Beth Israel Deaconess
CARE ORGANIZATION

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HARVARD MEDICAL SCHOOL
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Provider Strategic Responses to a Changing Coverage Landscape

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Agenda

- About BIDCO
- Payment model evolution
- Health plan market changes
- Discussion

About BIDCO

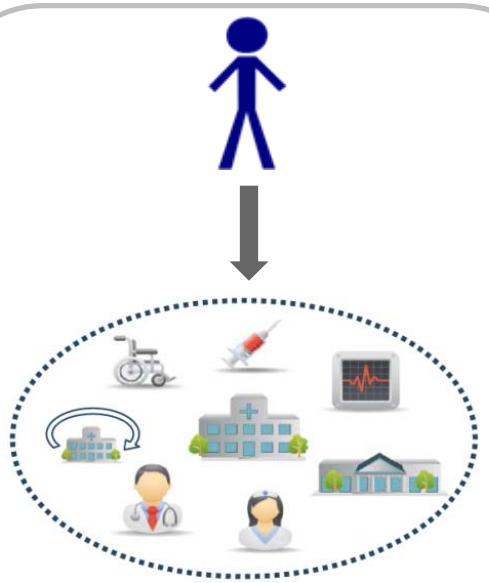
- BIDCO is a value-based, physician and hospital network and an Accountable Care Organization (ACO).
  - Located in Westwood, Mass.
  - Employs more than 80 staff members
  - Contracts with 2,400 physicians, including 550 primary care physicians and more than 1,800 specialists, and seven hospitals
  - Contracted by Centers for Medicare and Medicaid Services (CMS) as a Pioneer ACO
- Our highest level goal is to promote the best quality and value of care to patients, providers, health insurers, and employers.

Factors influencing creation of BIDCO

- Local and national pressure on cost containment
  - Chapter 224
- Movement to value-based purchasing and alternative payment models
  - CMS Pioneer ACO program
  - New CMS penalties
- Need to create alignment throughout continuum of care, particularly with PCPs and hospitals
  - Market consolidation

BIDCO as an ACO

- We offer physician groups and hospitals ways to effectively manage total medical expense (TME) and improve quality through:
  - Engaging in risk contracting
  - Engaging in a system of shared financial risk
  - Engaging with systems of population health management
- We currently manage approx. $1.3B in TME risk

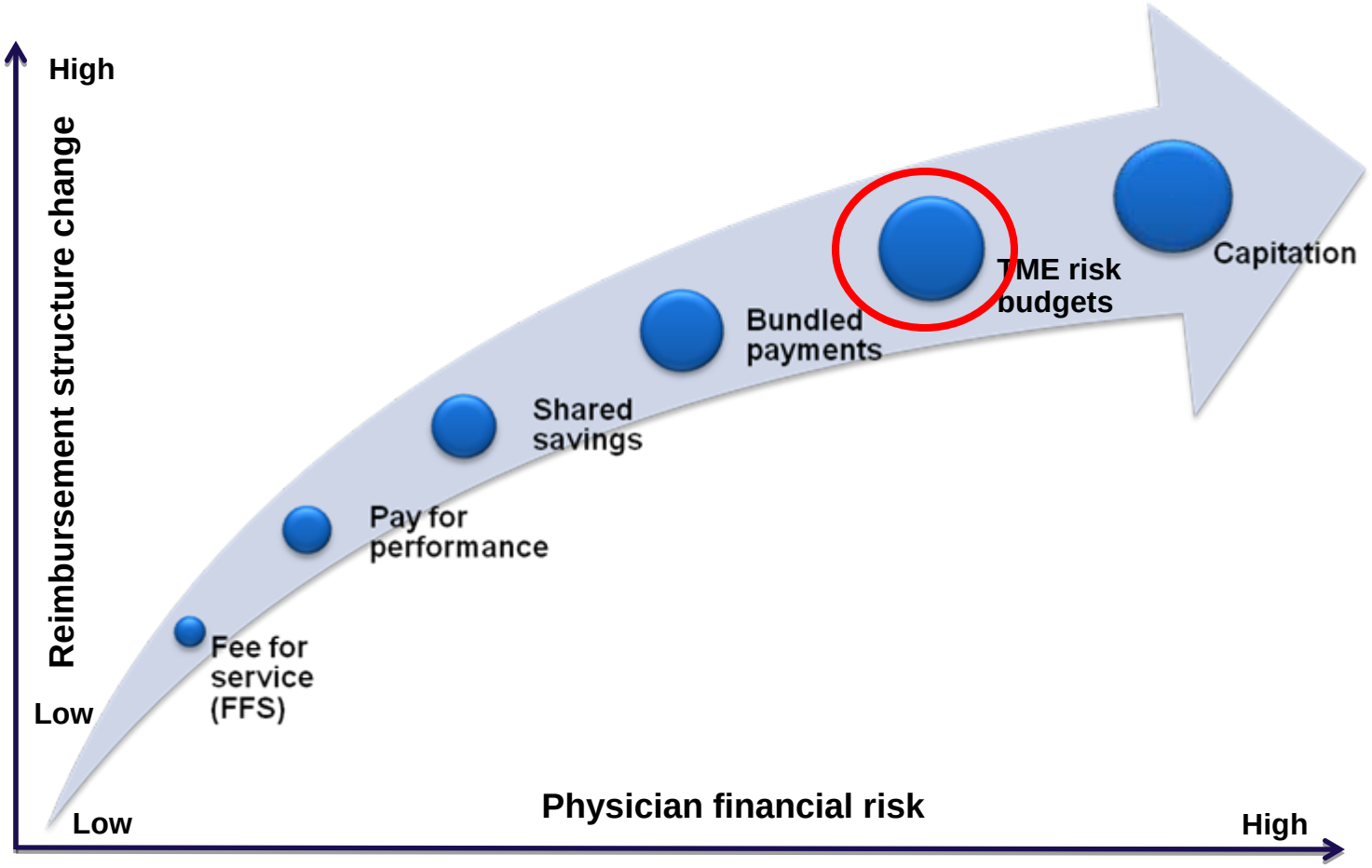


Goals
Improve quality
Manage total medical expense

Demonstrated success as a Pioneer ACO

- BIDCO was the top-performing Mass. Pioneer ACO in 2012 and 2013, third best nationally in 2013
  - 2012 beat budget by 4.2%
  - 2013 beat budget by 3.9%

Value-based contracting continuum



Source: athenaHealth

Straddling two worlds: FFS vs. value-based payments

- Having a foot in both worlds can create provider angst
- Angst is, arguably, often about the need for overall change — not true competing incentives
- This “conflict of two worlds” is also greater/lesser based on the participant

Changes in incentive for volume generation: FFS vs. value-based payments

	Primary care providers (PCPs)	Specialists	Hospitals
Fee-for-service (FFS)	H	H	H
Value-based payments	H	L	M

Transition from FFS to capitation

PCPs	Specialists	Hospitals
• Still about volume, different lens • Volume driven by need to see patients to achieve quality measures and not get care elsewhere	• Not affected in current BIDCO model, no "skin in the game" • This is a gap we must fix to succeed	• Most torn; focus on volume to see patients to hospital capacity, however, focus has transitioned to seeing the *right type* of patients

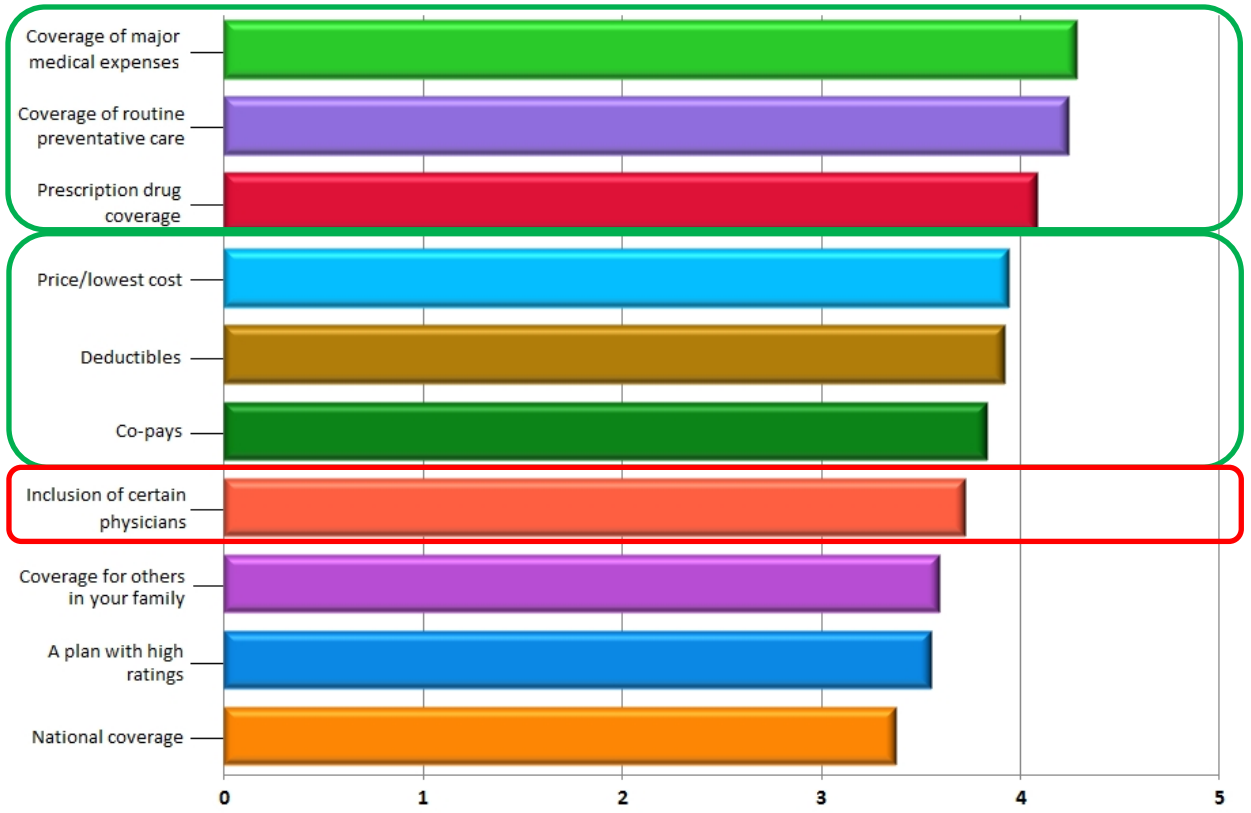
Evolution of the payor market

What market forces are at play in reshaping the payor market landscape?

- Changes in the way consumers purchase care
  - State and national health exchanges!
    - Few consumers access care through employers
    - Consumer-directed health care
- Emergence of alternative payors
  - Consumer co-ops
  - Provider-sponsored health plans
- Increased competition
  - Lower cost, value-based care
    - Limited network products

Patient choice

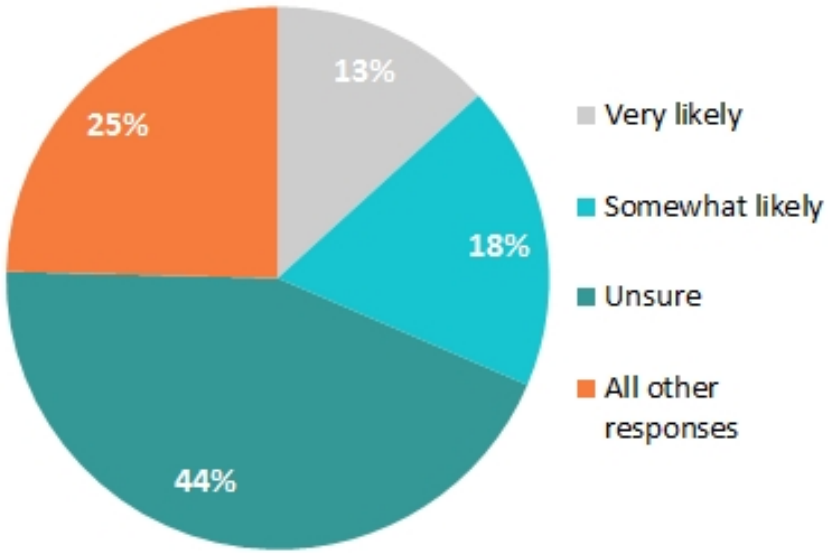
- Top-10 important factors for consumers when selecting health insurance



Source: Valence Health survey published in Accountable Care News, November 2013

What are patients' impressions of provider-sponsored plans?

- 31.5% of respondents very or somewhat likely to shift to local hospital or health system plan
  - 23% said hospital-sponsored plans would be less expensive, higher quality
  - 39% said provider-sponsored plans would offer more coordinated care



Source: Valence Health survey published in Accountable Care News, November 2013

The historic health plan business model are destined to change

- As more and more medical expense risk is pushed to ACOs, the health plan business model faces existential threats
- Traditional core components of current health plan business model will change
  - Primary relationship with customer source
    - Employers, government
  - Contracted provider network
    - Generally a “willing provider” model of participation
  - Licensed provider of qualified products
    - Hold reserves for TME liabilities
  - Source of value in generating TME savings to pass onto customers
    - Part of brand promise
- These core components have allowed health plans to generate great financial success with swift tools to correct margin erosion
  - Increase prices

High-performing ACOs now look more like health plans

- High-performing ACOs are quickly gaining tenured experience managing value-based payment risk
  - Growing scale of participating doctors and hospitals
  - Leveraging claims and EHR data to deploy sophisticated cost management tools
  - Exceling in managing patient outcomes through a cadre of population management approaches, such as:
    - High-risk case management
    - Telemedicine
    - House calls medicine
    - Disease management
    - Wellness and disease prevention

Therefore, ACOs are now well positioned to penetrate the health plan market space

- ACOs in the health plan market will disrupt health plans' value equation and customer source
  - ACOs will develop and put Qualified Health Plan (QHP) offerings on the exchange
  - ACOs will do business directly with government via Medicare and Medicaid ACOs
  - Employers will move from Defined Benefit Model to Defined Contribution Model
  - ACOs will conduct direct business with customers buying insurance on the exchange

What are the historic barriers to entry in the health plan market?

Barrier	Health plan control/competency
Distribution source	Primary relationship with customer source
Supplier network	Contracted provider network
Needed risk reserves	Licensed provider of qualified products (reserves to meet Department of Insurance RBC requirements)
Operational assets	Operational know-how/ claims engines

What happens when these forces converge?

- High-performing ACOs are largely prevalent in most markets
  - They are experts in managing total cost of care
  - They are large and have excellent competencies in sub-contracting for needed gaps in care continuum components
  - They are the trusted source of value in generating TME savings passed onto customers
- Health plans are disintermediated from customer source as employees will no longer need a health plan relationship to access a qualified benefit plan
  - Access to purchase product on exchanges
  - Defined contribution
- ACOs seek sources for reserves as a means to meet regulators licensure requirements
  - Or seek exemptions for government business
  - Unlike health plans trying to deliver on this value proposition, ACOs have the incentives and the control to get it done

How ACOs can erode traditional barriers to enter payor market

Barrier	Health plan control/competency	ACO
Distribution source	Primary relationship with customer source	Access customer through exchange, government, and direct to employer
Supplier network	Contracted provider network	Own the provider network, sub-contract for the remainder
Needed risk reserves	Licensed provider of qualified products	Build over time Seek exemptions Seek capital partner Seek a redistribution of existing health plan reserves
Operational assets	Operational know-how/claims engines	Build or buy

Questions and discussion