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5 lessons on launching a provider-sponsored health plan

Market trends are shifting to enable increased adoption of provider-sponsored health plans (PSHPs), often through strategic partnerships.

AT A GLANCE

Health systems with plans to launch provider-sponsored health plans should take five lessons from organizations that have excelled in pursuing such a strategy:

- Use data analytics to identify where best to focus care management efforts.
- Prepare for sustained losses in the first years after implementation.
- Create programs tailored to meet the needs of specific populations.
- Seek ways to partner with the health system's clinical team in developing high-value interventions.
- Invest in high-touch, high-tech solutions for member engagement.

As leading health systems begin to enjoy success in launching provider-sponsored health plans (PSHPs), the potential benefits of health plan ownership are coming into focus. Lessons learned from health systems that have succeeded in the area can serve as a guide to others that have struggled with finding the best way forward. Health systems that have navigated the PSHP terrain can show the way by illuminating the key challenges in operating a PSHP and pointing to the capabilities required for success.

Shifting health system interest in PSHPs

Interest in launching a PSHP has waxed and waned among U.S. health systems in recent years. By 2017, more than 100 health systems provided coverage to about 18 million members through PSHPs.^a It seemed that PSHPs might become the new normal, altering health systems strategies and enabling them to capture market share. Yet struggles to grow membership profitably caused excitement to dim for many health systems.

Today, however, interest in PSHPs has been rekindled in part by health systems' growing discontent with alternative "payer-provider partnerships." Over the past three years, the paucity of payer-provider collaborations that have successfully built true joint-risk models has caused many health systems to reconsider their health plan strategies.

a. Meinkow, E., "Provider-sponsored risk: Where are you on the journey?" infographic, Navigant, Jan. 16, 2017.

It is expected that many of the plans entering the Medicare Advantage (MA) market in the next two years will be PSHPs.^b Among executives of leading health systems responding to a 2018 survey, 27% anticipate launching an MA plan and 29% are confident in their systems' ability to do so.

Meanwhile, a recent risk-readiness survey also finds emerging interest in PSHPs:^c

- Among provider leaders surveyed, 72% (i.e., 86% of health system respondents and 66% of hospital respondents) plan to assume additional risk, including sponsoring a health plan, in the next one to three years.
- One-in-five respondents say they plan to assume risk by launching a PSHP.
- One quarter of respondents are already part of a PSHP.

(For additional discussion of the factors driving renewed interest in PSHPs, see the web-exclusive sidebar, "Providers explore new territory with health plan ownership," included with the online version of this article at hfma.org/hfm.)

How leading health systems are navigating success

Health systems that have successfully launched PSHPs invariably have already addressed capabilities and competencies needed to start a PSHP (see the sidebar on page 3.)

Here, we offer lessons learned from four health systems that are beginning to realize real benefits from their PSHP strategies.

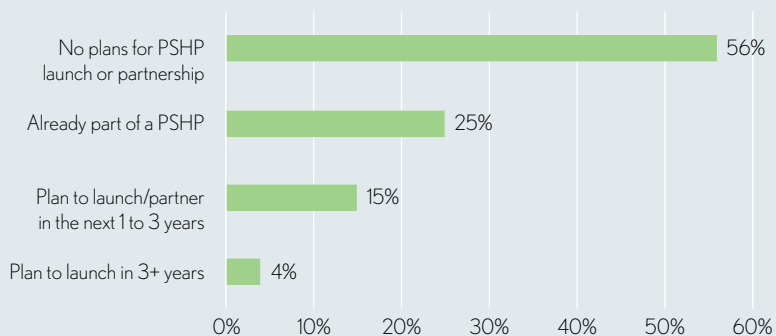
Lesson No. 1: Use data analytics to inform your approach. Optima Health, the health plan division of Sentara Healthcare, a 12-hospital system based in Norfolk, Va., uses artificial intelligence to identify members who are at high risk of developing sepsis.

b. Daly, R., "Provider interest in MA plans surges," HFMA News, Feb. 27, 2019.

c. HFMA/Navigant survey, "Providers prepared to increase risk model participation," infographic, June 19, 2019.

GAUGING HEALTHCARE ORGANIZATIONS' PSHP READINESS

Survey question: What are your organization's plans related to launching or partnering on a provider-sponsored health plan? (n = 116)



Source: "Provider Risk Readiness Report: Navigant/HFMA Survey," June 2019.

The health plan's approach has:

- Significantly improved accuracy of risk detection
- Reduced redundant nursing staff screenings by 70%
- Decreased manual screening hours by up to 72% while ensuring patients at risk receive the care they need more quickly

Meanwhile, use of data analytics has enabled the health plan to identify unnecessary emergency department (ED) encounters, realize opportunities for millions of dollars in ED savings and develop protocols, including patient education, that help ensure the right care is delivered at the right time.

"We're just beginning to understand the potential to improve quality of care and member relationships through data analytics and artificial intelligence," says Howard P. Kern, president and CEO, Sentara Healthcare. "Having a provider-sponsored health plan gives us a much richer view of the data needed to drive improvement."

Among other leading PSHPs that also leverage data analytics to design care management services that focus on the areas of greatest impact is Danville, Pa.-based Geisinger Health Plan. Care

What to know before rolling out a PSHP

Health system leaders interested in rolling out a PSHP should be aware of the following considerations:

- Start with a clear sense of the outlook for the PSHP.
- Know the steps to take to ensure the success of such an effort.
- Recognize that the capabilities and competencies needed to start a PSHP are significant, and that they often fall outside healthcare leaders' traditional skill sets and the organization's cultural predisposition.
- Understand substantial investments in capital and talent acquisition, data analytics capabilities and care management are required, as well as the structural changes to align interests equitably on the payer and provider side.

managers at the PSHP work with 15% to 20% of the health plan's Medicare population — a much higher percentage than under traditional payer models, where care management typically is limited to the top 5% of the highest-cost Medicare members. The results have been outstanding: Efforts to lower acute inpatient stays have reduced costs by 19% per member per month (PMPM).

“If you want to reduce PMPM costs, you need to know where your costs are coming from, and that varies by line of business and whether the plan is commercial, Medicare or Medicaid,” says Janet Tomcavage, RN, MSN, chief population health officer for Geisinger Health Plan. “In a Medicare population, most of the costs are coming from hospital admissions, ED visits and post-acute care. If you can prevent the inpatient admission, you'll also prevent a skilled nursing facility admission. The impact on cost is significant, since an avoided hospital admission for a Medicare patient saves on average around \$12,000. If the patient has more complex medical conditions, that amount could increase to \$18,000 to \$20,000.”

Lesson No. 2: Be prepared to sustain losses in the first years after implementation. Given the amount of investment in talent and infrastructure required to support a health plan, the enrollment

thresholds required for success and the challenges associated with managing the health of complex populations, health systems should plan for the time it will take to get such a large undertaking up to scale and fully operational.

“Until you've built sustainable scale, you have to accept that for a number of years, you're going to have losses,” Kern says. “Many health system leaders think, ‘I'm going to get a health plan, and it's going to be great. I'm going to make money, and I'm going to improve health outcomes.’ They overpromise results to their board. As a consequence, when the health plan experiences losses, they are greatly disappointed, and they end up losing trust. They get a lot of pressure to dump everything and exit.”

Kern notes that Optima Health lost money the first 12 years after the health plan was launched. “We learned a lot of hard lessons those early years,” he says.

Lesson No. 3: Create programs tailored to meet the needs of specific populations. Presbyterian Health Plan, part of Presbyterian Healthcare Services in New Mexico, offers home-based care for high-need Medicare Advantage (MA) members and Medicaid members with serious illnesses and functional decline who are at risk for long-term institutional care. The goal of this program, called Complete Care, is to focus on the 5% of members who account for 50% of total medical costs.

Complete Care uses a multidisciplinary care team and wrap-around approach to care, including:

- In-home access to primary care
- Same-day urgent care
- Foot care (critical for members with diabetes facing high risk of amputation)
- Limited spectrum of acute care services, such as X-rays, lab collection and vaccine administration
- Social support and palliative care as needed

Complete Care began as a home-based program and expanded in 2018 to include an outpatient

Presbyterian Health Plan in New Mexico offers home-based care for high-need MA and Medicaid members who are at risk for long-term institutional care.

clinic. Its approach is designed to reduce costs of care while helping members achieve their quality-of-life goals.

“Complete Care’s readmission and hospitalization rates are less than expected for this population,” says Sharon L. Fletcher, PhD, MBA, president of Fluent Health, a subsidiary of Presbyterian Healthcare Services that leverages Presbyterian’s 30 years of managed care experience to partner with providers seeking to start or strengthen their PSHPs. “Not only does this represent a significant decrease in costs, but also a seamless care experience,” Fletcher says.

At Optima Health, MA members are concentrated in specific medical practices that are uniquely positioned to meet the complex care needs of MA patients, including patients with multiple chronic conditions and behavioral health needs.

“We’ve found that when the MA population is spread too broadly, we’re unable to achieve the same level of effectiveness as when these members are directed to practices that are finely attuned to working with MA members,” Kern says.

Kern cites two other keys to success in managing MA members’ health:

1. The use of extensivists who can extend care for MA members outside traditional care settings, such as the home or assisted living facilities.
2. The addition of specialized coding staff within MA-focused practices.

Lesson No. 4: Seek ways to partner with the health system’s clinical team in developing high-value interventions. At Presbyterian, the health plan

pharmacist has collaborated with the care delivery team to promote the use of highly effective, cost-efficient prescription drugs, thereby lowering medication costs and driving positive member outcomes. Such innovative approaches are critical given that Americans spent \$535 billion on prescription drugs in 2018, while rate hikes in 2019 average 6% for more than 1,000 medications.^d

“Over 90% of our physicians now prescribe more cost-effective medications to our members,” Fletcher says. “We’ve focused on diabetes, hepatitis C and growth-hormone drugs to establish best practices in prescribing that improve care while reducing costs.”

Through collaboration with clinical pharmacists, physicians and other Medicaid health plans, Optima Health has developed opioid prescribing interventions that have reduced opioid prescriptions by 43% since October 2017. Today, 30% fewer members receive prescriptions for opioids, which is a potentially life-saving improvement, given the addictive nature of these drugs and the nation’s opioid epidemic.

Lesson No. 5: Invest in high-touch, high-tech solutions for member engagement. At a time when tech-enabled MA startups are clamoring for enrollees, PSHPs are compelled to tightly hone their member-engagement strategies, including the use of digital tools that help members manage their health and the cost of their care.

d. Picchi, A., “Big pharma ushers in new year by raising prices on more than 1,000 drugs,” CBS News, Jan. 2, 2019.

Providers explore new territory with health plan ownership

There is renewed interest among U.S. health systems in launching provider-sponsored health plans (PSHPs), despite the rocky start that many organizations experienced with this strategy over the past decade. New factors and circumstances have emerged to create an environment much more conducive to success.

Historical perspective

Health systems that were first to test the PSHP waters shared one thing in common: They were pioneers embarking on a bold strategy, with hard-to-predict challenges ahead. Not surprisingly, from 2010 to 2017 there were more failures than successes.

Plans that had little understanding of the levers required for success. Often, their leadership had limited experience in running a health plan. As a result, PSHPs largely were encumbered by low margins and unrealistic expectations. They faced challenges in understanding how to effectively manage utilization and drive greater efficiency as their organization operated in a largely fee-for-service environment. They also struggled to meet enrollment thresholds that would better position them for success, largely because they didn't have the scale to price premiums lower than their competitors.

Some PSHPs also lacked the analytical capability to extract insights from claims data to stratify and manage member populations. This led to their revenue suffering because of their limited ability to demonstrate to Medicare that certain enrollees were more expensive to cover. Most PSHPs also were not highly skilled in negotiating rates and establishing truly high-performing, quality-driven networks.

These and other factors put these plans at a competitive disadvantage relative to

large commercial plans. Just four of the PSHPs launched from 2010 to 2015 posted a profit in 2015, while some recorded heavy losses and five went out of business.^a

Given the tremendous challenges confronting healthcare organizations that wish to take on a PSHP, what accounts for renewed and emerging interest? Key factors include the following.

The example set by leading health systems

Successes of leading PSHPs prompt leaders to ask, "What if?" In 2016, Geisinger Health Plan, founded in 1984, made a bold promise: If its members weren't happy with the quality of care or service they received, they could receive a refund of up to \$2,000 in out-of-pocket costs. Geisinger's success as a PSHP

— including a 28% decrease in emergency department visits for congestive heart failure patients, a 13% decrease in total health spending among Geisinger Health employees and a 19% decrease in per-member-per-month costs through reduced acute inpatient stays — positioned the health plan to stand by its guarantee of a phenomenal patient experience.^b

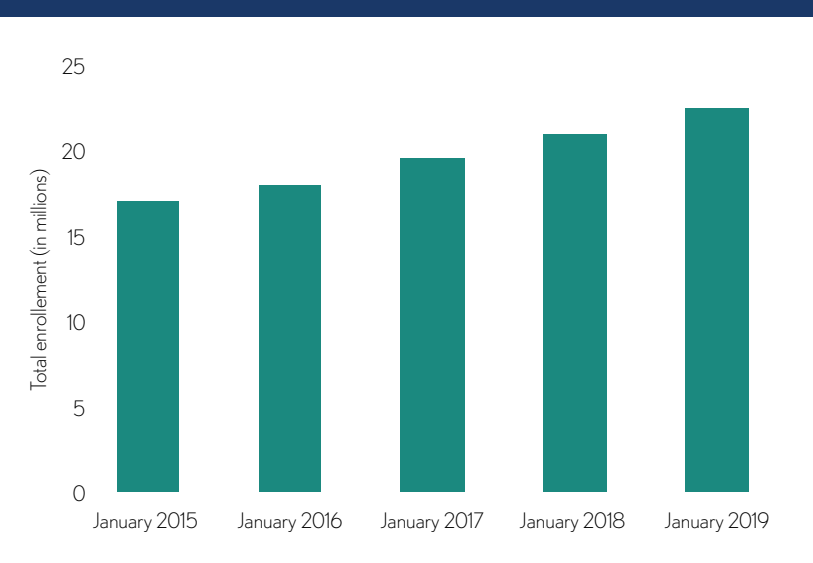
A surge in enrollments in MA plans

Managing a Medicare Advantage (MA) population is considered key to success at a time when one-in-six Americans will be age 65 or older by 2020 and margins for these plans average 4% to 5%. Beneficiaries that grew up with and are used to managed care are now aging into and more willing to sign up for MA. As a result, one-third of Medicare enrollees are

a. Baumgarten, A., *Analysis of Integrated Delivery Systems and New Provider-Sponsored Health Plans*, Robert Wood Johnson Foundation, June 2017.

b. Venkataraman, R., "Geisinger Health Plan's Commitment to Heart Health," AHIP blog, Feb. 15, 2018; and Navigant, *Building Payer-Provider Partnerships for Care Management*, October 2018.

MEDICARE ADVANTAGE ENROLLMENT CONTINUES TO CLIMB



Source: CMS.gov, "Monthly contract and enrollment summary report," Medicare Advantage/Part D contract and enrollment data.

currently covered under MA plans, and half of Medicare enrollees could be in an MA plan by 2023. Meanwhile, policy changes have made MA plans more attractive to administer.

Health systems' interest in MA plans also are being fueled by regulatory changes such as the phase-out of Medigap plans, a final rule that expands access to telehealth as a basic benefit for MA members in 2020, Medicare initiatives that have slowly pushed providers into risk-bearing arrangements and continued bipartisan support that has led to annual increases in revenue funding. Among not-for-profit hospitals, in particular, MA plans offer the opportunity to drive increased revenue while providing seniors with new opportunities for care.

Discontent with payer-provider partnerships

Among respondents to a recent survey, 56% of health systems and 48% of hospitals say they have faced barriers to collaboration with national and local payers in their market.^c Nearly one-third cite lack of alignment in goals or strategies as a barrier to collaboration. One-in-four say challenges around data sharing and transparency hold them back from payer-provider partnership.

These barriers to partnership come at a time when commercial and government payers, as well as employers, are ramping up efforts to shift financial risk to healthcare organizations. The move toward value-based payment models, with penalties for high readmission rates and low scores on quality and cost of care, poses significant financial and reputational risk for hospitals and health systems. Among the competencies it requires are care coordination, network design and administration, contract negotiation and

c. HFMA/Navigant survey, "Providers Prepared to Increase Risk Model Participation," Infographic, June 19, 2019.

performance measurement. Because these competencies are similar to those required to sponsor a health plan, some healthcare boards and leaders are exploring whether their organizations could reduce reliance on commercial payer contracts through health plan ownership.

Impact of health plan consolidation on hospitals and health systems

Health insurers are again rapidly consolidating, with Centene's planned acquisition of its rival, WellCare, strengthening its position in the Medicare managed care market. A 2018 American Medical Association study shows half of all health insurance markets are now highly concentrated.^d Competition levels dropped in health insurance markets across 25 states, with Anthem holding the position of the largest insurer in more metropolitan statistical areas than any other insurer. The result: an increase in consumer premiums for healthcare insurance, according to economists, and more limited contracting power for providers. Increased premiums also can prompt consumers to forgo health insurance and delay needed healthcare services, heightening the potential for bad debt when they do seek care.

To compete in an era of disruption, new PSHPs must develop bold strategies that redefine what it means to manage member health. Both providers and health plans should pay attention to the innovations of technology-led disruptors like Oscar Health and Devoted Health, which are poised to reshape the consumer experience for MA enrollees.

Oscar Health. Backed by \$1.3 billion in funding, including private equity and venture fund capital, Oscar will enter the

d. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, American Medical Association, American Medical Association, Nov. 28, 2018.

MA space in 2020. The company uses technology to simplify the healthcare experience, with apps that enable members to consult with a physician at any time, get prescriptions without leaving home, track their health history and earn incentives for healthy behaviors. Oscar was one of the first companies to offer telemedicine services free of charge to members.^e The company also offers concierge care teams and the ability to book appointments from a mobile device and continually uses data analytics to design new services. While Oscar currently serves individuals and small businesses in 10 states, its expansion into the MA market could position the plan to become the "Uber of healthcare."

Devoted Health. With \$300 million in venture capital funding in 2018, Devoted has become what it calls "a payvidor": managing the cost of member care, partnering with providers to provide the right services at the right time and launching its own healthcare services — including a medical group that makes member house calls. Devoted also uses data science to determine the highest-value providers in the communities it serves and direct members to those providers. Its goal: to make healthcare more personal and less fragmented for seniors.^f

These moves require that health systems think carefully about how they will compete with disruptors before launching a PSHP, including what investments they are willing to make to support a technology-enabled member experience and how the PSHP will engage physicians in providing complex populations with a member-centric experience.

e. Thompson, N., "Health Care Is Broken. Oscar Health Thinks Tech Can Fix It," *Wired*, Aug. 14, 2018.

f. Tindera, M., "Devoted Health, New Medicare Advantage Business, Raises \$300 Million," *Forbes*, Oct. 16, 2018.

SelectHealth, the PSHP for Intermountain Healthcare in Salt Lake City, partnered with a vendor to develop a mobile pharmacy benefit app that helps members save money on their prescriptions.

SelectHealth, the PSHP for Intermountain Healthcare in Salt Lake City, partnered with a vendor to develop a mobile pharmacy benefit app that helps members save money on their prescriptions. The mobile app provides information around:

- Drug prices and potential lower-cost alternatives
- Medications covered by the plan
- Tier statuses of prescription drugs
- The member's prescription copays and benefits
- Maintenance drugs
- Explanation of benefits for the members' drug claims
- Preauthorization and step-therapy requirements
- Participating pharmacies

"The most effective tools enable members to do things themselves, such as schedule appointments with specialists, check their prescriptions and transfer records," says Eric Cannon, PharmD,

FAMCP, associate vice president of pharmacy benefit services for SelectHealth.

A revitalized opportunity

After briefly seeming to lose steam, PSHPs are coming around again. This time, health systems that plan to launch a PSHP for the first time have the benefit of drawing from other providers' experiences to design their approach. ■

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