# Network Development and Evolution at Texas Health Resources

## Leadership Institute

### Millennium Group

10/18/17

# Objectives

Draft

- **Describe the evolution of Texas Health Resources' approach to physician network development**
- **Approach to assuming progressively more risk in contracting and in population health management**
- **Infrastructure development/challenges**
- **Cultural challenges along the way**
- **Lessons learned**

# Texas Health Resources Physician Network Evolution

Draft

- **Historical Market Context**
  - No Certificate of Need
  - Minimal Historic Clinical Physician Alignment with Health Systems
  - Highly independent and entrepreneurial physician market
  - Booming population
  - Booming economy
  - “Community Standards” that are very different from the rest of the USA
  - Very expensive relative to the rest of the USA; utilization > unit cost

# Texas Health Resources Physician Network Evolution

Draft

- **Historical Market Context (continued)**
  - Very little large group formation
  - Messenger Model IPAs and not much else
  - Isolated instances of physician-led acceptance of risk, almost exclusively Medicare Advantage
  - Minimal or no health system participation in risk contracts (or even value based contracts of any kind, for that matter)
  - “Pay, or I won’t play” attitude from most physicians, leading to:
    - Lots of JV activity (“a fraction of something vs. 100% of nothing”)
    - Huge commitments on call pay, medical directorships, “co-management”

# Texas Health Resources Physician Network Evolution

Draft

- **Phase One: Pre-2011**
  - Employment and ….
  - Grow the group to fill the beds
    - Focus on PCPs
    - Constant threat of losing core specialists to the competition leads to a rapidly growing specialty employment model
  - Build an infrastructure to make sure that the physicians compliantly get the patients into the beds
    - Navigation, navigation, navigation…group becomes 40% NPSR by 2016
  - Contracting strategy that embodies very little risk and leverages hospital rates at the expense of physician rates
    - Big practice losses

# Texas Health Resources Physician Network Evolution

Draft

- **Phase One: Pre-2011**
  - Medical group dives into MA “gainshare” program
    - Almost exclusively focused on RAF adjustment
    - Very successful
    - Upside only with Secure Horizons as only contract
    - Since THR didn’t play, the incremental revenue “was stackable”
  - Lots of outreach to independent physicians with very little uptake
    - Independent
    - Fee for service still lucrative even for the small practice, growing population
    - Very little dependence on governmental payors for many in the market
    - For the specialists, the JV facility still a really good revenue source

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Two: 2011-2014**
  - Very little change in the physician market other than the formation of Baylor Scott White and the creation of the Baylor Quality Alliance
  - Very little movement towards risk in the marketplace as the population continues to grow and the economy continues to bring a constant flow of high-paying, commercially insured jobs into the market
    - THR actively seeking more “value based” contracts, but there is little interest in the payor/broker/employer community
    - First hint of narrow networks starting to pop up
  - Upside only MA still fairly lucrative although changes to RAF methodology begin to eat into that value
  - Continued pressure to do specialist-based facility JVs, employment at significant premium to market

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Two: 2011-2014**
  - Pioneer ACO partnership with North Texas Specialty Physicians
    - "Purpose-built" IPA for governmental risk; had been in upside only arrangement with Secure Horizons MA and ran their own MA plan (5-10,000 lives)
    - NCQA certified managed care infrastructure to support UR/UM, network management
    - Two cohorts: 2011 cohort and 2012 blended cohort
    - 2011 cohort upside down in both 2011-12, but within shouting distance entering 2013 (< 1.0% loss on ~16,000 members)
    - 2012 cohort upside down by 5.9% on ~24,000 members
    - National benchmark "disadvantages" Texas market
    - Bailed out before the two-way risk model went into effect

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Two: 2011-2014**
  - Begin conversations in April, 2013 with University of Texas Southwestern Medical Center on affiliations opportunities
  - Commit in Summer 2014 to partner with UTSW in MSSP 1 ACO for 2015 using UTSW infrastructure
  - Commit in Summer 2014 to partner with NTSP in full risk MA with Secure Horizons for 2015 using NTSP infrastructure
  - Fall 2014 get a little bit sidetracked with Ebola Crisis

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Three: 2015-present**
  - Medicare ACO
    - Track One for 2015-16 covering 75-85,000 lives
    - 3.7% - 3.8% savings rates yielding $30 million and $37 million savings
    - Move to NextGen 2017
      - APM implications
      - Upside opportunity
      - Still a very high benchmark, easily identified opportunities in post-acute and specialist utilization

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Three: 2015-present**
  - Full risk Medicare Advantage
    - Subcontracted with NTSP
    - Strong UR/UM performance and reduction in specialist utilization/post-acute utilization not enough to overcome contract shortcomings in Year One
    - Struggles with RAF scoring in Year Two negates continued utilization reduction
    - 1% premium adjustment in Year Three makes the contract very profitable
    - NTSP shopping itself in the market along with its MA plan

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Three: 2015-present**
  - Finally execute a definitive agreement with UTSW to create Southwestern Health Resources in April, 2016
    - Joint Operating Company for the Dallas Hospitals
    - Comprehensive Academic Affiliation Agreement
    - "Family" of Physician Networks under the Southwestern Physician Network
      - "Docking Stations" for faculty, employed, independent PCPs, and specialists
      - CAPS program (Clinically Affiliated Physicians) begun by UTSW in 2013
    - Population Health Services Company

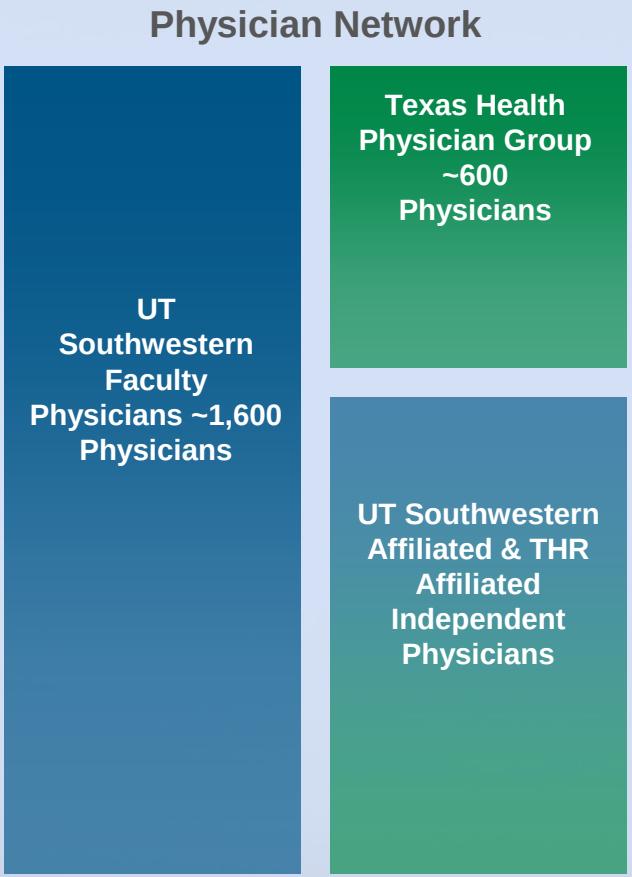
# Business Description – Physician Network

Draft

## What is the physician network?

**Clinically Integrated Network (PN)**
UTSW Faculty, THPG, and UTSCAP Members

**Risk Network**
CIN plus PCEPN and EPN Members
Governance of the PN and Risk Network will be unified and Risk Network members will participate in all committees and Board.




**PN and Risk Network Differences:**

- PN contracts together for FFS and gainshare contracts
- Risk Network contracts for MSSP, MA and full risk contracts
- PN requires immediate participation in CI program
- PCEPN requires participation in CI program within 18 months; EPN does not

# SWHR PN/EPN

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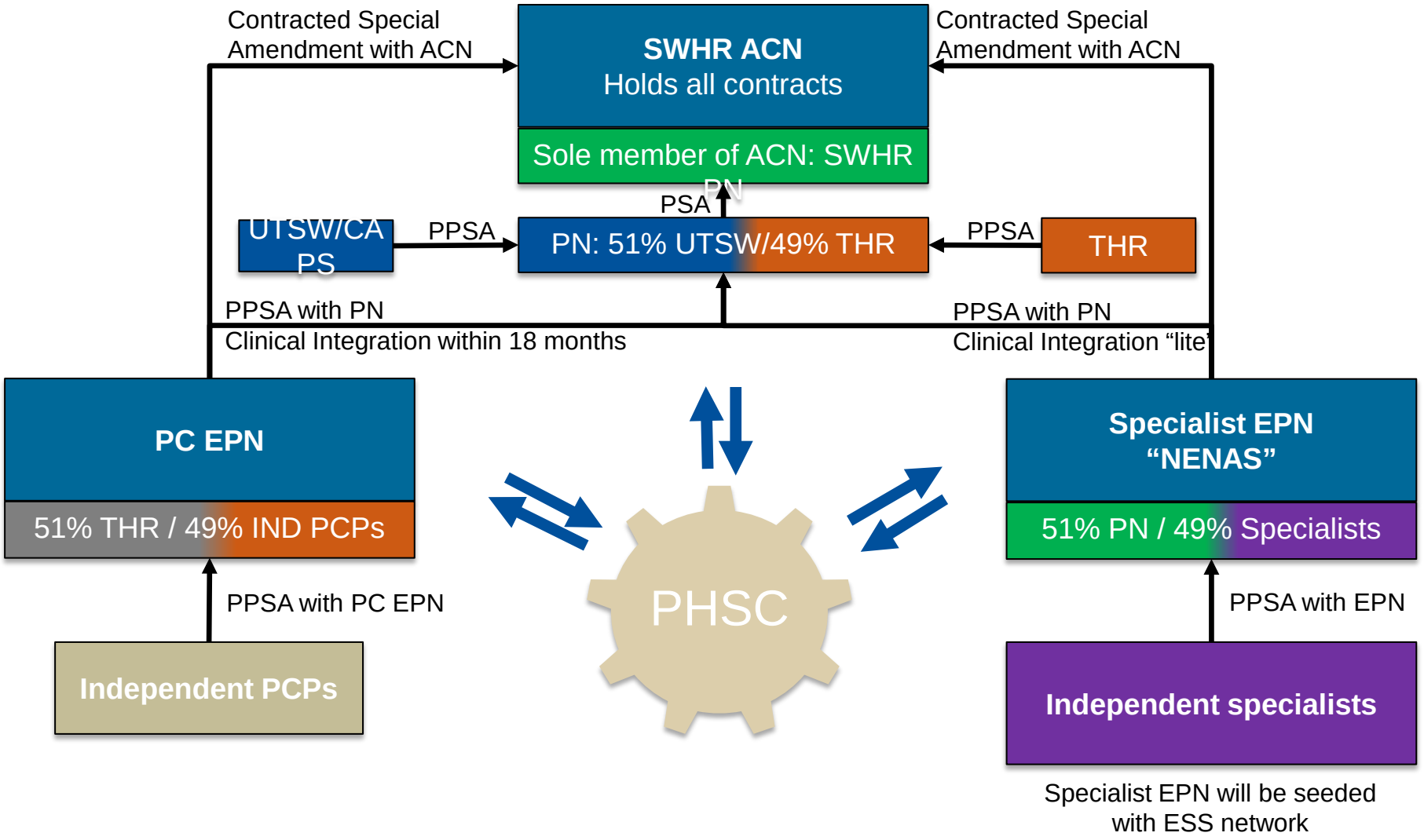
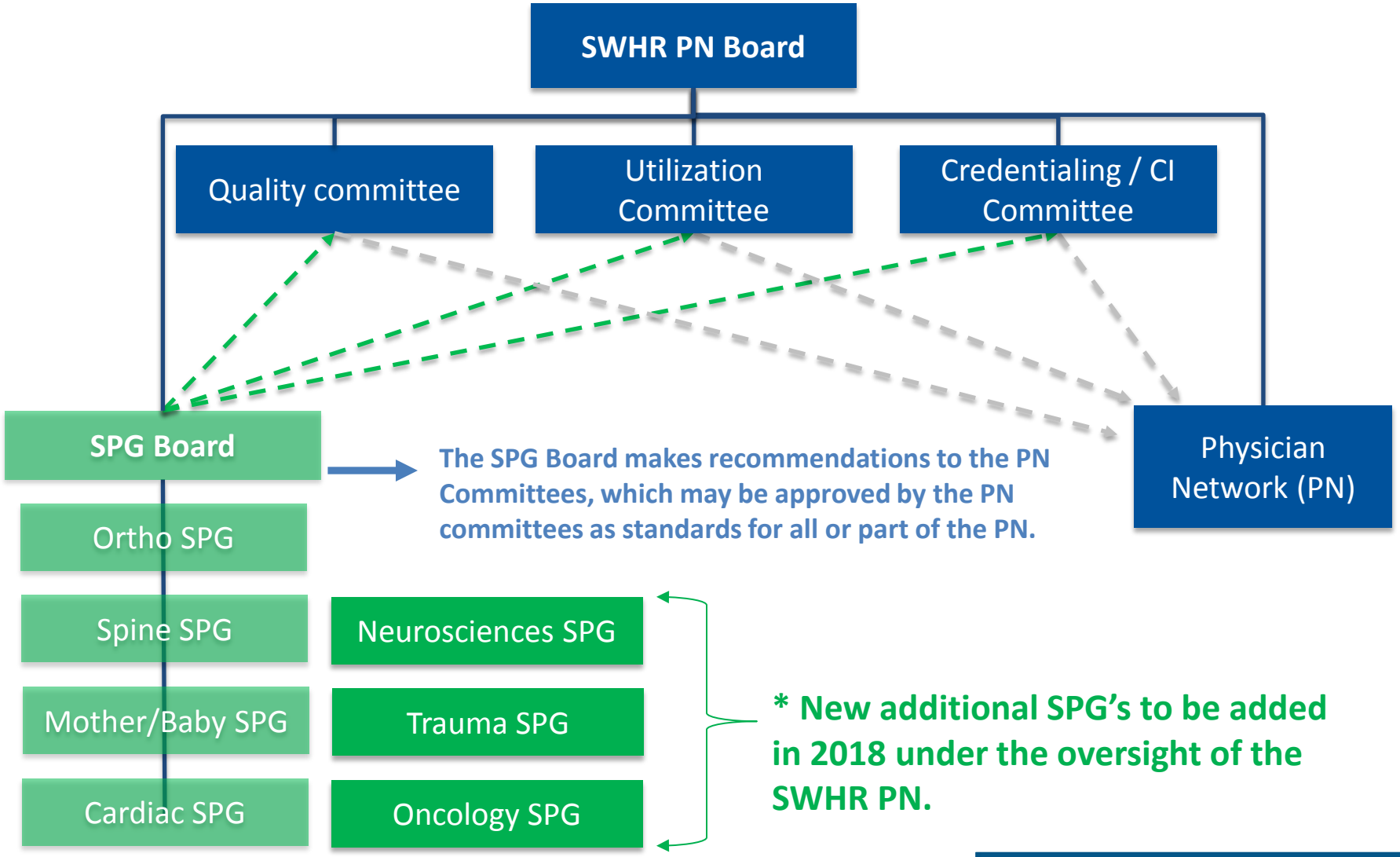


# SPG structure, planned service line growth



# SWHR PN Performance

Aggregate funds pool for SWHR PN through at-risk contracts for managing populations and episodes of care

(e.g. Medicare/Commercial ACO contracts, bundled care etc.)

**Process Payments for Quality & Performance**

- **Primary Care (QPP)**
- **Specialists (QIF)**

**Shared Savings (outcomes-based)**

- **Primary Care**
- **Specialists**
- **Hospitals**

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Three: 2015-present**
  - SWHR current status
    - Currently almost 3,000 physicians in network (600 plus PCPs)
    - Almost 200,000 lives in risk/ACO arrangements
    - Managing almost $1.5 billion in two-way risk models
    - Slow growth in “tightly aligned” models in the network
  - Payor relations challenges
    - Highest priced specialty network in the market combining with the second highest priced hospital network in the market
    - Hard line on contracting with the Network, threatening challenge to Clinical Integration

# Texas Health Resources Physician Network Evolution

Draft

- **Phase Three: 2015-present**
  - Joint Venture Health Plan with Aetna goes live 7/2017
  - Increasing price sensitivity in the marketplace with UCCs in return for “steerage” through narrow networks the order of the day and the preferred vehicle for brokers advising large, self-insured employers
  - Emergence of Venture Capital funded aggregation of independent physicians around targeted plays to leverage price differentials and/or retained earnings
    - Optum/WellMed, Privia, and Lumeris all in the MA game
    - Large IPA using payor provided data to move utilization out of hospital/HOPD to lower cost venues with significant gainsharing opportunities
  - Not much value seen in APM solution for MACRA in the market given the low level of participation in MC FFS

Draft

# The Big Lessons Learned and the Questions We Should Have Answered First

Draft

# Why Are You Creating This Network?

# Why Are You Creating This Network?

Draft

- **UTSW created the CAPS program to:**
  - Be their PCP Network
  - Avoid the cost of employment
  - Feed their tertiary and quaternary specialty services
  - Present a more complete package to the payor marketplace
- **THR created their employed group to:**
  - Stabilize critical workforce
  - Formalize physician/hospital relationships
  - Facilitate program development in key service lines
  - Present a more complete package to the payor marketplace

# Why Are You Creating This Network?

Draft

- **What are we doing with SWHR Physician Network now**
  - Cautiously stepping into two way risk
  - Loosely managing care
  - Worrying about the implications of success in managing care
  - Slowly growing a network while the market moves quickly
  - Haggling over the structures
  - Haggling over the cost of the infrastructure
  - Fighting our split personalities on referral management
  - Struggling with the consequences of our historic success in the fee for service marketplace
  - Continuing to operate primarily as a hospital operating company

# Why Are You Creating This Network?

Draft

- **Community IPAs are aggregating physicians to:**
  - Make some progress on commercial rates
  - Leverage market pricing disparities to their advantage with the help of payors to created significant physician gainshare opportunity
  - Commoditize health systems
  - Preserve private practice in a loosely managed model as long as possible
- **Investor backed physician aggregation seeks to:**
  - Aggregate physicians around government payor risk opportunities and ancillary service arbitrage; cover the cost of infrastructure, share the upside with MDs
  - Commoditize health systems
  - Execute an “easy first, hard later” medical management approach that is not terribly disruptive to physician practice

Draft

# How Disruptive Do You Want to Be, AND How Disruptive Can You Afford to Be????

# Implications of a Disruptive Network

Draft

- **How disruptive do you want to be to historic revenue streams?**
  - UCCs in the context of a total cost of care promise?
  - Big commitment to UM/UR with a little share shift on the come?
  - Institute clinically appropriate venue of care shifts at the expense of established hospital service line revenue?
- **How disruptive do you want to be to historic referral relationships?**
  - High performing network at the expense of the historic water carriers and cash cows?
  - PCP income growth at the expense of specialist referral revenue?
  - Developing network relationships with competitors based on quality/cost/service?

# Implications of a Disruptive Network

Draft

- **How disruptive do you want to be to your historic contracting strategy?**
  - More or less risk?
  - Total cost of care approach versus trying to continue to squeeze out year over year rate bumps for the facilities?
  - Moving annual contracting yield from facilities to physicians to create the “shock and awe” factor?
- **How disruptive do you want to be to clinical practice/clinical operations?**
  - “Easy money” approach versus true clinical transformation at the physician practice level?
  - Really getting after clinical operational efficiency and effectiveness across the continuum of care; using “exposure” as the impetus to achieve this?

# How Hot is the Heat in the Kitchen?

# How Hot is the Heat in the Kitchen?

Draft

- **Where is the market relative to:**
  - Movement to risk?
  - Consolidation?
    - Providers?
    - Payors?
  - Physician aggregation?
  - Physicians/non-hospital organizations controlling lives and premium?
  - Big employers ready and willing to press for big change?
  - Cost?
- **Are you willing to start the fire/raise the temperature yourself?**

# Do it Yourself or With a Friend/Enemy?

# Going Solo or in Partnership

Draft

- **For most health systems, a lot of this work requires new and different competencies**
  - Can you organizationally learn quick enough?
  - Can your culture tolerate a lot of internal transformation on its own?
  - Are your core operations strong enough to weather the impact of the change?
  - Are you big enough to get to scale quick enough to make it all work?
- **If you choose not to go it alone**
  - Are you good at partnering?
  - Are you potentially willing to work with a competitor to make something big happen?
  - Are you willing to turn some historic relationships upside down to make it work?

# What Are You Prepared to Do?

# Commitment

Draft

- **Even if the environment is forcing you to move**
  - These investments don't usually meet your capital investment IRR hurdles
  - Are expensive even if you partner with someone else who has money
  - Don't pay off this year
  - Don't pay off the way you are used to
  - Disrupt the way you have always done things
  - Don't come easy
- **If you are forcing the market yourself, then everything above is harder**
- **Need to realize that this is as much, if not more, a cultural transformation as a strategic transformation; as much an emotional exercise as it is a factual exercise**
  - Facts are stubborn and real, but so are the emotions