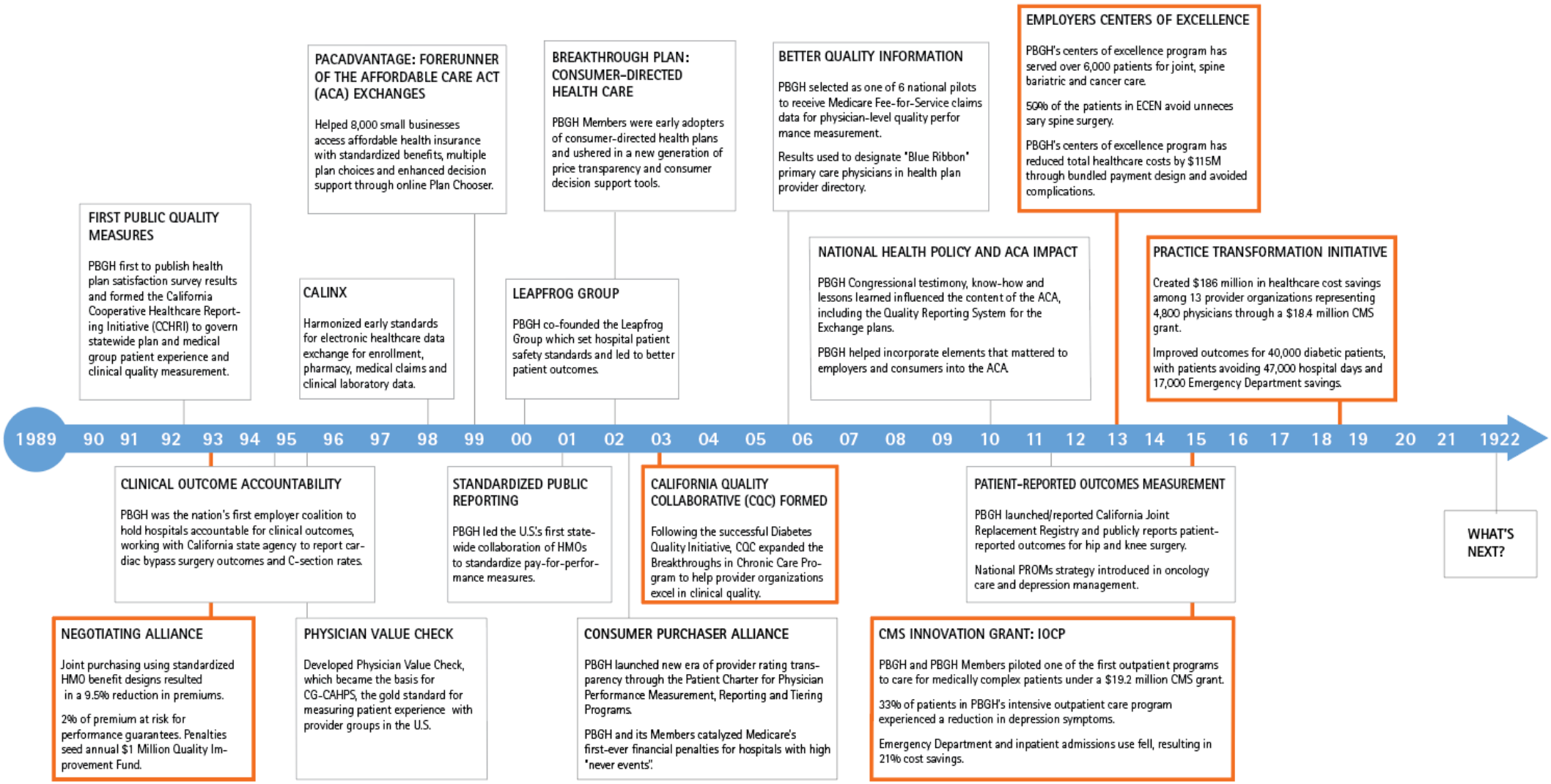
CMMI (2030)

Top Ten Health Care Trends

1. From Pandemic to Endemic?
2. Workforce: The Great Retirement, Burnout and Provider Shortages
3. Medicare and Medicaid Expansion and conversion to managed care
4. Consolidation and Market Power
5. Private Equity and Venture Capital Investment and Roll-ups
6. The Shift to the Ambulatory Environment (Home and Street as Clinical Setting)
7. Digital Health Redesign including Disruptive Competitors
8. Integrating Mental Health
9. Delivering on Health Equity
10. Employer Activation

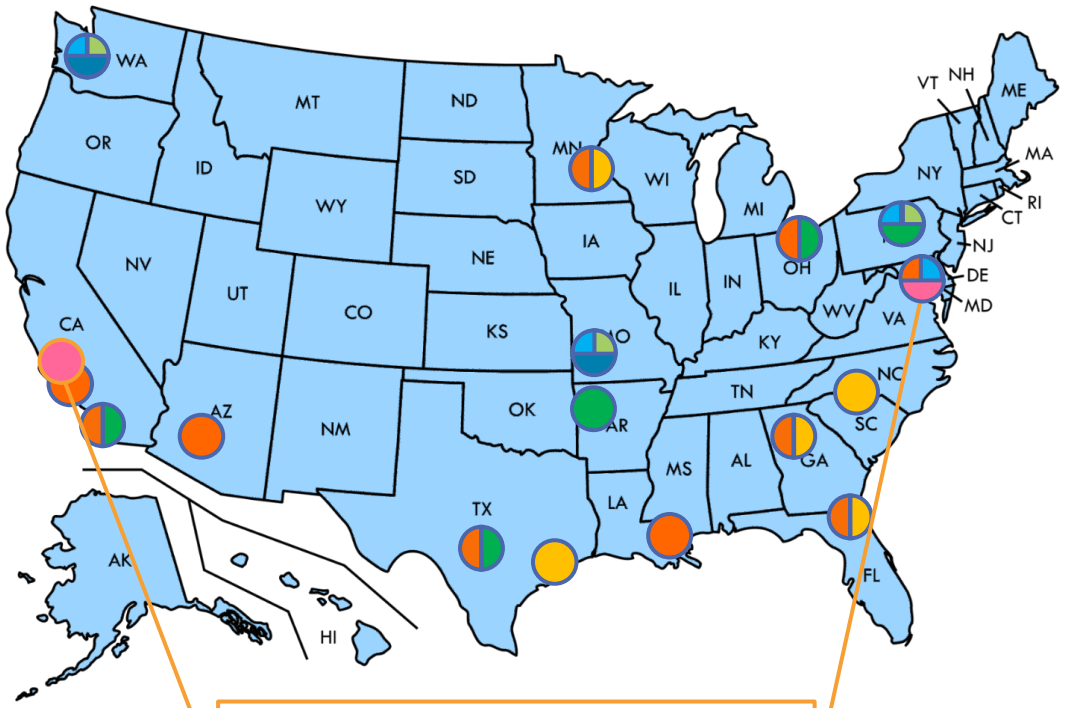
Source: Ian Morrison, Health Care Futurist

30 Years of Meeting Our Mission



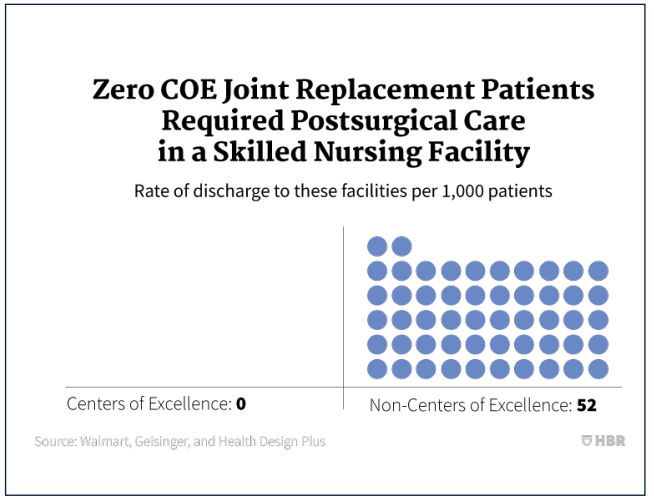
Better Care Costs Less

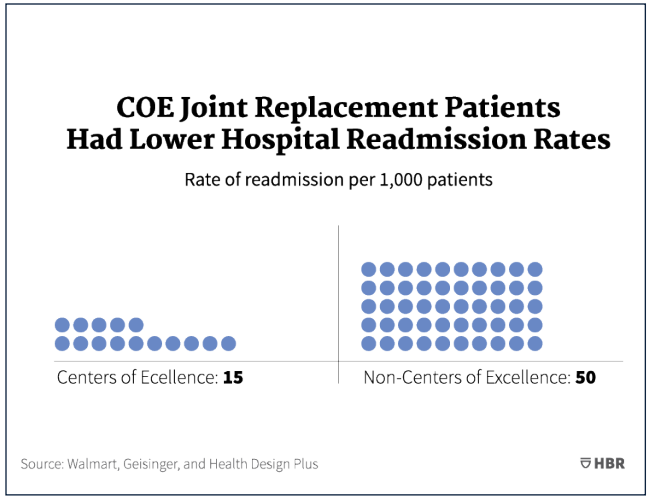
The Network

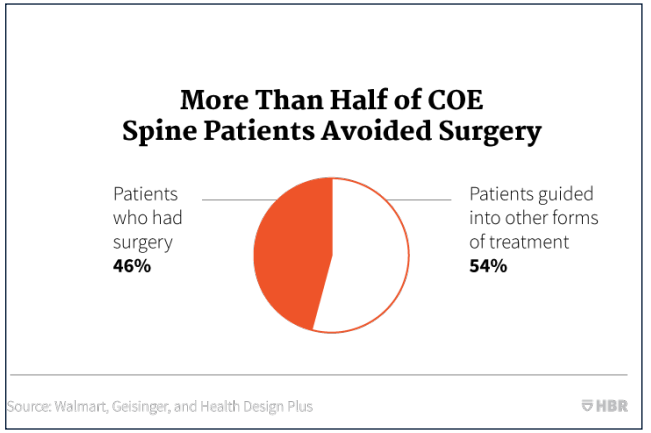


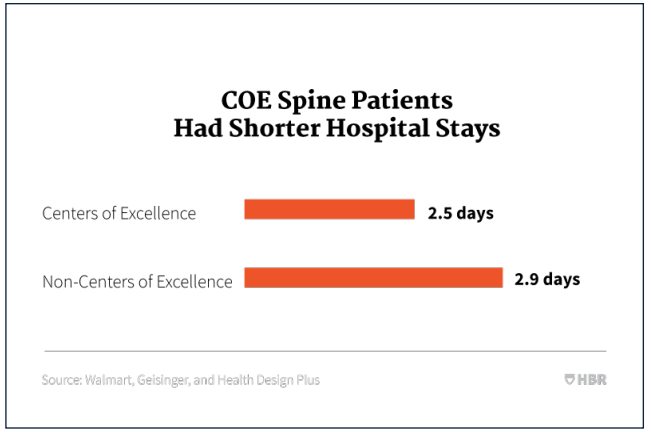
Launched Spring 2019 Oncology CoE
City of Hope, Duarte, CA, launched March 2019
East Coast CoE, launching Sept 2019

Early results for Walmart



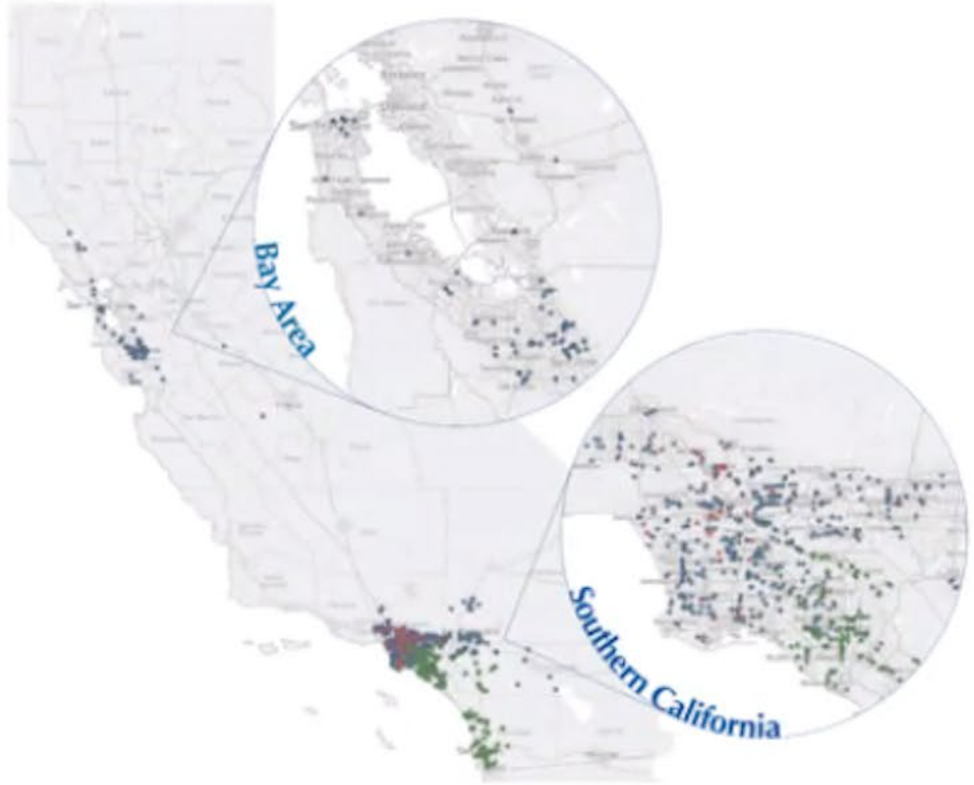






We Know It Works Because We've Done It

The Network



The Impact

$345M
COST SAVINGS

- **$6.63** SAVED PER $1 INVESTED
- **$35K** SAVED PER CLINICIAN

REDUCED UTILIZATION

- **67K** AVOIDED ED VISITS
- **59K** AVOIDED HOSPITAL ADMISSIONS

IMPROVED PATIENT OUTCOMES

- **26K** DIABETICS WITH IMPROVED HbA1c CONTROL
- **700K** PATIENTS WITH IMPROVED CARE PROCESSES

Taking on the Tough Fights – And Winning

The New York Times

Sutter Health to Pay $575 Million to Settle Antitrust Lawsuit

The deal resolves allegations of anti-competitive behavior by the large hospital system in Northern California.

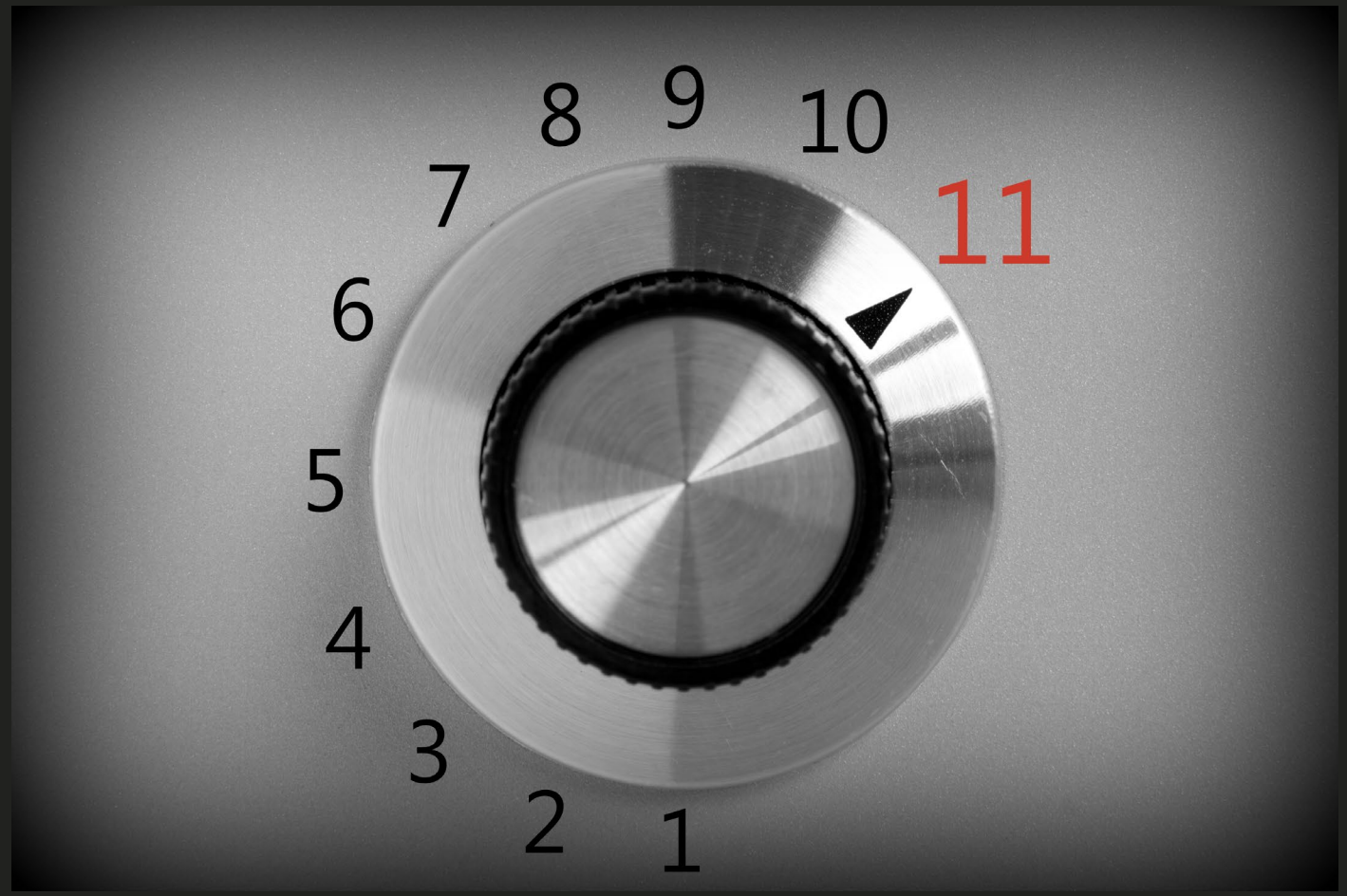
The Sutter Medical Center in Sacramento, part of the vast Sutter Health hospital system in Northern California. Rich Pedroncelli/Associated Press

By Katie Thomas

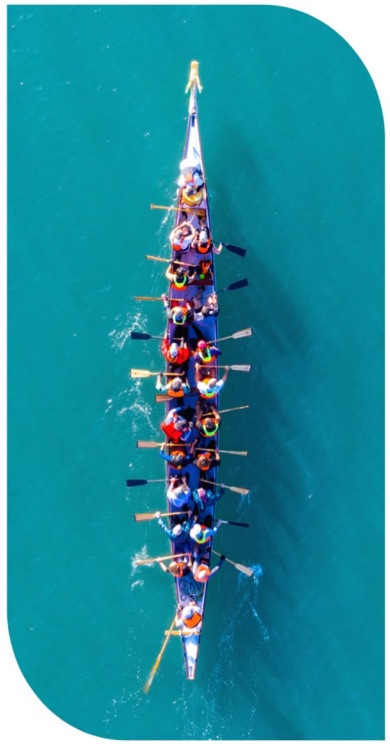
The Windfall for Employers

- $575 million settlement
- Estimated average payout for overpayment per organization: $243,000
- Potential greater dollar value to employers and purchasers – the 10-Year injunctive relief:
  - Limits chargemaster increases
  - Reduces surprise billing
  - Prevents all-or-nothing contracting practices

Scaling for National Change



A Joint Purchasing Agreement



Employer Health Plan Common Purchasing Agreement

for Advanced Primary Care

Purchaser Business Group on Health

Purchasing Advanced Primary Care

PBGH members collectively spend over $100B annually buying health care for their employees and families but too often do not achieve good clinical outcomes or experience. Members of PBGH are assuming an active leadership role in health care purchasin by clearly articulating the quality, value and experience they expect for their significant health care spend. They are setting purchasing standards on behalf of their employees and creati mechanisms for health plan accountability. The aim of these standards is to help achieve for all employees and fami

As purchasers, we will not partnerships with innovati standards and needs. We w to work on our behalf to in purchasing that reflects ou

Page 2

[Insert employer name] seeks to support a higher value health care system with a strong primary care foundation. We believe that better primary care will enable higher quality, better patient experience and outcomes and lower costs for our employees. We know the current fee for service payment system creates barriers for optimal primary care and we are seeking to drive change through the design and implementation of payment models that support advanced primary care (APC). The common purchasing agreement states the shared priorities and objectives of [Insert employer name] and the other employers who have endorsed the standards for better care at lower cost. We recognize that achieving better care at lower costs will also require accountability of the delivery system surrounding primary care.

To achieve our aims, the common purchasing agreement includes a set of clearly defined health plan requirements and accountability expectations focused on APC with a three-year implementation timeline. The requirements in this Agreement presume the need for payment changes to enable whole person and population health and are built upon a set of principles developed by employers in collaboration with the Purchaser Business Group on Health (PBGH) and rely on lessons learned from PBGH's California Quality Collaborative-led practice transformation initiative,[1] National Academy of Medicine's Implementing High-Quality Primary Care reports[2] and other national and regional primary care transformation efforts.

We recognize that these standards will require significant changes in contracting and operations. We also appreciate that there are varying degrees of readiness among providers and across markets. In light of this variation, we expect implementation sequencing of these requirements will depend on the level of market readiness. We believe these changes are necessary and overdue and look forward to working together with our partners to implement them in the near term. We also believe that working together we can drive multipayer alignment on key elements of the payment model including performance measures, attribution, data sharing (timing and formats), and benchmarking, enabling greater primary care participation through such administrative simplification.

Purchasers
- Set quality and value standards
- Select plan and provider partners
- Ensure patient/provider incentives align
- Ensure partner accountability

Health Plans
- Efficiently administer value-based payments
- Identify and transparently report on quality and value
- Enable data-sharing for care inte

Providers
- Provide high-quality effective evidence

What we want to buy	How we enable it	How we know we have it
Integrated Whole-Person Care/Population Health Management	**Payment Method**	**Accountability**
• Employee/patient engagement and activation	• Comprehensive primary care payment +	• Common performance measure set
• Integration of physical, behavioral, and social needs	• Prospective and flexible	• Clinical outcomes
• Robust access spanning after hours, weekends and including virtual care options	• Care transformation or care management fee (limited duration) plus	• Member experience of care
• Informed referrals and prescribing	• Performance incentives	• Total cost of care
• Coordinated care		• Access to care
• Risk stratification and care management		• Health equity
• Health and wellbeing promotion		
• Data and information sharing		

The PBGH Primary Care Payment Reform Workgroup has developed this Common Purchasing Agreement — guided by evidence-based reform principles — for jumbo employers and health care purchasers to clearly articulate their priorities to partners. It is intended to be used to remove barriers to better care and achieve

Key Components of Advanced Primary Care (APC) Purchasing

The key components that are integral to purchasing APC: characteristics of person-centered APC, changes to provider payments that serve as a mechanism to shift the delivery system to APC and a set of priority accountability measures that demonstrate achievement of high-quality care at lower costs. These

readiness. For example, provider groups who have experience participating in an alternative payment model for primary care that is based on a FFS chassis may be ready to move to a fully capitated prospective payment model and may not require the care management fee which is designed to help build the care delivery

Primary Care Payment Reform Implementation

Primary care purchasing agreements and sample contract language for employers to use in multiple ways:

- ☑ 1. Use collective leverage to incorporate into plan contracts
- ☑ 2. Direct contract via ACOs, direct primary care, own clinics and other vendors
- ☑ 3. Build own network (e.g., Emsana primary care COEs)

Purchasers Adopt Primary Care Standards

Three of California's largest health care purchasers are contractually requiring their health plans to adopt quality measures to support enhanced payments for advanced primary care for the 2022 plan year.

Combining Forces to Push the Market

Percent spent on primary care is <u>decreasing</u>

- Only 5.6 – 8.0% of total spend
- More dollar spend on primary care but not keeping up with total spend increases

Unwarranted variation with use of low-value care

- Most plans did not report stating that their **contracts with providers do not permit reporting**
- Unnecessary low back imaging ranges from 0-44% for Anthem
- Even Kaiser shows variation ranging from 0-18%

All results for depression screening and use of collaborative care codes were dismal

- Reflects major opportunity for integrated behavioral health and primary care

30 PBGH members (and counting) have aligned to demand what they need from plans.

Shared Quality and Accountability Standards

Performance Insights and Benchmarking

QI and Technical Assistance

Example: Custom Employer Health Value Index Report

- Carrier-specific
- Data quality
- Results summary
  - Data reported
  - Action guide for employers
  - Collaborative action through PBGH
- Detailed review of measures
  - Why we selected the measure
  - Challenges
  - What we measured
  - Your results
- Data Appendices

Metric	UHC Reporting Capability	Data Period
1. Benchmarking Primary Care Spend	◒	2018, 2019
2. Integration of Primary Care and Behavioral Health	○	2018, 2019
3. Depression Screening Utilization	◒	2018, 2019
4. Reporting on Depression Screenings and Remission Rates	◒	2019
5. Use of Two-Sided Risk Payment Models	○	N/A
6. Efforts to Avoid Low-Value Care	○	N/A
7. Adoption of Biosimilars	●	2019
8. Site-of-Service Optimization	◒	2019
9. IHA-PBGH Commercial ACO Measure Set	●	2020, 2021

● = Good ◒ = Fair ○ = Poor

Policy Wins: We are Having an Out-Sized Influence

Hospital Price Transparency: the Administration published an update to the regulation in which they accepted our recommendation.

Surprise Billing: the draft rules for the "qualified payment amount" were very close to PBGH recommendations. PBGH is actively involved in negotiating a second set of proposed regulations focused on the arbitration process in the best interest of purchasers and employees.

Anti-competitive Contracting Practices: President Biden's recent Executive Order on Competition in the American Economy included many PBGH recommendations.

PBGH brought together employers, unions and California's Attorney General: successfully filed a class action suit against Sutter Health. This has been a 10-year effort by PBGH that was settled December 2019.

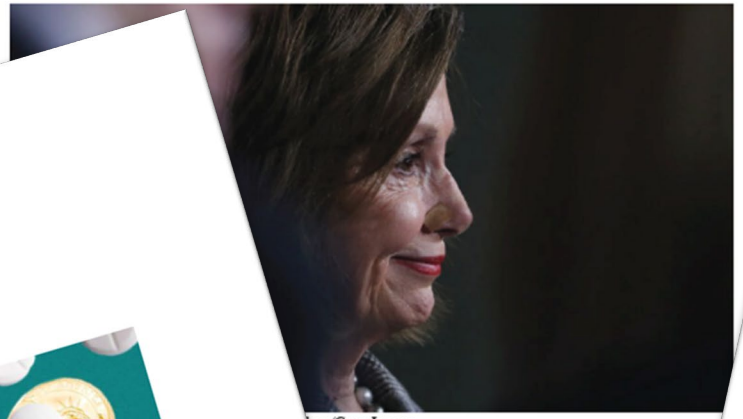
Influenced House to modify the provisions of the 2021 budget reconciliation bill: to lower drug costs to include people with commercial coverage, not just Medicare, bringing additional savings to employers and working families.

A Huge Win for Employers on Drug Legislation

STAT

Here's who wins and loses in Democrats' new prescription drug pricing deal

By Rachel Cohrs[1] [2] Nov. 2, 2021



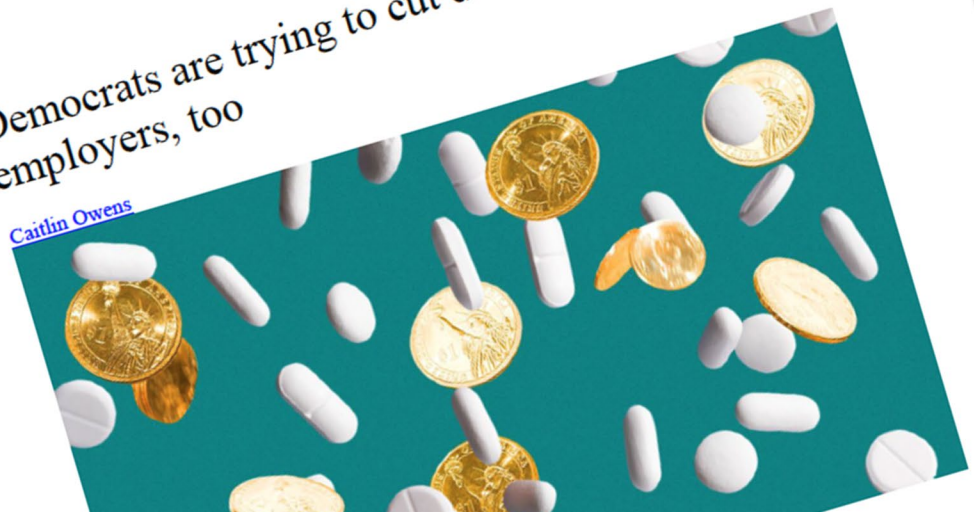
Democrats on Tuesday announced they h
prescription medicines.

lowed to negotiate drug prices for bo
ors' offices for drugs older than 9 y
o pay penalties if they hike prices
iors' out-of-pocket costs would
l.

n Sinema (D-Ariz.) and Re
about Democratic leaders
Leader Chuck Schume

Democrats are trying to cut drug costs for employers, too

Caitlin Owens



Health Law & Business

Drug Price Deal Hailed by Employers as Key Step to Slash Costs

By Sara Hansard

Nov. 3, 2021, 1:19 PM

- Employers won't benefit from Medicare price negotiations
- Inclusion in inflation cap provision is 'foot in the door'

Employers view the drug pricing deal agreed to by congressional Democrats as an important "foot in the door" even though they won't benefit from a provision allowing Medicare to negotiate some of the highest-priced drugs.

The agreement reached this week allowing the government to negotiate prices on a small number of expensive drugs is "an important first step," in making drug prices affordable for workers and their employers, Bill Kramer, executive director for health policy with the Purchaser Business Group on Health (PBGH), said in an interview. "We've broken through the fortress wall that pharma has erected over decades, and this is the first time we've been able to get through with anything."

Still, Kramer added, "We have a long way to go in order to get drug prices that are affordable for the payers and their workers and families." The PBGH represents 40 private employers and public entities across the U.S. spending about $100 billion a year to cover more than 15 million workers

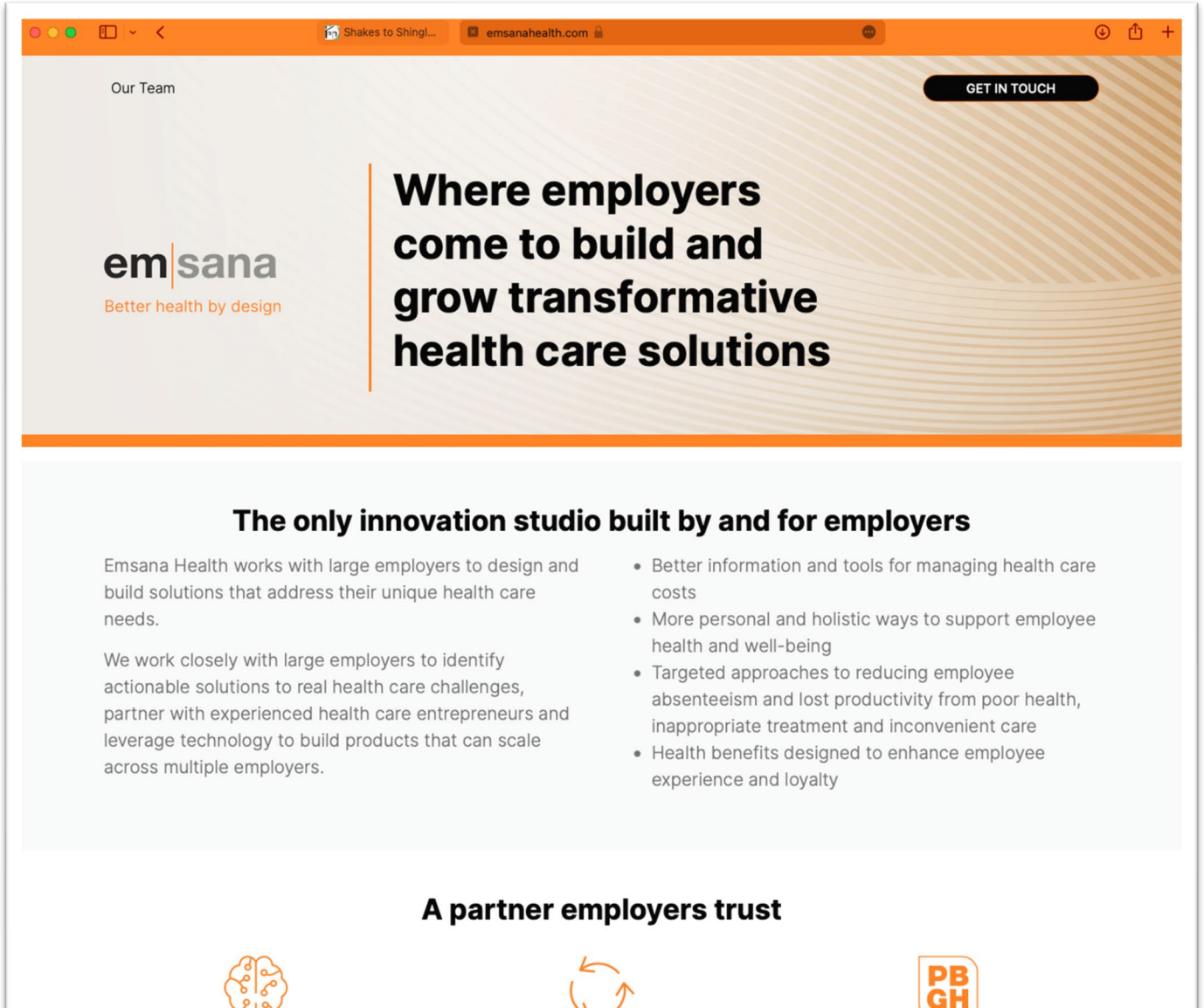
Employers had lobbied heavily to be allowed to take advantage
negotiates. Although not successful on that
Democrats' agreement.

What We're Doing About It Next

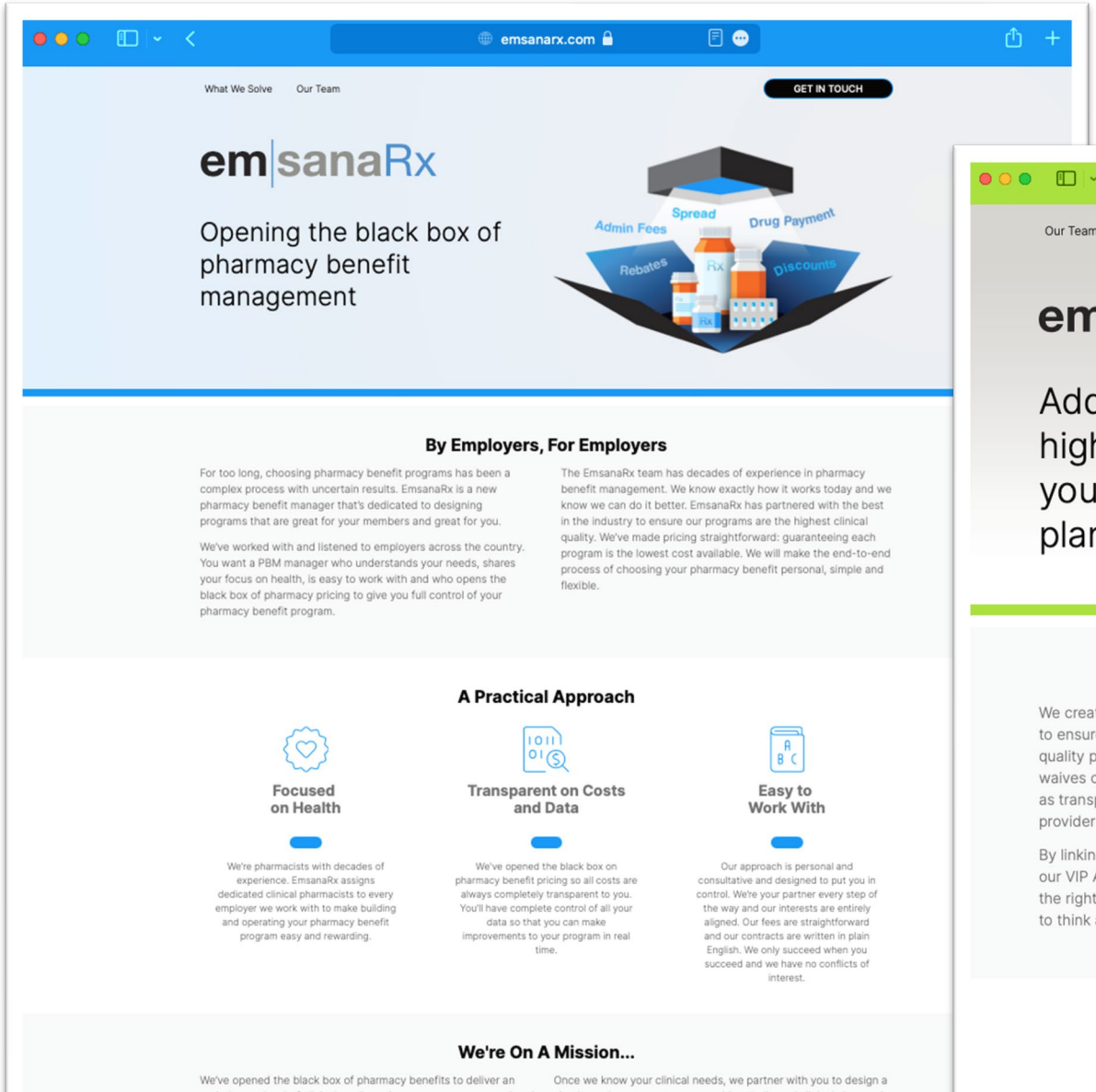
emsana

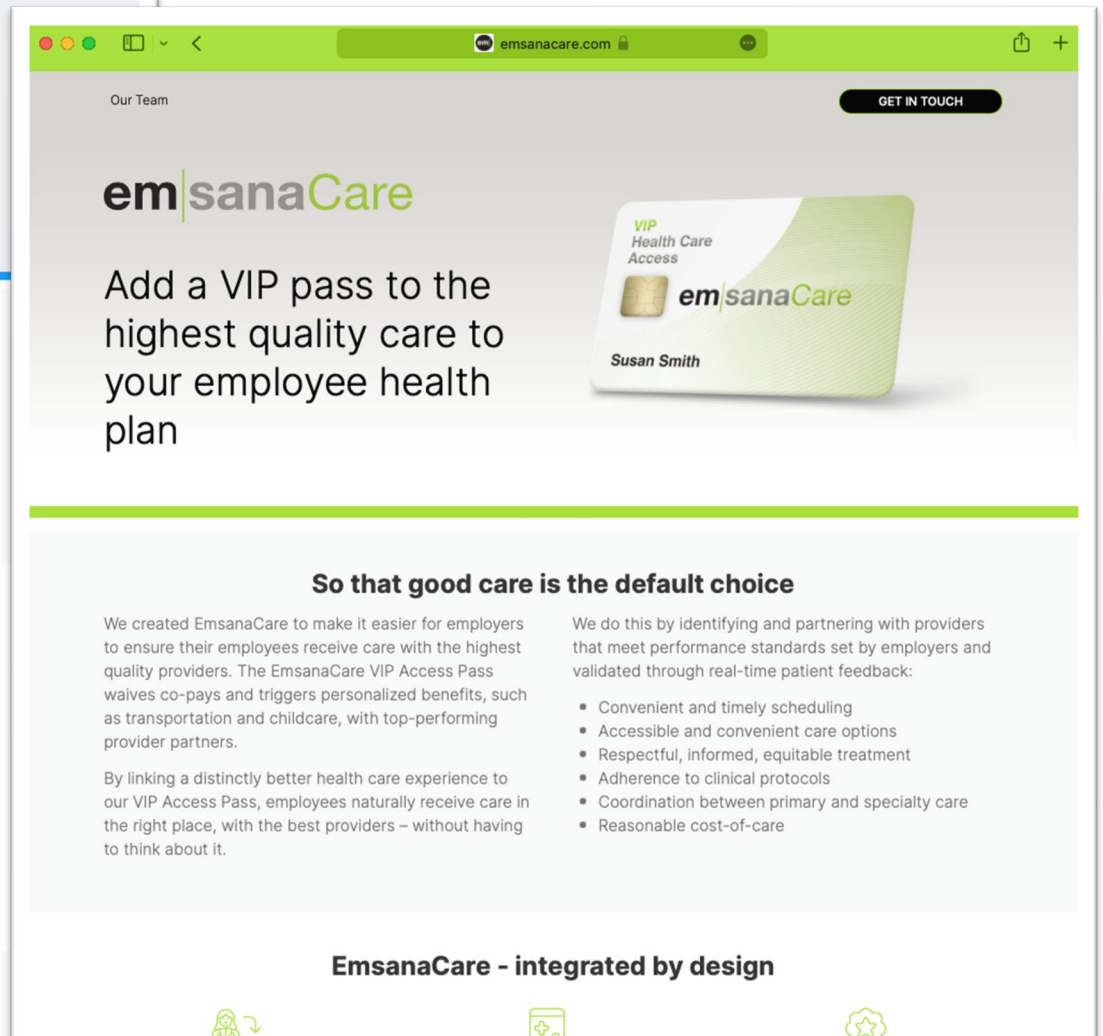
The PBGH Innovation Lab

We work with large employers to identify solutions to real health care challenges, partner with health care entrepreneurs and leverage technology to build products that can scale across multiple employers.



Two Products So Far





What Will It Take?

- Alignment
- Partnership
- Accountability
- Pooled Resources
- Fortitude

Purchaser Business
Group on Health

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Navigating to Value
LINKING PRICE TO QUALITY & OUTCOMES
In Person December 8, 2021

Board NorthStar Overview

Ted Barrall
Benefits Director,
The Friedkin Group

Dan Burke
Benefits Director,
Turner Industries

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Break / Networking / Exhibits

Exhibit Hall across the walkway through the front entrance of the Auditorium

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Hospital Transparency, Challenges & Opportunities

Marilyn Bartlett
Fellow Senior,
National Academy
For State Health Policy

Gloria Sachdev
President & CEO,
Employers Forum
of Indiana

Chris Skisak (Moderator)
Executive Director,
Houston Business Coalition
On Health

Panelist Slides

Hospital Transparency, Challenges & Opportunities

Marilyn Bartlett
Fellow Senior,
National Academy
For State Health Policy

Hospital Transparency

November 8, 2021

Marilyn Bartlett, CPA, CMA, CFM, CGMA
Senior Policy Fellow

Employer as Fiduciary

ERISA: Duty of Loyalty (Exclusive Benefit Rule)

The obligation to discharge fiduciary duties solely in the interest of plan participants and beneficiaries. A fiduciary must:

- Act for the exclusive purpose of providing benefits to participants and beneficiaries; and
- Pay plan expenses that are reasonable and relate only to plan activities

Consolidated Appropriations Act - Transparency and Attestation

- Plan may not enter into an agreement with **TPA, Provider, or other Service Provider** who restricts access to Plan data
- Plan may not enter into agreement with **broker or consultant** that does not disclose indirect and direct compensation received from other sources for Plan
- Plan required to "demand" this information

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Do you know your contract?

"The amount TPA pays to a healthcare provider through the TPA contract with the provider may be different than the amount paid pursuant to the plan, because the allowed amount under the plan will be the Plan's contracted rate with the TPA, and not the contracted amount between the TPA and the healthcare provider."

"Employer or a contractor acting on behalf of Employer may not contact any healthcare provider concerning information in reports or data, unless the contact is coordinated by TPA."

"TPA utilizes Third-Party vendors, that may include affiliated companies, for managing and/or coordinating care or cost of care for the Employer Plan. Claims payments may include fees paid to such third-party vendors, including TPA fees to support these programs."

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NASHP Hospital Cost Tool

- **Data Entry from Hospital Medicare Cost Report**
  - The only national, public source of hospital costs
  - Submitted to CMS by all hospitals serving Medicare patients – hospital level data
  - **https://www.nashp.org/hospital-cost-tool**

- **Developed by the National Academy for State Health Policy (NASHP) with support from Arnold Ventures:**
  - Help purchasers and policy makers better understand hospital *costs*
  - Can be used as a complement to recent findings reported in RAND Corp.'s *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans*

- **Collaboration with RICE University**
  - Link Hospital Cost Tool to HCRIS data
  - National, State, Regional, Hospital Type comparisons and benchmarking

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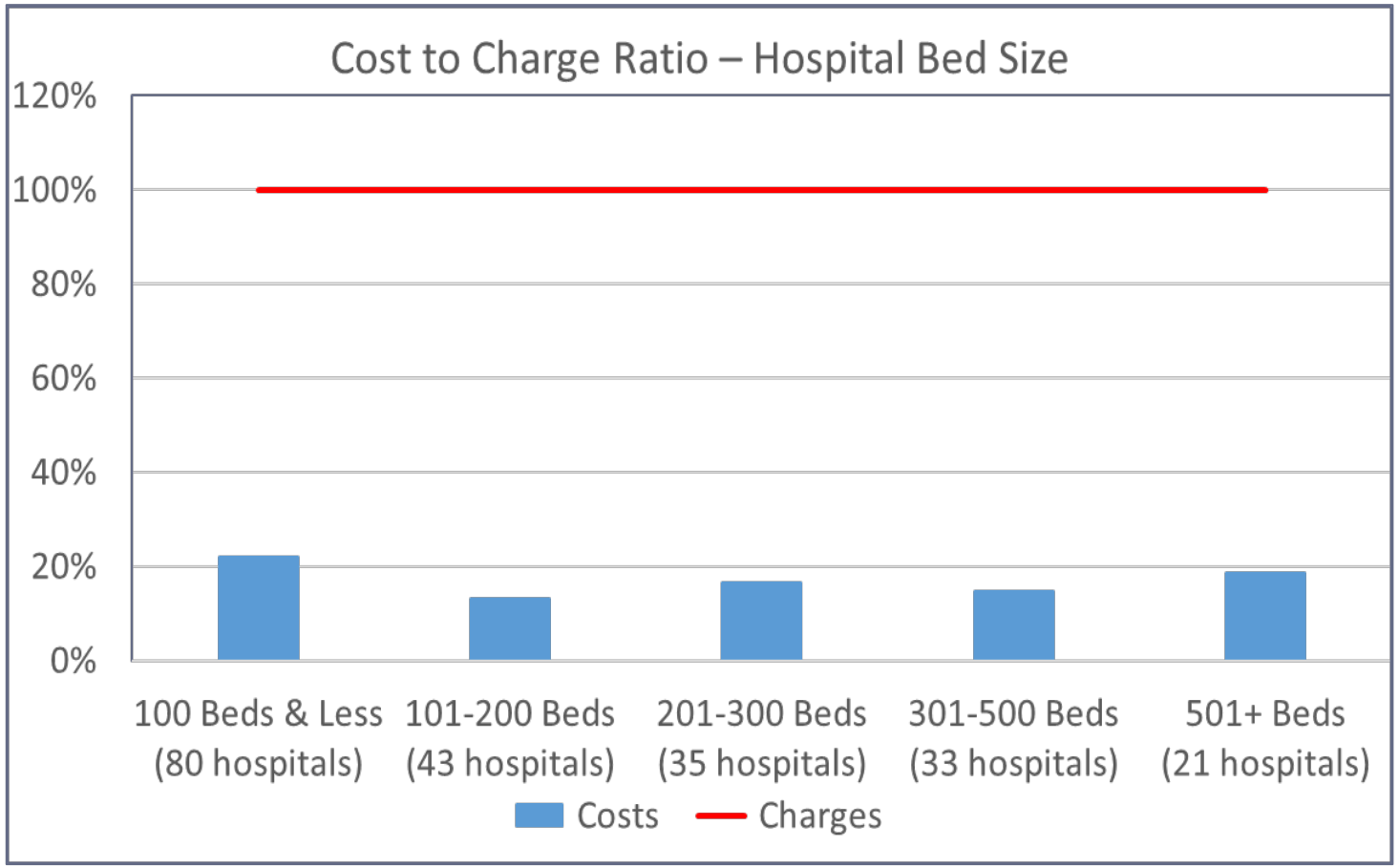
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Texas Acute Care and Critical Access Hospitals



Source: NASHP Hospital Cost Tool and Rice Data Extract - 2019

Charges The "sticker price" set by the hospital for services

Costs

1) Hospital Services
- *Salaries & Benefits*
- *Contracted Services*
- *Equipment and Supplies*
- *Rent, Depreciation, Interest, etc.*

2) Non-Hospital Services
- *Research*
- *Joint Ventures*
- *Ancillary Services (Gift Shop, Retail Pharmacy, Cafeteria, etc.)*

Allowed Negotiate rate

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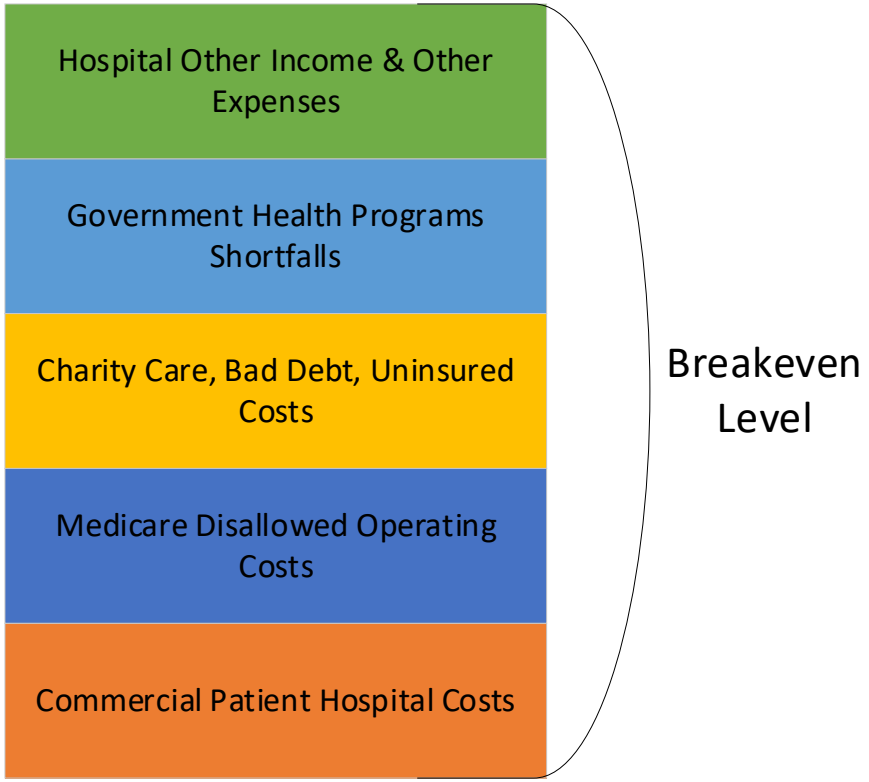
NATIONAL ACADEMY FOR STATE HEALTH POLICY

What is Breakeven?



Revenues = Expenses

- Payment required from a commercial payer for hospital to Breakeven
- Expressed as multiple of Medicare

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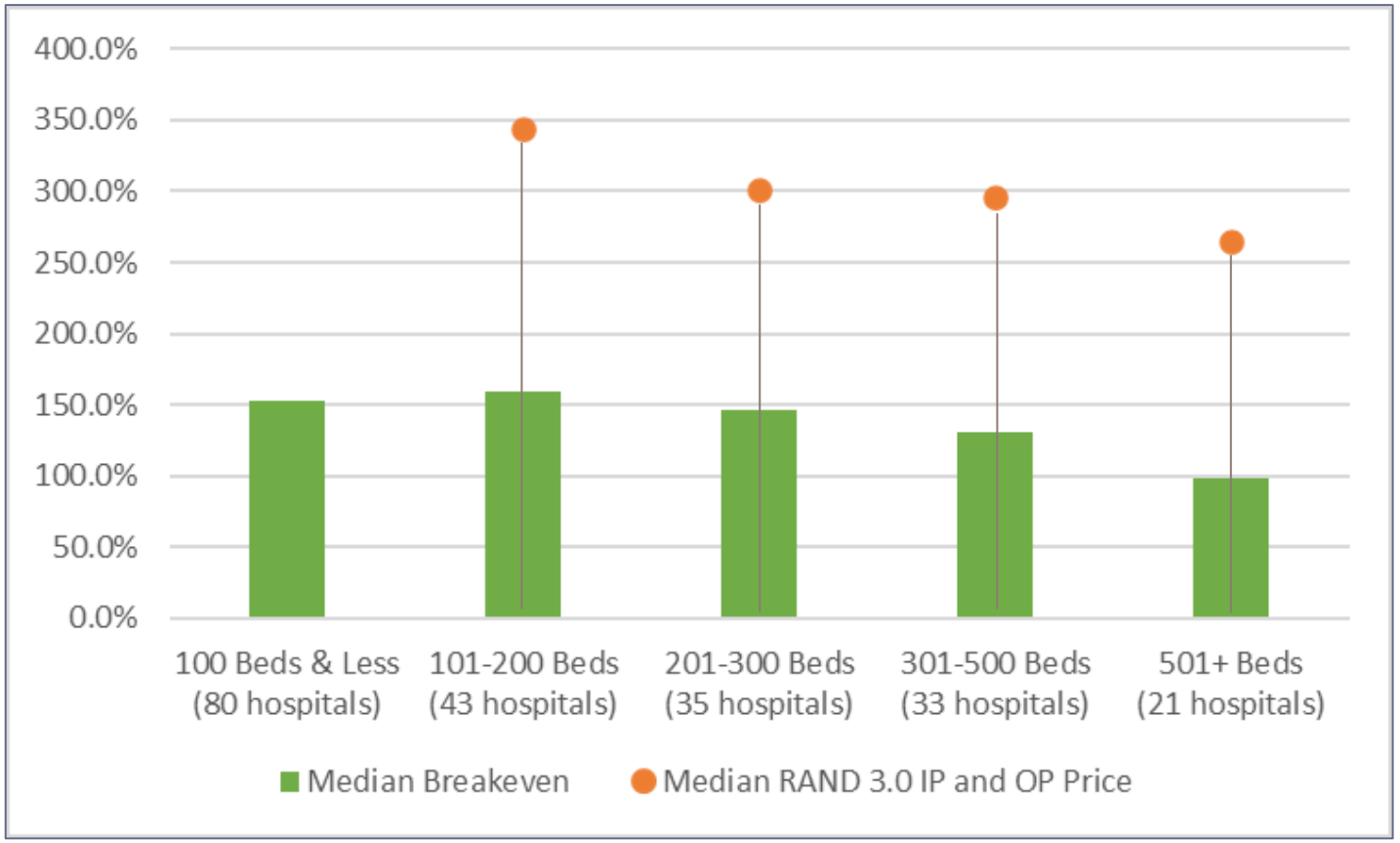
NATIONAL ACADEMY FOR STATE HEALTH POLICY

TX Hospital Benchmarking – Bed Size



Source: NASHP Hospital Cost Tool and Rice Data Extract - 2019

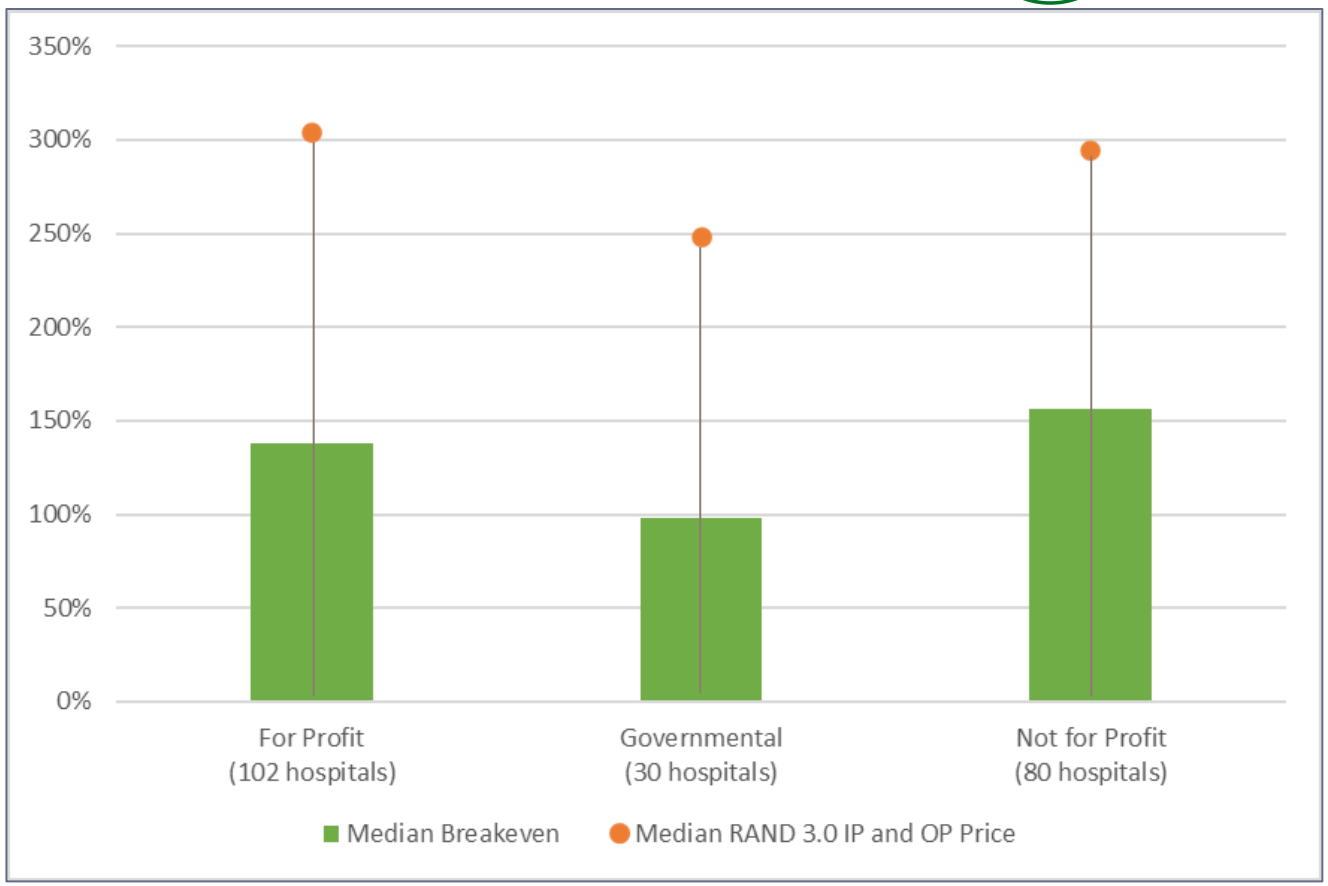
Can Hospitals make a profit on Medicare payments?

- Efficient Hospitals -1%
- All Hospitals -8.7%
- Not-for Profit Hospitals -10%
  For-Profit Hospitals 0.5%

Source: March 2021 MedPac Report to Congress

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

TX Hospital Benchmarking – Hospital Ownership



Source: NASHP Hospital Cost Tool and Rice Data Extract - 2019

- "When **nonprofit hospitals** have more resources, they tend to spend those resources because non-profit hospitals do not have shareholders to distribute profits to…..These expenditures lead to ***higher costs per discharge and lower profits*** on Medicare patients."

- In contrast: "When **for-profit hospitals** have high profits from non-Medicare sources, they tend to retain the additional profits for shareholders ***instead of increasing their cost structure***."

Source: March 2019 MedPac Report to Congress

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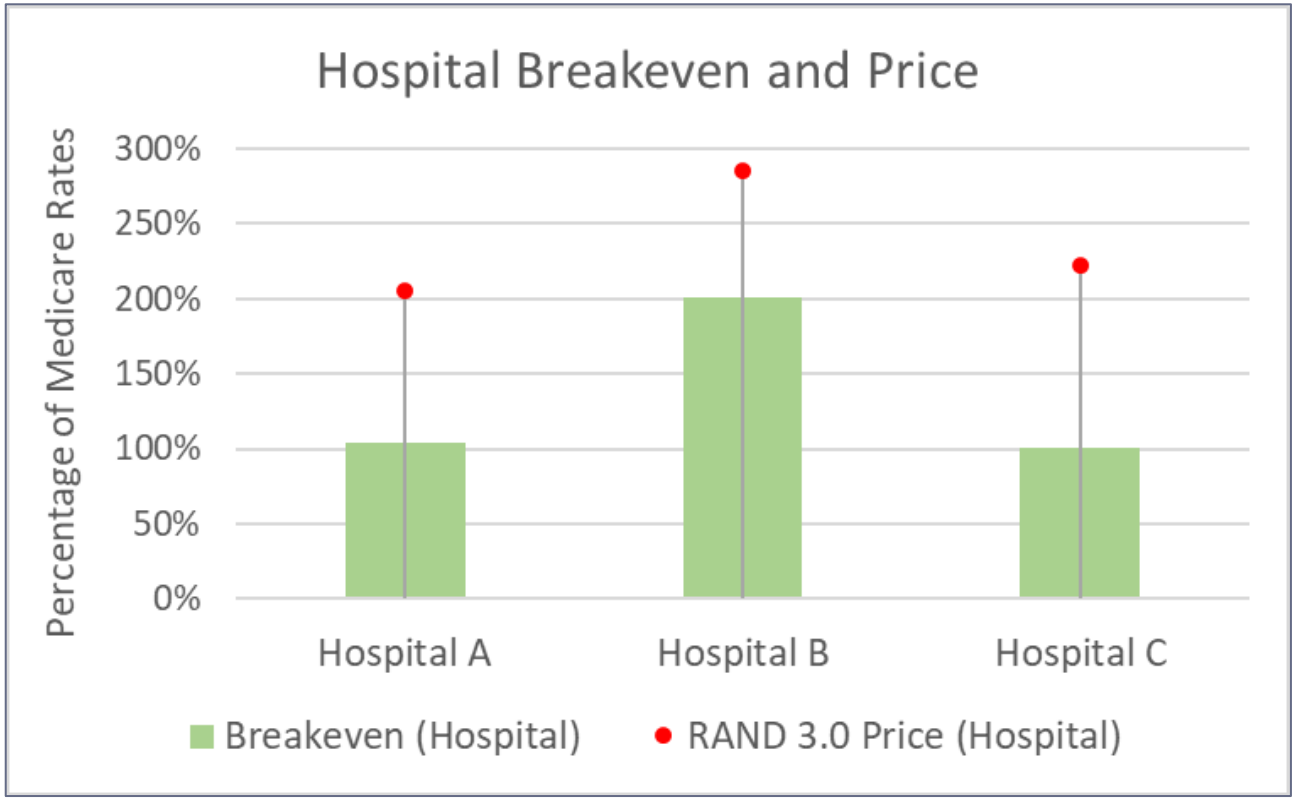
NATIONAL ACADEMY FOR STATE HEALTH POLICY

3 Houston Hospitals



Source: NASHP Hospital Cost Tool and Rice Data Extract - 2019

Breakeven (Bed Size 501+)

- National Median = 135%
- Texas Median = 100%

Why does Hospital B have a high Breakeven Point?

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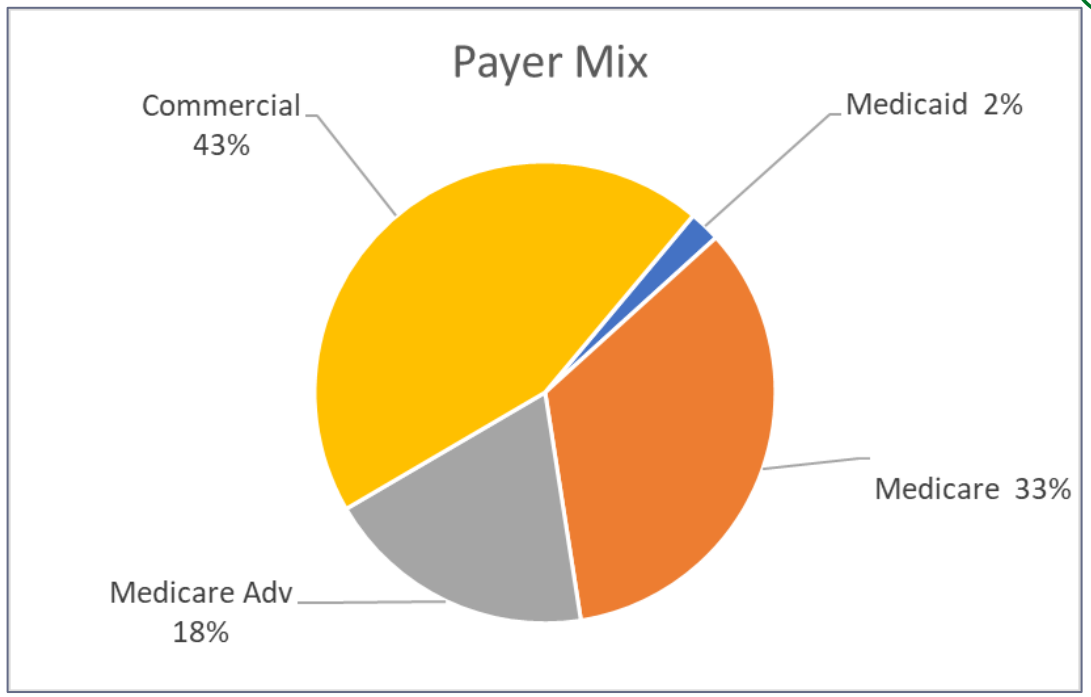
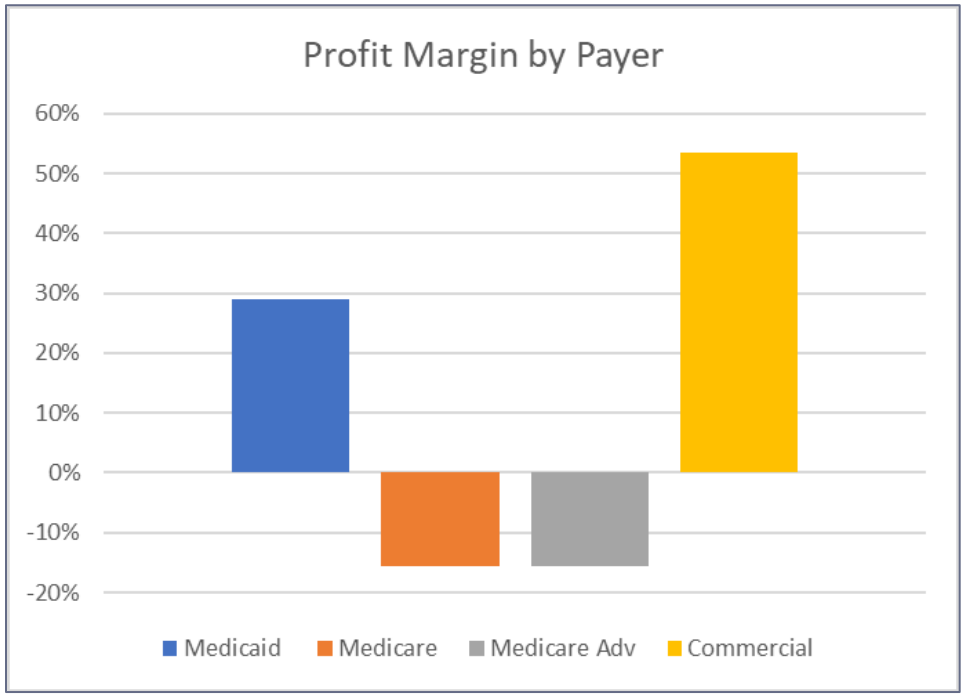
Hospital B





Why does Hospital B have a high Breakeven Point?

Medicare Losses = -16% Profit Margin on 51% of Payer Mix

Source: NASHP Hospital Cost Tool and Rice Data Extract - 2019

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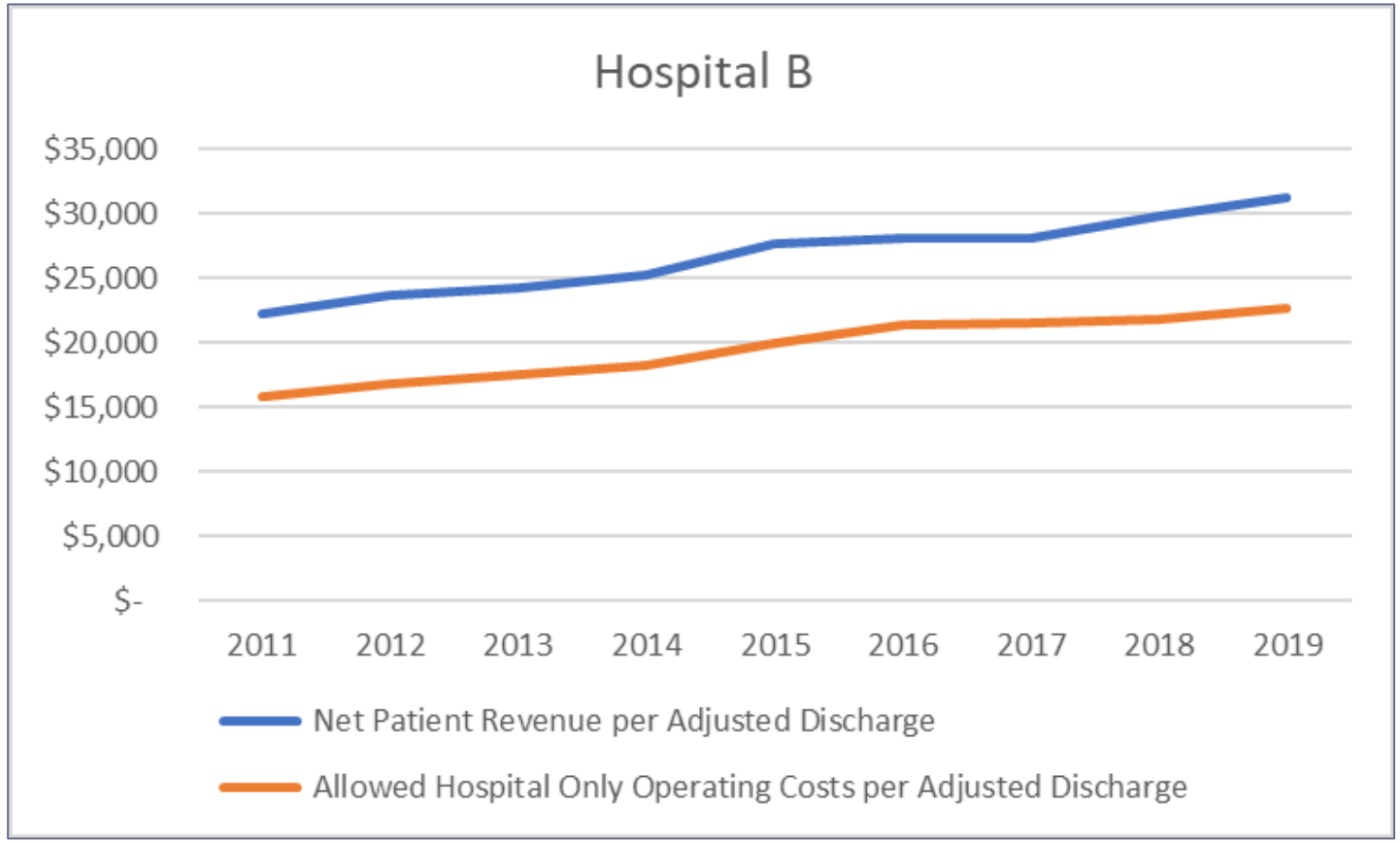
Hospital B



- Price and Cost Trend
- Adjusted Patient Discharge

Texas Hospital 501+ Beds

- NPR Median $12,092
- Hospital Cost Median $11,491

Source: NASHP Hospital Cost Tool and Rice Data Extract - 2019

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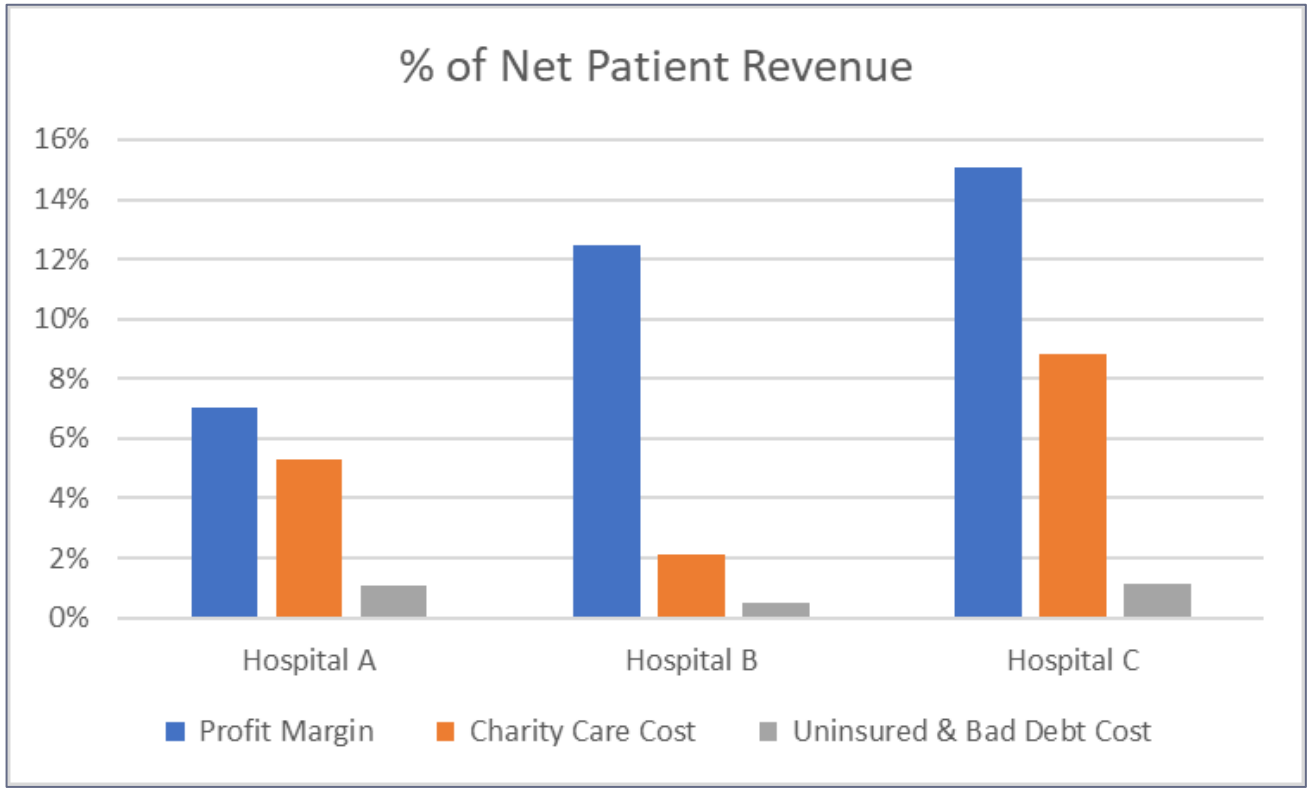
Uncompensated Care



Percent of Net Patient Revenue

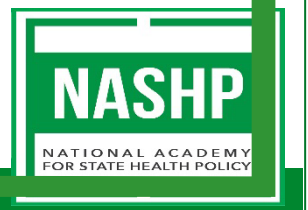
- Used for Charity Care Costs
- Used for Uninsured & Bad Debt Costs
- Retained by Hospital

Not-for-Profit vs For-Profit Hospitals

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Thank you!

mbartlett@nashp.org



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Gloria Sachdev
President & CEO,
Employers Forum of Indiana

Employers Aligning Payment with Value

Gloria Sachdev, BS Pharm, PharmD
President and CEO, Employers' Forum of Indiana
gloria@employersforumindiana.org

Houston Business Coalition on Health
Virtual, 12-8-21

Where Did Our Journey Begin?

$$\text{VALUE}_{\text{for employers}} = \frac{\text{Quality}}{\text{Price} \times \text{Quantity}}$$

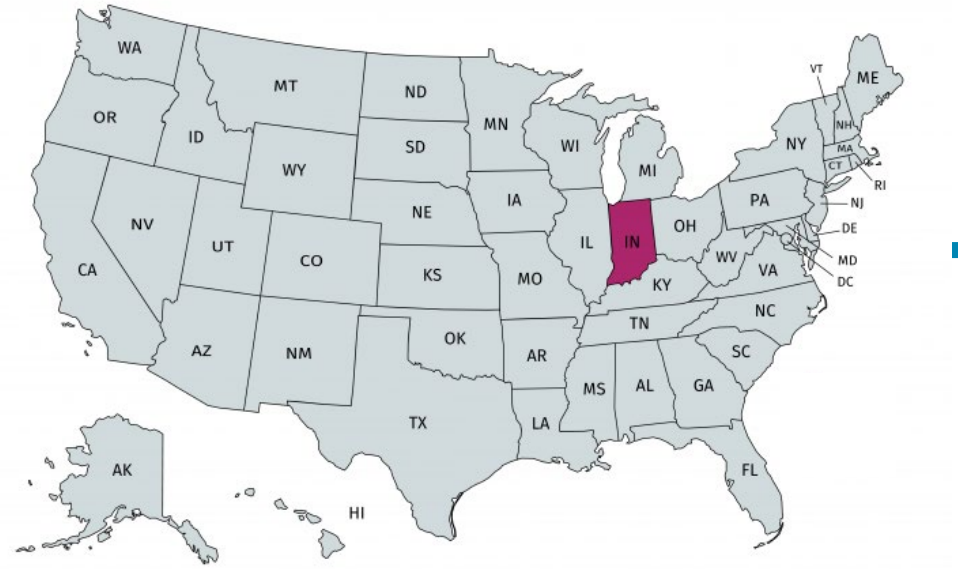
RAND Hospital Price Transparency Studies

- First of their kind in the country
- Commissioned by the Employers' Forum of Indiana
- Funded by the Robert Wood Johnson Foundation & employers

RAND Studies

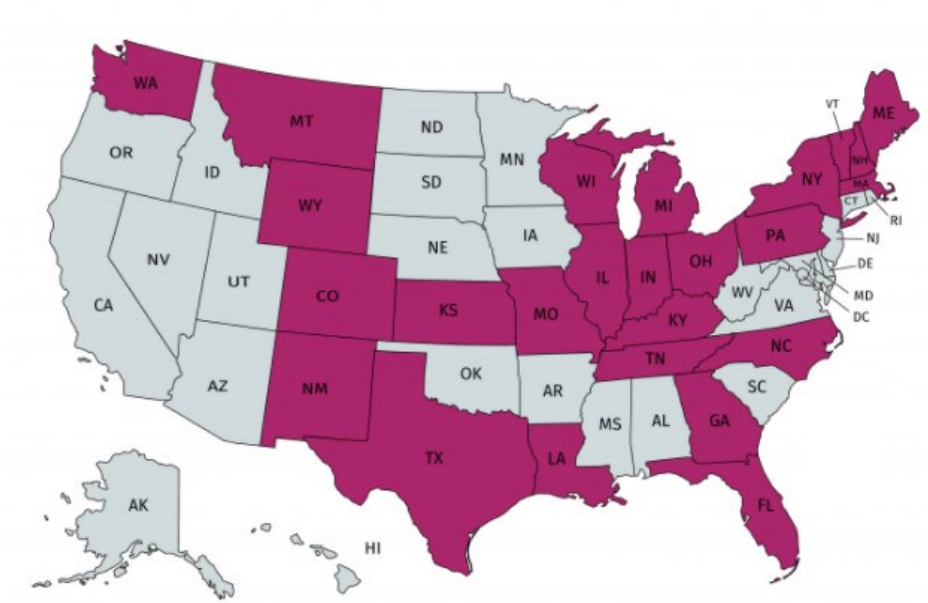
RAND 1.0

Published in 2017



RAND 2.0 study

Published in 2019



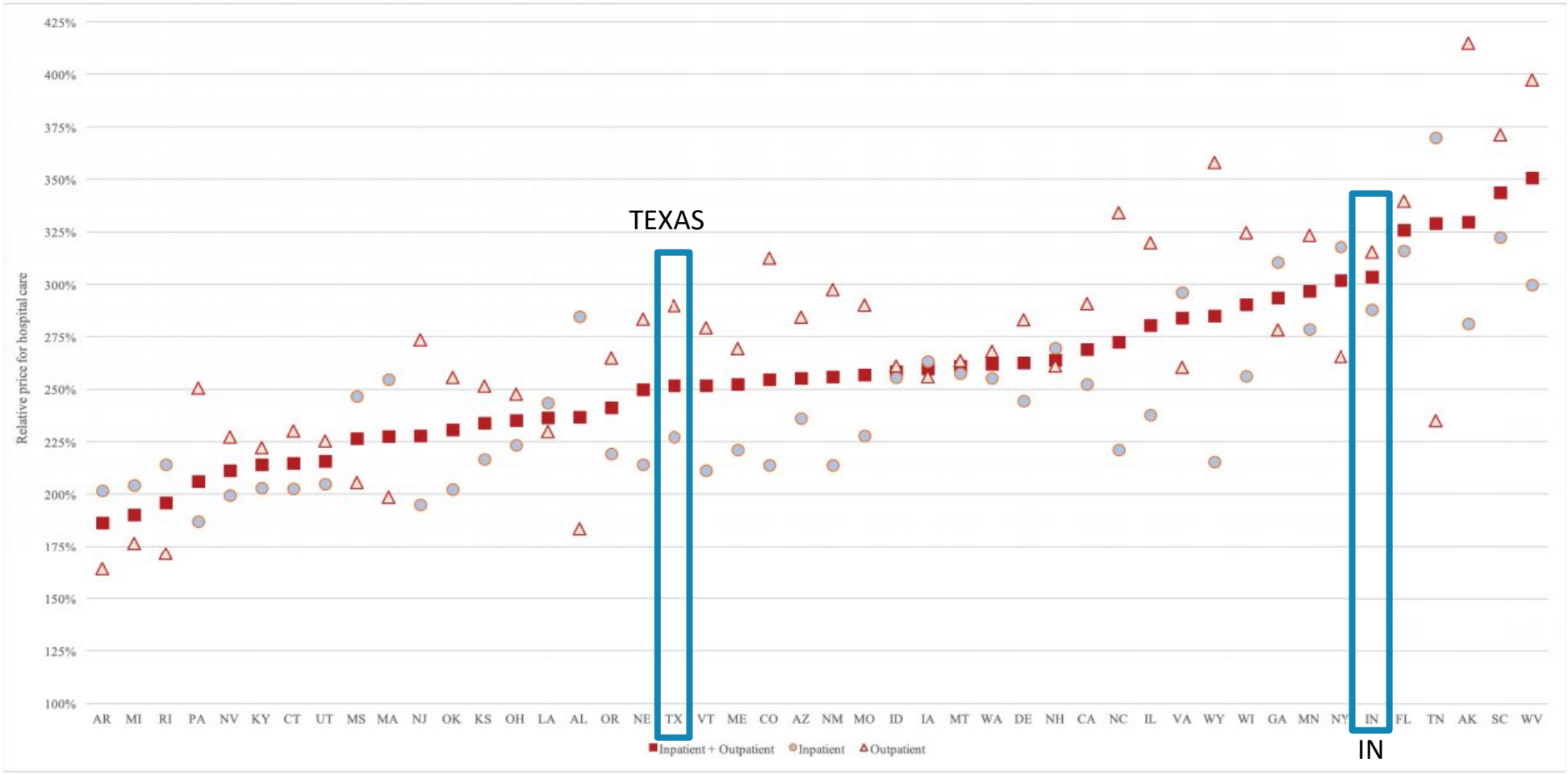
RAND 3.0 Study

Services	Hospital Inpatient and Outpatient Fees Professional Inpatient and Outpatient Fees
States	**49 states and the District of Columbia** (excludes Maryland)
Years	January 2016 – December 2018
Hospitals	3,112
Claims	750,000 for inpatient hospital facility stays (and professional fees) 40.2 million claims for outpatient services (and professional fees)
Allowed Amount	$33.8 billion total: $15.7 billion inpatient $14.8 billion outpatient $3.3 billion professional
Data Sources	Self-insured employers, 6 state all-payer claims databases, & health plans across the U.S.
Published	September 18, 2020
Funders	Robert Wood Johnson Foundation & optional for self-funded employers if they wanted a private report

https://employerptp.org/wp-content/uploads/2020/09/RAND-3.0-Report-9-18-20.pdf

RAND 3.0 Hospital Prices Relative to Medicare by State, 2018

Total, Inpatient and Outpatient services to include facility and professional prices



National avg is 247%

NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. Prices include prices for inpatient and outpatient services and group facility and professional fees.

Source: Whaley, 2020, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans findings from Round 3 of an Employer-Led Transparency Initiative

Download RAND 3.0 Study

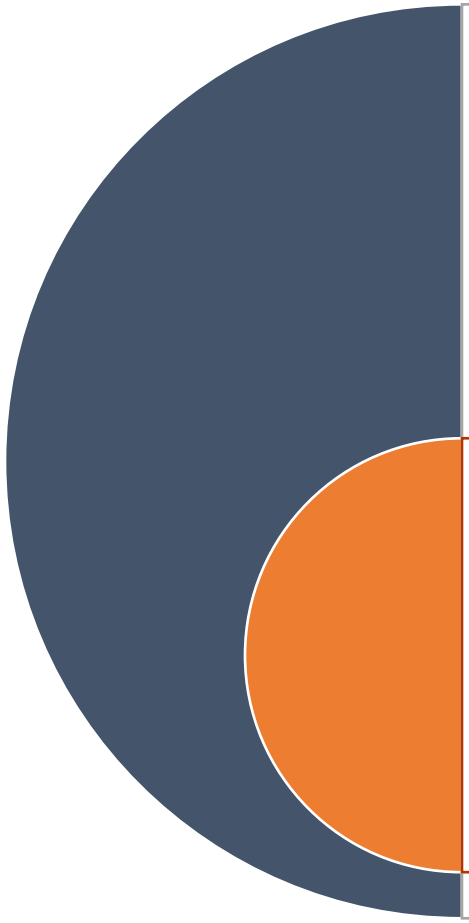
- https://employerptp.org/rand-hospital-price-studies/

- Download Supplement
- Hospitals Tab: 3112 hospitals
- Each State has a Tab noting health-system level data
- All freely and publicly available

Where Are We Today?

- Trying to Reducing Hospital Prices
- Legislative Policy
- Employers Aligning Benefit Design with Value

Payment Reform



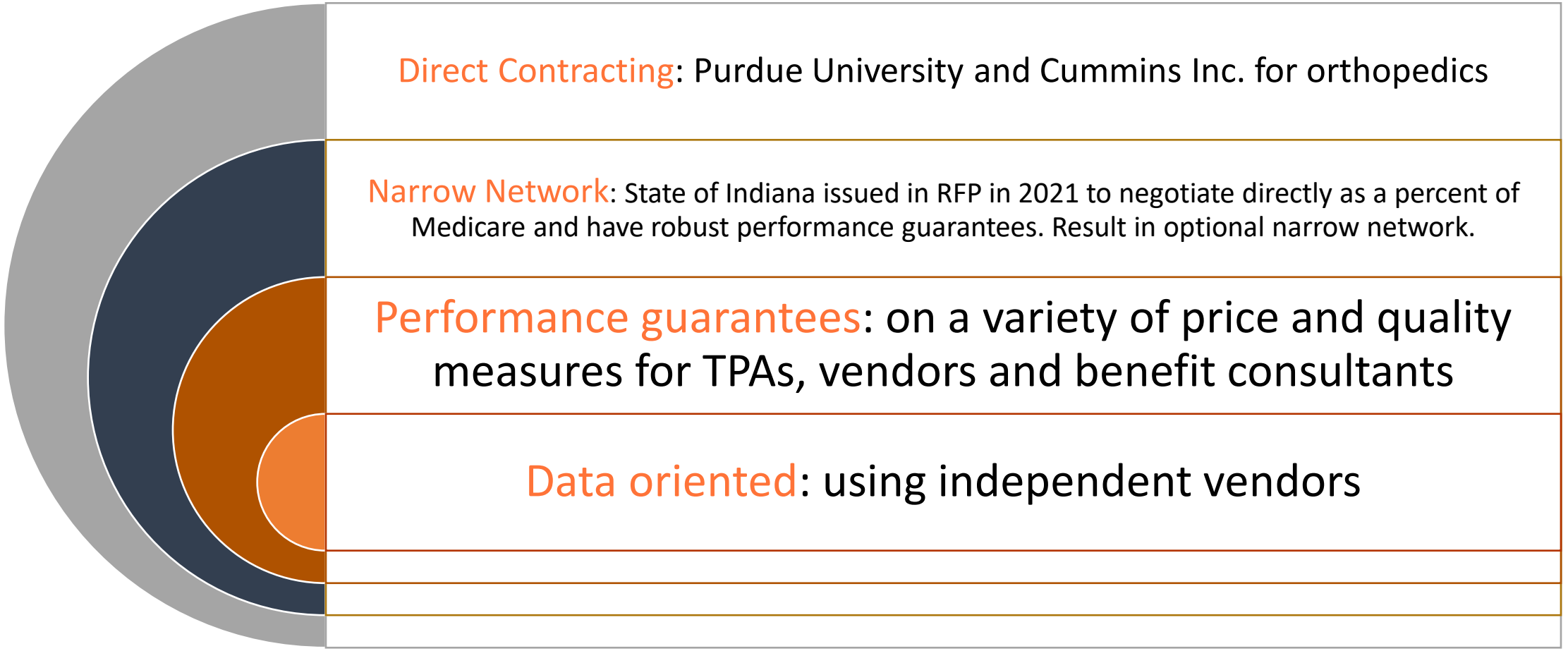
Payment Model: Anthem Indiana was negotiating outpatient services based on discount of charges, which is terrible!

Beginning January 2020, they began contracting using percent of Medicare corporate wide for outpatient services.

Contracts: Employer Pressure and Support for Anthem renegotiating a Parkview Health contract in Fort Wayne.

Agreement on 7-30-20: reduced in-network payment rates.

Empowered Employers



Legislative Policy Pursued in Indiana, 2020

House Enrolled Act 1004

- Good Faith Estimate - providers must provide GFE within 5 days of patient request 7-1-20, & provide without patient request beginning 2021 **LAW**
- Surprise Billing - Prohibits in-network providers or practitioners from charging patients more than in network rate cost of care according to the patient's network plan unless at least 5 days before the health care services are scheduled to be provided, the covered individual is provided a statement that of GFE and patient signs consent to be charged for out of network rate. **LAW**
- Site of Service - Specifies health care billing forms to be used in certain health care settings. **DIED**

Read the latest version here

Legislative Policy Pursued in Indiana, 2020

Senate Enrolled Act 5

- Prohibit Gag Clauses - Prohibits non-disclosure clauses in health provider contracts so purchasers can request the negotiated rate from insurers and providers. **LAW**
- Price Transparency - Requires hospitals, ambulatory surgical centers, and urgent care facilities to post certain health care services pricing information on their Internet web sites. **LAW**
- Benefit Consultant Disclosure - Requires an insurance producer to disclose commission information to client…..**LAW** (but we wanted benefit consultants to disclose any funds they receive from an organization they recommend).
- All-Payer-Claims-Database (APCD) - Requires the department of insurance to submit a request for information, a request for proposals, and contract concerning the establishment and implementation of an APCD. **LAW**

Read the latest version here

Legislative Policy Pursued in Indiana, 2021

HB 1405 and SEA 325

- Annual Public Forum meeting for select non-profit hospitals to which their BOD must attend, discuss their finances, how help community, and receive community feedback…LAW
- Shore up APCD by adding advisory board…..LAW
- Prohibit Anticompetitive Contract Language…DIED
  - all-or-none, anti-steering, and anti-tiering
- White Bagging….successfully blocked legislation
- COPA (Certificate of Public Advantage)….passed but blocked worst part

Read review here

Where Are we Going?

More Transparency: Hospital Value Dashboard (HVD)

Data Sources for Beta 1 Testing through December 2021

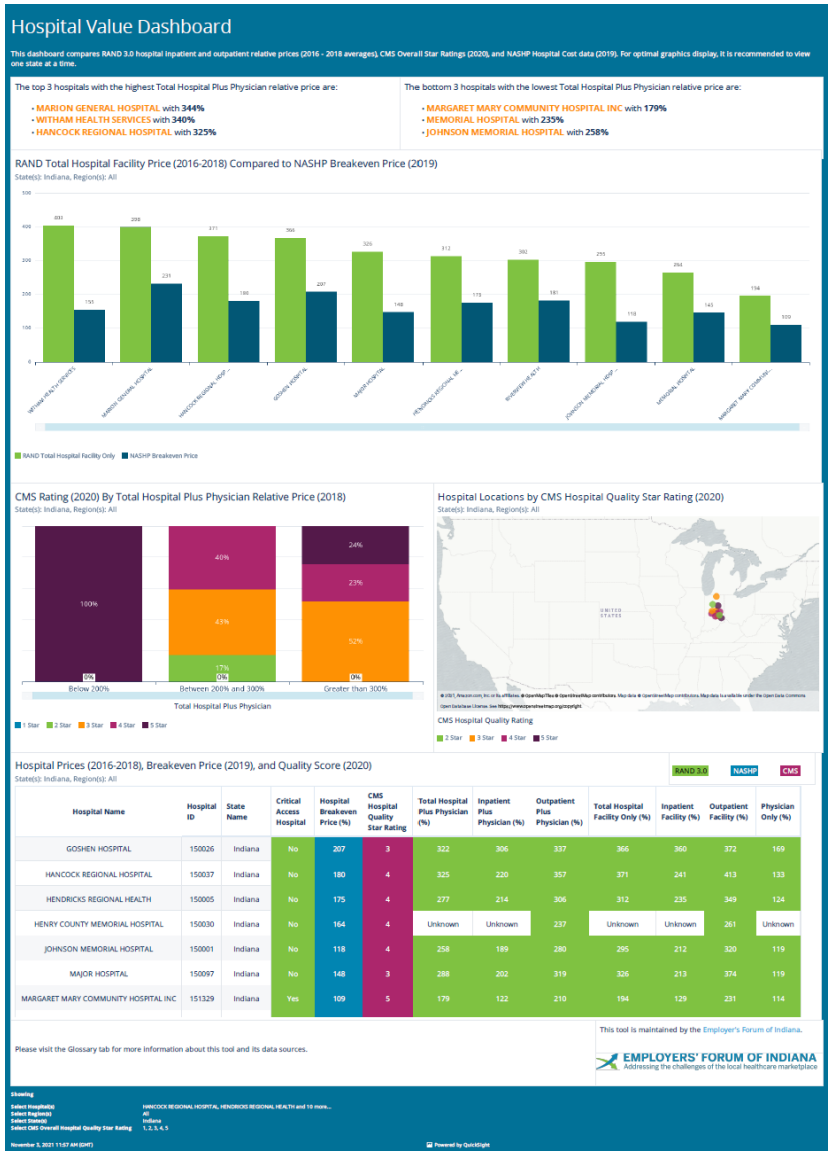
- RAND 3.0 Hospital Prices (National)
- National Academy of State Health Policy Hospital Cost Tool - Hospital Commercial Breakeven as a Percent of Medicare (Indiana)
- CMS Hospital Quality Star Ratings (National)
- Quantros/Healthcare Bluebook Hospital Quality for 39 clinical categories (Private Use)

Data Sources for Full Launch - March 2022

- RAND 4.0 Hospital Prices
- National Academy of State Health Policy Hospital Cost Tool - Hospital Commercial Breakeven as a Percent of Medicare (National)
- CMS Hospital Quality Star Ratings
- IT partner TBD using hospitals own websites prices per their machine readable format filesQuantros/Healthcare Bluebook Hospital Quality for 39 clinical categories (Private Use)

Launch of Hospital Value Dashboard & RAND 4.0 at the National Hospital Price Transparency Conference: Indianapolis March 11, 2022

All Invited!



Thank You

Questions Welcome

Gloria Sachdev

gloria@employersforumindiana.org

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Healthcare Delivery Moving to Value

James McDeavitt, MD
Executive Vice President and Dean of Clinical Affairs, Baylor College of Medicine

David Carmouche, MD
EVP, Value-based Care & Network Operations, President, Ochsner Health Network, Ochsner Health

Dave Milich
CEO, TX & OK, United Healthcare

Tony Lin, MD
CEO & Chairman of Board of Managers, Kelsey-Seybold

Clive Fields, MD
Co-Founder & Chief Medical Officer, VillageMD

Josh Berlin (Moderator)
CEO, Rule of Three, LLC & Chief Medical Officer, VillageMD

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Primary Care at the Epicenter of Healthcare's Future

Juliet Breeze, MD
CEO,
Next Level Urgent Care

Jennifer Sargent
Chief Commercial Officer,
Vera Whole Health

Tom Banning
CEO,
Texas Academy of Family Physicians

Patrick Carter, MD
Medical Dir. For Care Coordination & Quality Improvement, Kelsey-Seybold

Ken Janda (Moderator)
Founder & CEO,
Wild Blue Solutions

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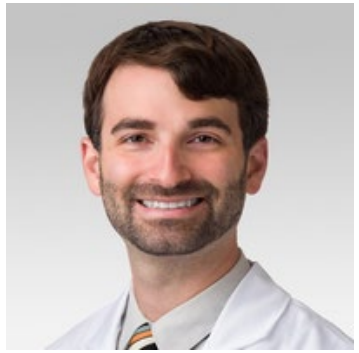
Mental Health Integration Must Be a Part of any Solution

Jenn Roberts
VP Consultant Relations,
Hello Heart

Andy Keller, PhD
CEO,
Meadows Mental Policy Institute

Kara Hill
Director, Integrated Health,
Mental Health America-Houston



Andrew Carlo
Asst. Prof.
NW, Sr. Med. Dir. for Health Systems Integration,
Meadows Mental Policy Institute

Ken Janda (Moderator)
Founder & CEO,
Wild Blue Solutions

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Panelist Slides

Mental Health Integration Must Be a Part of any Solution

Andy Keller, PhD
CEO,
Meadows Mental Policy Institute

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Why Must Mental Health Integration Be a Part of the Solution?

Andy Keller, PhD | Wednesday, December 8, 2021

THE CURRENT MENTAL HEALTH CARE SYSTEM

8,119
SUBSTANCE RELATED DEATHS in Texas in 2019

3,891
DEATHS BY SUICIDE in Texas in 2019

The Goal of Health Care: **LIVING YOUR LIFE** in the COMMUNITY

WORK | SCHOOL | HOME | FAITH | FAMILY

HEALTH CARE

- Primary Care
- Specialty Care
- Inpatient Care
- Best Practice Anchor
  e.g., UTSW Simmons Cancer Center, MD Anderson

MENTAL HEALTH CARE

Crisis

- Law Enforcement
- ER / Hospital
- Jail

Fragmented Care

- Specialty Care
  Insufficent Network Capacity
- Primary Care
- Best Practice Boutique
  e.g. McLean, Johns Hopkins

The best Mental Health Care is like the best Health Care

COVID-19 and Mental Health Impacts

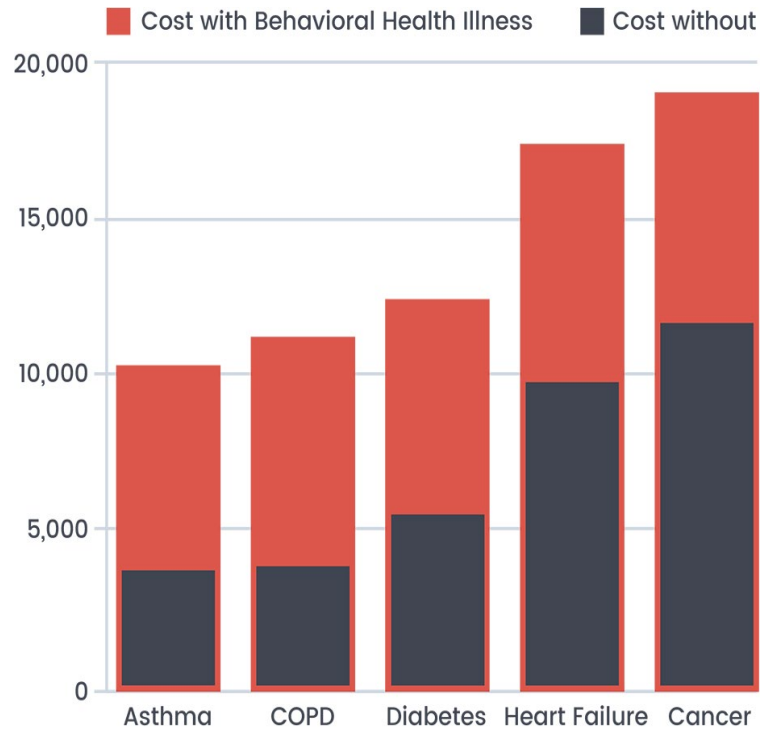
COVID-19 has dramatically increased mental health needs.

- The **Centers for Disease Control and Prevention (CDC)** now tracks mental health needs. As of mid-October, 2021:
  - **Symptoms of anxiety disorder up 3.4x** (28% vs 8%)
  - **Symptoms of depression up 3.4x** (22% vs 7%)
- **Rates of death from overdose are up over 30%**.
- Early in the pandemic, the proportion of mental health-related ED visits increased **24% among children aged 5–11** and **31% among adolescents aged 12–17**.
- The rate of pediatric emergency room visits for suicide is now **double pre-pandemic levels**.

Just as with COVID-19, early detection and treatment are key.

Case for Change: Behavioral Health Is Expensive

For chronic and comorbid conditions, total cost of care is higher when mental illness co-exists



"COPD"=chronic obstructuve pulmonary disease
Source: Cartesian Solutions, consolidated health claims data

Population	% with Behavioral Health Diagnosis	PMPM Without Behavioral Health Diagnosis	PMPM With Behavioral Health Diagnosis	Increase in Total PMPM with Behavioral Health Diagnosis
Commercial	14%	$340	$941	276%
Medicare	9%	$583	$1429	245%
Medicaid	21%	$381	$1301	341%
All Insurers	15%	$397	$1085	273%

PMPM=per member per month costs
Source: Melek, Norris, & Paulus. Economic impact of integrated medical-behavioral healthcare: Implications for Psychiatry. Milliman, 2014

MEADOWS MENTAL HEALTH POLICY INSTITUTE

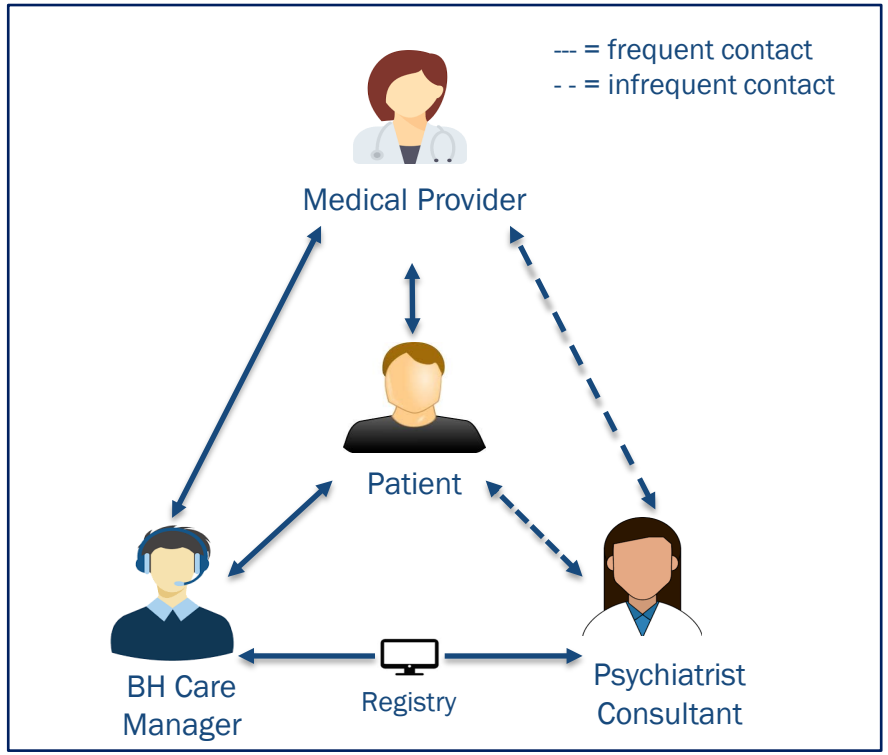
Collaborative Care Returns Results

CoCM is a team-based, data-driven, patient-centered population health approach to mental health and substance use disorder care

60% Increase in response to mental health and substance use treatments. (Archer 2012)

6:1 Return on investment for patients (reduction in total medical spend over cost of program). (Unutzer 2008)

↓ Reduction in markers of chronic disease, ED visits and hospitalizations. (Rossom 2017, Reiss Brennan 2016)

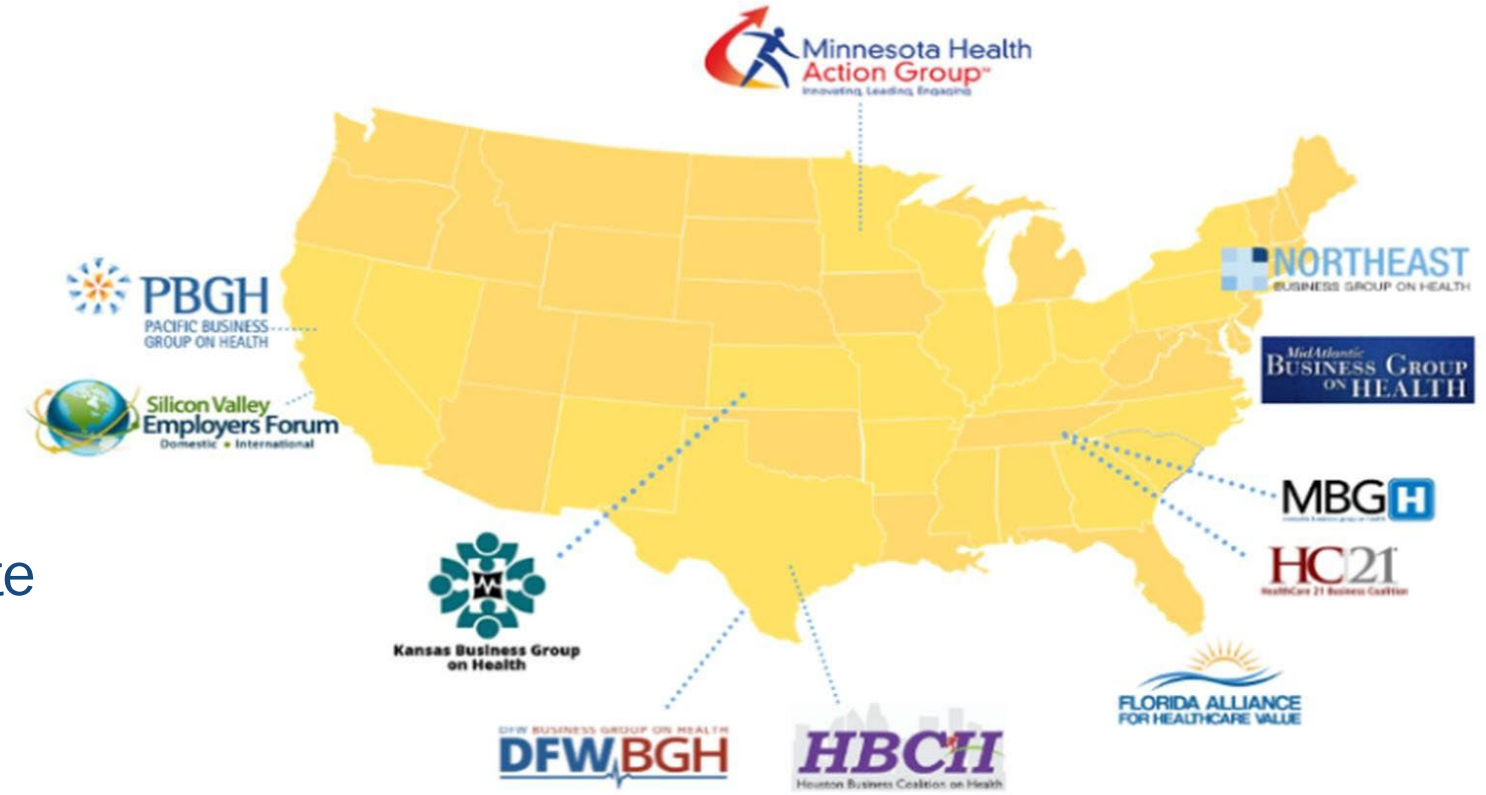


- 80+ Randomized controlled trials showing improved access, value, outcomes, and patient and provider experience.
- New billing codes from AMA and CMS make CoCM a separately reimbursable covered benefit.

MEADOWS MENTAL HEALTH POLICY INSTITUTE

The Path Forward: A Purchaser Driven Initiative to Scale Reform

- Purchaser-led, Market-driven
- National and Regional Execution
  - National Steering Committee
  - 8 Regional Employer Stakeholder Engagement Teams (RESET Regions)
- Development of **industry-level processes and standards** to create opportunities to achieve higher quality and maximize efficiencies
- Commitment to Measurable Improvements



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THE IDEAL HOUSTON MENTAL HEALTH SYSTEM

The Goal of Health Care: **LIVING YOUR LIFE** in the COMMUNITY

WORK SCHOOL HOME FAITH FAMILY

HEALTH CARE

SPECIALTY CARE

- Outpatient
- Rehabilitative Care
- Inpatient Care
- Best Practice Anchor
  e.g., Houston Methodist Hospital, MD Anderson Cancer Center, Texas Children's Hospital

Integrated Primary Care

Measurement Based Care ⟷ *Collaborative Care*

MENTAL HEALTH CARE

SPECIALTY CARE

Sufficient Network Capacity

Sufficient Networks

- Outpatient
- Rehabilitative Care
- Inpatient Care
- Best Practice Anchor
  e.g., UTSW O'Donnell Brain Institute, New York Presbyterian Hospital

The best Mental Health Care is like the best Health Care

MEADOWS MENTAL HEALTH POLICY INSTITUTE

THE HACKETT CENTER FOR MENTAL HEALTH

okay to say

The truth is: mental illness affects more people than you may think, and we need to talk about it. It's Okay to say…" okaytosay.org

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Mental Health Integration Must Be a Part of any Solution

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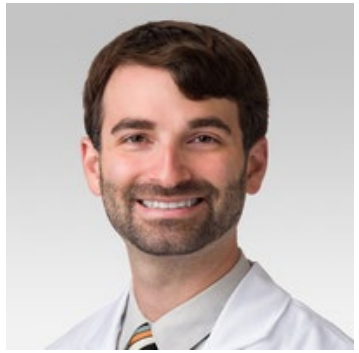
VP Consultant Relations,
Hello Heart

Andy Keller, PhD
CEO,
Meadows Mental Policy Institute

Kara Hill
Director, Integrated Health,
Mental Health America-Houston



Andrew Carlo
Asst. Prof.
NW, Sr. Med. Dir. for Health Systems Integration,
Meadows Mental Policy Institute

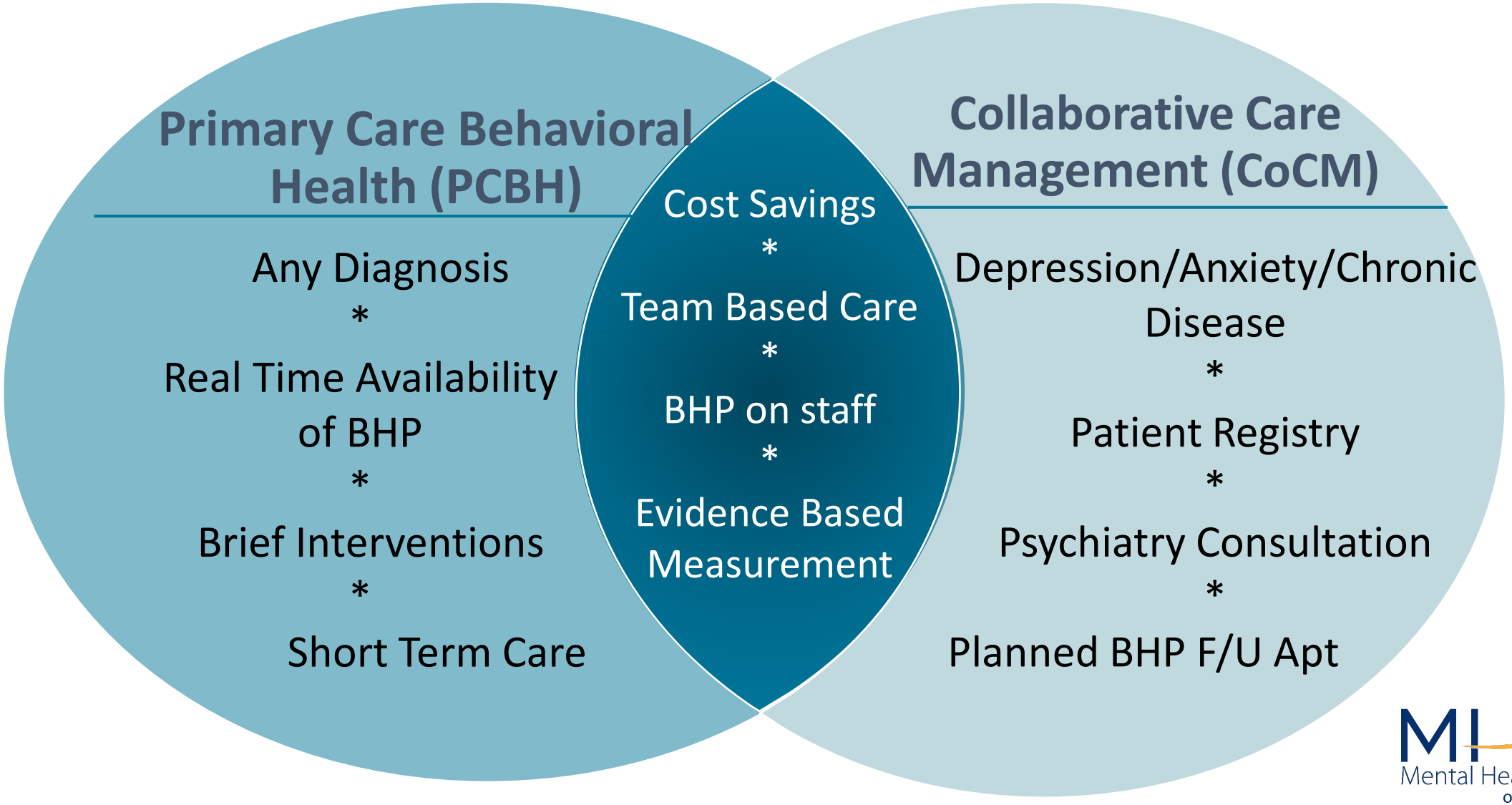
Ken Janda (Moderator)
Founder & CEO,
Wild Blue Solutions

Panelist Slides

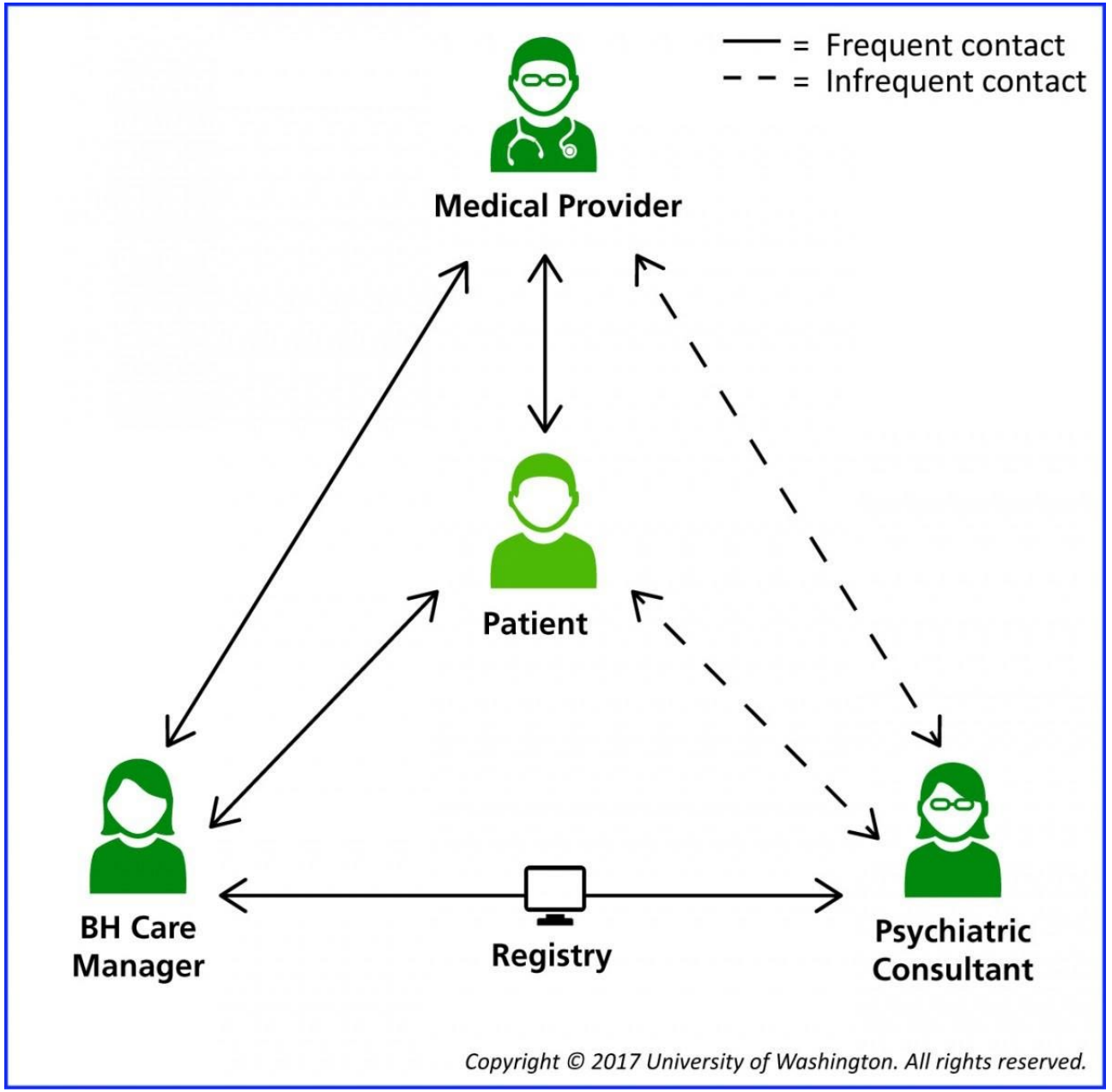
Mental Health Integration Must Be a Part of any Solution

Kara Hill
Director, Integrated Health, Mental Health America-Houston

Integrated Health Care – Model Comparison



MHA
Mental Health America
of Greater Houston



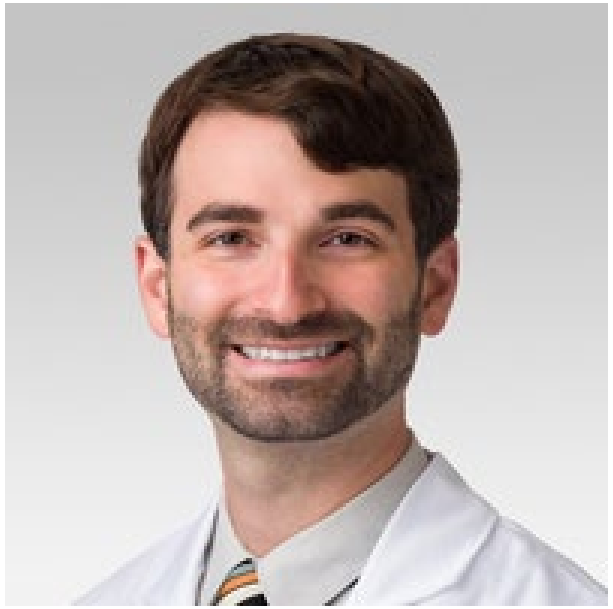
Collaborative Care Management (CoCM)

- Patient w/ MH/BH diagnosis
- PCP/Medical Provider
- BH Care Manager
- Patient Register
- Psychiatric Consultant
- Regularly Scheduled Team Meetings

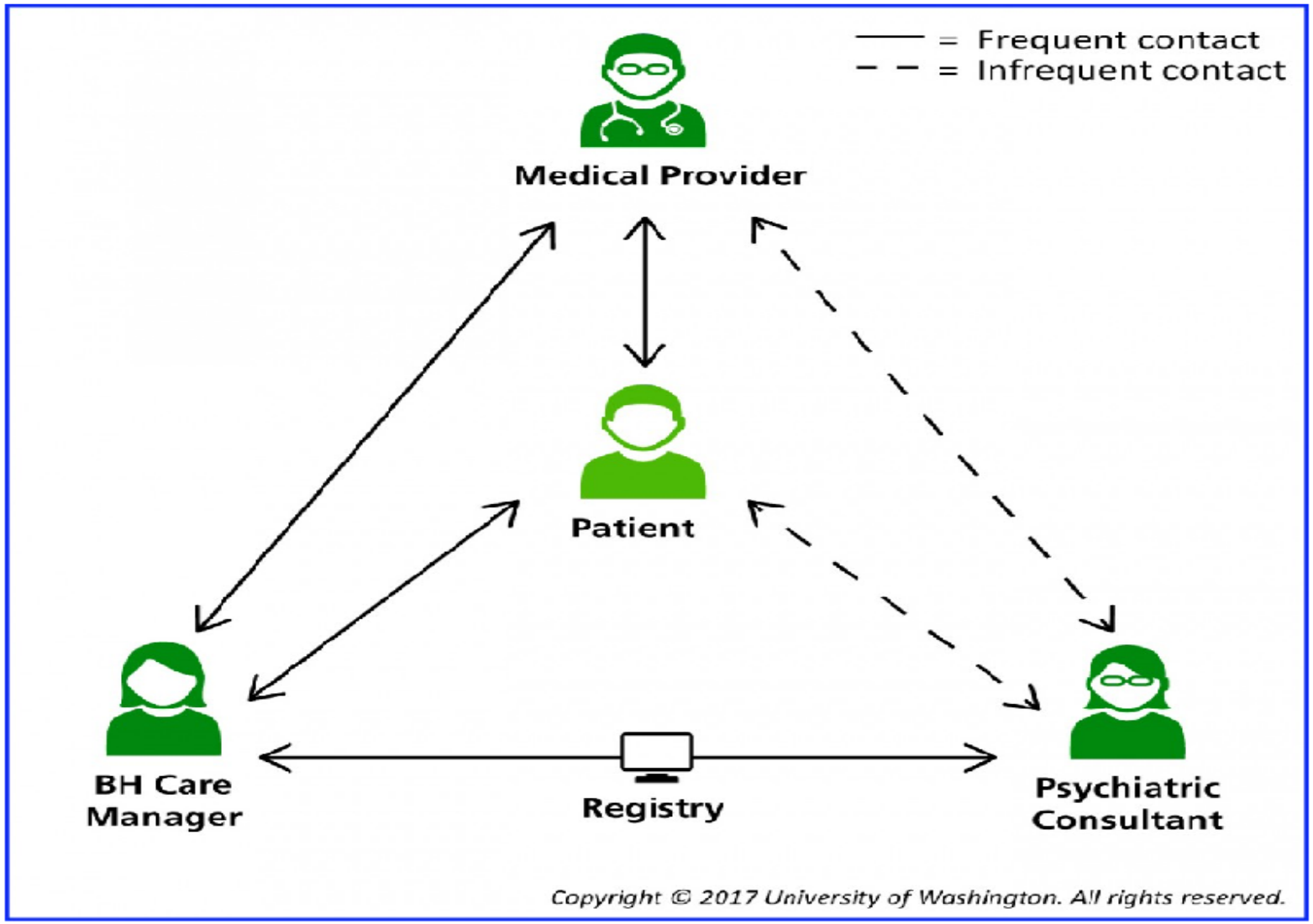
MHA
Mental Health America
of Greater Houston

Panelist Slides

Mental Health Integration Must Be a Part of any Solution



Andrew Carlo
Asst. Prof. NorthWestern,
Sr. Med. Dir. for Health Systems Integration,
Meadows Mental Policy Institute


= Frequent contact
= Infrequent contact
Medical Provider
Patient
BH Care Manager
Registry
Psychiatric Consultant
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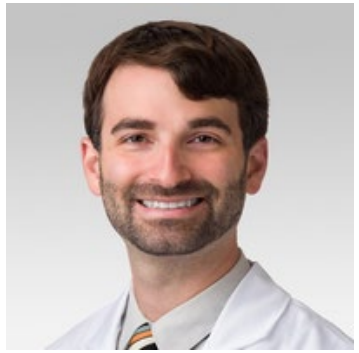
Mental Health Integration Must Be a Part of any Solution

Jenn Roberts
VP Consultant Relations,
Hello Heart

Andy Keller, PhD
CEO,
Meadows Mental Policy Institute

Kara Hill
Director, Integrated Health,
Mental Health America-Houston



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Break / Networking / Exhibits

Exhibit Hall across the walkway through the front entrance of the Auditorium

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Breakout Sessions

Breakout Session #1 – Auditorium

Employers and Health in the Community

Breakout Session #2 – First Floor, Room #106

Evidence-Based Navigational Support

Breakout Session #3 – Second Floor, Room #280 (Lecture Hall)

Navigating to Value in Cancer Care

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Breakout Session

CTB 1 – Employers and Health in the Community

Elena Marks
President & CEO,
Episcopal Health Foundation

Brett Perlman
CEO,
Center for Houston's Future

Trudy Krause
Associate Prof. of Management, Policy & Community Health,
UT School of Public Health

Dan Burke (Moderator)
Benefits Director,
Turner Industries

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Panelist Slides

CTB 1 – Employers and Health in the Community

Brett Perlman
CEO,
Center for Houston's Future

CENTER FOR HOUSTON'S FUTURE

Houston Health Equity Innovation Cluster Initiative

October 18, 2021

Center for Houston's Future

- Center for Houston's Future (CHF) works to address matters of highest importance to the long-term future of the greater Houston region, by engaging diverse leaders, providing impactful research, and defining actionable strategies. We bring business and community together to innovate for the future of the greater Houston region. CHF is an organization devoted exclusively to thinking and acting strategically for the long-term future of the Houston nine-county region.

- Three program areas provide a framework for accomplishing its mission:
  - Strategic Planning (Health Care, Energy Transition, Immigration)
  - Business/Civic Leadership Development
  - Community Engagement

- Through our research work we identified the concept of a "Health Equity Innovation Cluster". We have applied for a federal grant to support this work with UTHealth as the lead, UH College of Medicine as a partner and 30 regional institutions as coalition members.

Health Equity Innovation Cluster Initiative

- **The Houston region has a health care "plenty paradox":** A large health sector but a high number of individuals with chronic conditions who lack access to health care services. These resources and needs can fuel a new industry cluster focused on both improving the health care delivery systems and addressing health equity issues.

- **Pandemic increased urgency and accelerated transformation of health care**. The pandemic disrupted health care and, in doing so, created the space for new innovative delivery approaches and increased the level of urgency to address health equity issues.

- **Focusing on underserved populations provides an opportunity to innovate** in health care delivery since the needs of these groups are unlikely to be addressed by traditional approaches to health care delivery innovation

- **3 projects focused on scaling existing programs:** Many elements to develop a new health care delivery model already exist and are ready to be scaled (examples include: new models for value based care, such as the UH Direct Primary care model and new models for providing community based services such as EFH's maternal health pilot project, etc.) while others (such as the Texas All-payor Claims Database for better population health analytics or the Community Information Exchange to extend the Houston Health Information Exchange to address social determinants) still need to be developed.

- **Strong support from Houston's anchor institutions**: Health care institutions, social service agencies and the business community are key partners in developing this new health care delivery model.

Health Equity Cluster – 32 Participating Organizations including 4 Major Hospital Systems, 13 Health & Community Services, 6 Health IT Groups, 3 Universities, 2 Government Entities

Category	Type	Organizations
Health	Health Care Organizations	MD Anderson, Memorial Hermann, HCA Houston Healthcare, Houston Methodist Hospital, Texas Children's Hospital, UTPhysicians
	Health Care Payors	United HealthCare, Community Health Choice, Cigna
	Health Services Organizations	Accountable Communities, City Health Department, City of Houston Health, Grand Aides, Harris County Public Health, Network of Behavioral Health, UH Healthy Start
	Mental Health Service	Houston Path Forward, The Harris Center- Mental Health
Health IT	Health IT Organizations	Greater Houston Healthconnect, PCIC, Texas Health Institute, The Institute for Health Policy, UT Center for Health Data, UT School of Biomedical Informatics
Community	Community Service	American Heart Association, Brighter Bites, CCPPI, City of Houston Complete Communities, Houston Food Bank, March of Dimes, United Way
	Academic Organizations	Texas State University, University of Houston Public Health, University of Houston College of Medicine, UTHealth
Economic	Employer Organizations	Greater Houston Partnership, Houston Business Coalition on Health
Government	Economic Development Organization	Houston Galveston Area Council (H-GAC)
	Local Government	Mayor Sylvester Turner

Health Equity Cluster – Creating a New Health Delivery Model

	Description	Programs
 **Layers of engagement** System of consumer and patient engagement (e.g., search, wearables, e-commerce, behavioral health aps, loT)	• Build out workforce development paths with Health Equity focused training of Community Health Workers, Nurses and Doctors • Build range of tools for neighborhood community health (broker and facilitate funding and collaboration)	• Training and capacity building • UH DPC / Grand Aides / Pathways HUB / Complete Communities • HERO – Health Equity Resource Organization
 **Layers of intelligence** Systems to covert data elements into insights and intelligence to inform or drive actions	• Leverage Linder and Kinder Survey structure to create sight-lines into the community • Leverage Health Data sources through data analysis to benchmark and monitor key indicators • Identify goals and evaluation metrics and create dashboard	• Community Survey – HHS • Build Data Analysis Capability across health systems • Develop Evaluation Metrics & Dashboard
 **Layers of infrastructure** Systems to data capture, curation management, and interoperability	• Extend health information exchange (HoustonHealthConnect) to support a warm handoff between medical providers and social service agencies • Identify and implement funding model to ensure sustainability	• Connecting Health Data Systems • Business Model and Sustainability

Health Equity Cluster - Benefits to Business Leaders

Layers of engagement

Layers of intelligence

Layers of infrastructure

Benefit to Business Leaders

- Improve community health
- Reduce cost of medical care
- Increase employee productivity
- Visibility into employee community need

Opportunity for Business Leaders

Financial

Hire local: training programs

Buy local: smaller contracts

Invest local: small business loans, training grants

Donate local: targeted community contributions

Policy

Support policies aimed at SDoH in your community

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On-site / Near-site Clinics as Primary Care Hubs

Scott Conard, MD, DABFP, FAAFM (Moderator)
CEO,
Converging Health

Donna Gibson
Staff Vice President, Associate Benefits, Anthem

Krista Williams
Associate Vice President, Operations, Premise Health

Kristin Wade, RN, MSN, CMPE
COO Affiliate & Clinical Operations, Baylor College of Medicine

Jeff Wells, MD
CEO & Co-Founder, Marathon Health

Johnathan Markert
Total Rewards Global Advisor, bp

Panelist Slides

On-site / Near-site Clinics as Primary Care Hubs

Scott Conard, MD, DABFP, FAAFM (Moderator)
CEO,
Converging Health

Developing A Corporate Primary Care Strategy

Scott Conard, MD, FAAFP
Founder of
Converging Healthcare Data Analytics and Care Transformation

Absolute Risk

(Not Modifiable)

- Medical Conditions
- Complexity of Care
- Toxicity of Care

Quality of
System S

are
f Care
ness of
ns

Every Individual A Score

Healthcare
Utilization

How They Use the System

pecialist vs PCP Care
lary Care Utilization

- Adherence/Compliance w Meds/Care

114


Low Risk: High Cost
Most will get well over the course of a year
Pregnancies, Appendectomy, Gall Bladder, Accident, ER Visit
1 – 2% Members – 2 – 4% Spend
High Risk: High Cost
These are the sickest-will get well, die, retire, reduce spend, or continue to be high spend
Heart Attack, Stroke, Cancer, Substance Abuse, Inpt Mental Health, MSK Surgery
8 – 10% Members: 80% of Spend
Low Risk: Low Cost
These are the Healthy – Keep them Healthy
Immunizations, annual exams, preventive screenings
55% Members: 6 % of Spend
High Risk: Low Cost
These are the High Risk – Get them into Primary Care!!
Metabolic Syndrome, HTN, DM, Plaque, Anxiety, Depression, Early Cancer
35% Members: 10 – 12% of Spend
Last 12 Months Spend
Clinical Risk Score

115

Last 12 Months Spend

Specialists & Facilities = 10%

Primary & Mental Health Care = Prevention & Pathways = 90%

Clinical Risk Score

116

Improving Health Care Value with Advanced Primary Care

What makes primary care "advanced" primary care?

1 Enhanced Access for Patients
Convenient access, same day appointments, walk-ins, virtual access, no financial barriers to primary care

2 Disciplined Focus on Health Improvement
Risk stratification and population health management, systematic approach to gaps in care

3 More Time with Patients
Enhanced patient engagement and support, shared decision-making, understanding preferences, social determinants of health

4 BH Integration
Screening for BH concerns (e.g., depression, anxiety, substance use disorder) and coordination of care

5 Organizational & Infrastructure Backbone
Relevant analytics, reporting, reporting and communication, continuous staff training

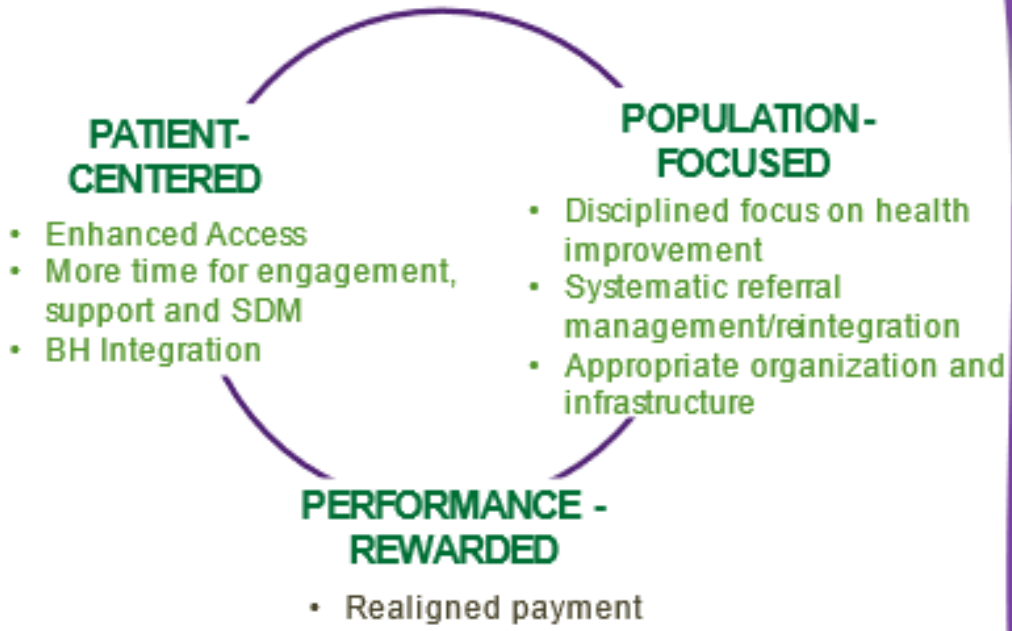
6 Referral Management
More limited, appropriate and high-quality referral practices, coordination and reintegration of patient care

7 Realigned payment methods
Patient-centered experience and outcomes, quality and efficiency metrics, deemphasize visit volume

The Promise of APC

Improve and Increase
Health, patient engagement, satisfaction, personalized and holistic care

Reduce
Unnecessary care and referrals
Urgent care, ER visits, and hospitalizations
overall reduced total cost of care



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Krista Williams
Associate Vice President, Operations, Premise Health

Premise Health

Get to Know Premise Health

Krista Williams, AVP, Operations, Premise Health

Our Vision

To be the premier direct healthcare company in the world

Dedicated – Proactive – Primary – Comprehensive – Aligned

Our Mission

To help people get, stay and be well

Our Values

Providing high-quality, tech-enabled, personal care that is focused on health improvement and an exceptional member and client experience

Courageous – Engaged – Innovative – Accountable – Quality-Focused – Respectful – Ethical

SIZE AND SCALE

11M+ eligible members

800+ wellness centers

45 states and Guam

EXPERIENCE AND VALUE

94 net promoter score

95th percentile HEDIS

29% claims-based savings

Premise Health.

Total Population Care for Optimal Outcomes

Digital Wellness Center

Delivered by centralized care teams, virtually, for non-proximate and proximate (after hours) populations

Physical Wellness Center

Delivered by local care teams, virtually or in person, for proximate populations

24/7 Convenience / **Centralized** / **Nationwide**

30+ Products / **Local** / **Familiar**

Premise Health.

Over 30 Healthcare Products and Growing

More integrated care than any other direct healthcare company

Primary Care

Condition Management
Dental
Pandemic Readiness
Vision
Women's Health

Pharmacy

Clinical Pharmacy
Provider Dispensing

Connected Care+

Care Management
Care Navigation
Care Consult
Care Excellence

Behavioral Health

Occupational Health

Case Management
Ergonomics
Injury and Illness Care
Medical Surveillance

Musculoskeletal

Acupuncture
Chiropractic
Massage
Occupational Therapy
Physical Therapy

Fitness

Wellness

Biometric Screenings
Nutrition
Wellness Coaching
Wellness Program Management

Premise Health.

Our Approach to Care

Premise Health.

Why Traditional Healthcare Doesn't Work for Organizations

Member Engagement

Fragmented Solutions

Misaligned Incentives

Premise Health.

Why Traditional Healthcare Doesn't Work for Members

Barriers to Access

Disconnected Experience

Variable Cost and Quality

Premise Health.

Next generation primary care

Different on purpose

Fully integrated, full-spectrum care

Over 30 care products

Barrier-free access anywhere, anytime, in every form

Flexible for clients and members

Clients can customize their care mix to **meet total population needs**

Members have **access to multiple care products**

Lifestyle medicine

Holistic, whole-person, wellness-focused approach

Seamless experience

Secure and fully integrated member portal

Results in a **single point of provider contact** for a coordinated, unified care plan across multiple products or specialists

Addressing social determinants of health

Connect members with support services and community resources when and where they need it

Premise Health.

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COO Affiliate & Clinical Operations,
Baylor College of Medicine

Baylor College of Medicine

Kristin Wade, RN, MSN, CMPE

Chief Operating Officer of Affiliate & Clinical Operations

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Closing Comments

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Post Reception

Hilton
HOTELS & RESORTS

(Within Walking Distance)
9th Floor, Rooftop Bar