HEALTHLEADERS MEDIA
CFO EXCHANGE

Insights Report

November 2013 | Report 2 of 3

Dealing With Risk

FINANCE LEADERS ON THE NEW PAYER ENVIRONMENT

Analysis and in-depth discussions from healthcare finance leaders taken from the HealthLeaders Media CFO Exchange in August 2013

HealthLeaders Media
A Division of HCPro

Analysis

RISK ADOPTION REMAINS UNEVEN

PHILIP BETBEZE

Senior Leadership Editor
HealthLeaders Media

Since at least 2010, when the Affordable Care Act passed Congress, healthcare leaders have been hearing that making preparations to take on risk both in commercial payer contracting and with government payers will be essential to their survival. Many have taken that advice to heart, but now are starting to wonder whether the investments required to thrive on risk have been premature.

That sentiment was among the thoughts heard from participants at our annual invitation-only HealthLeaders Media CFO Exchange, which took place in August at The Broadmoor in Colorado Springs.

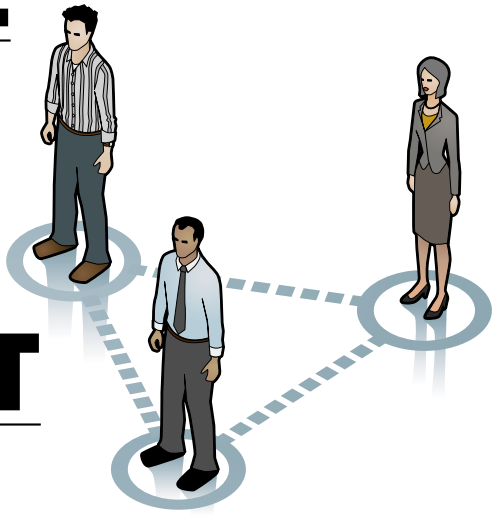
The CFOs said that much of the push for evaluating the effects of this transformation lands squarely on their desks. CFOs have the unenviable task of determining the likely financial impact of such risk-taking, whether it means being accountable for outcomes or simply being evaluated—and rewarded or punished—based on their organization's record on process measures and metrics. Used to focusing on the bottom line, what CFOs realize is this: Whenever risk becomes more widespread, the upside is limited, and overall revenues are unlikely to expand.

Many say they are glad to be ahead of the curve in their preparations, but living under the reality of two very different payment philosophies is challenging. Even for the most aggressive systems, most would agree that the percentage of their revenue at risk remains low—in some cases as low as 1%.

This report highlights the challenges CFOs are facing and the actions they are taking in the next year. Of course, in 2014, we will check back with the members of our 2013 HealthLeaders Media CFO Exchange to see if the reality around risk-based reimbursement has begun to match the hype. EIR

Discussion

NAVIGATING THE MINEFIELD OF RISK-BASED REIMBURSEMENT



PHILIP BETBEZE

The drive to push risk onto providers of healthcare services is moving unevenly nationwide. While some hospitals and health systems have faced aggressive overtures from commercial payers about reworking how they're paid, they are among a relative minority. While population health management and bundled payment demonstration projects—to name just two initiatives—are being introduced, many health systems aren't seeing much traction in taking on risk, even when they try to be the instigators.

Without a blueprint on how to effectively change a decades-old business model of payment for volume to a new one that incorporates value into the equation, hospitals and health systems are often left to develop their own prescription for how to demonstrate value to both patients and payers. Included in their calculations is whether to lead such change or follow pioneering organizations. That strategy decision is a calculated risk in itself, however.

By waiting too long, will hospitals and health systems have partners, or will they have been left out? Preparing for the future has never been fraught with so much uncertainty.

Speed of change varies

Charlie Hall, chief financial officer at Piedmont Healthcare in Atlanta, says his metro market is still unconsolidated, and payers aren't being particularly innovative in developing risk products for providers, leaving health systems to largely find their own way. There are some demonstrations and small scale partnerships, but so far, those partnerships have neither paid off financially nor attained scale enough to challenge current payment practices based on fee-for-service.

"We've done some things with Cigna, and we've increased patient satisfaction and patient care, but we're certainly not saving any money," he says. "In fact, it's cost us more money than it would have otherwise, and Cigna's participated in that, too."

In the meantime, Hall says Piedmont is learning through a relationship with Arlington, Va.–based Evolent Health aimed at helping providers across the country improve value to the patient and payer. Evolent Health is an independently managed and governed company that was founded in 2011 by Pittsburgh-based UPMC Health Plan and The Advisory Board Company, which is headquartered in Washington, D.C. "UPMC has had this insurance company

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they've been operating now for seven or eight years, and now they're in the process of letting other people use their expertise and their infrastructure to expand," says Hall.

But for now, partnerships with local payers are less than ideal in that they are effectively demonstration projects, and the cost savings and efficiencies are as yet unproven.

"We've learned some things, but we can't yet get to a point that we can partner with somebody," Hall says. "Let's say you have a certain amount of savings that you've accomplished. After a period of time, you rebalance from where we've taken the cost out. We've shortened the length of stay. We have expanded services and now we've got a new face financially that we've got to operate from, and that just won't work for us long term. I mean, we're not going to get into something strategically that's going to cut our throat four or five years from now."

Rick Newsome, vice president and CFO at Kaiser Permanente Colorado, says his system has undergone significant change over the past five years—from a point at which the system had no cost sharing products or members.

"Now we have more commercial members with cost sharing plans than we do HMO members, so it's been a rapid change for us," he says.

Jeffrey Limbocker, CFO of Our Lady of the Lake Regional Medical Center in Baton Rouge, La., is also trying new payment structures, such as a bundled payment initiative in orthopedics, but he says that's "just a toe in the water" and an opportunity to convince some of the medical staff to try it.

"This is where we think the future is headed, but it's still a long trip

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between fee-for-service and fee-for-value," Limbocker says.

With value-based reimbursement structures barely past the experimental stage with many payers in his market, Limbocker says the health system will continue to evaluate value-based offerings.

"We did an extensive study on ACOs and decided to take a pass on that," he says. "I personally believe that having a couple of good partner payers is going to be the way to go unless you're willing to do what Piedmont is doing or you have your own health plan. To be able to take on what is essentially capitation soon, you really have to have a great partnership with the payer or have your own payer."

The data challenge

Julie Soekoro, chief financial officer of Trinity Medical Center in Birmingham, Ala., says the hospital is at risk for a portion of payment based on various quality factors, but those contracts are difficult to administer because of a lack of data.

"We are at risk for a portion of our payment related to various quality factors—readmissions is one, infection reduction is another—and there is actually a dollar portion of our contract that is tied to a metric that we either achieve or we don't achieve," she says. "The payer is having a hard time telling us what our readmissions are because it spans not only our health system but other hospitals in the area, so we don't necessarily know when there is a readmission. So some of these factors that are a piece of our contract are difficult to manage and in fact even get the data on."

Greg Pagliuzza, CFO at UnityPoint Health, Trinity, in Rock Island, Ill., has similar issues on the commercial side

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because of factors related to one dominant payer.

"They own two-thirds of the commercial market," he says. "We've contracted with them for a narrow network locally, and in developing this product we asked for an exclusive."

The payer refused exclusivity, but Pagliuzza and the leadership team have the ability to opt out if the insurer does make such an arrangement with a competitor.

Regardless, says Pagliuzza, leadership is not concerned and in fact is investing heavily in care coordination in a bet that performance will be a differentiator for them. Further, competition can potentially work both ways, as Pagliuzza believes the health system's investments will pay off to the extent that it will be able to work deals directly with employers and possibly compete with insurers. Though still in the investigation phase, it is a strategic possibility.

"If the premium's dollar [is] going to be spent and the insurance companies get 5% to 7% off the top, why don't we keep [it] since we're investing in all this infrastructure and managing care?" he says. "We are looking into it and it's in the assessment phase."

Risk levels vary significantly

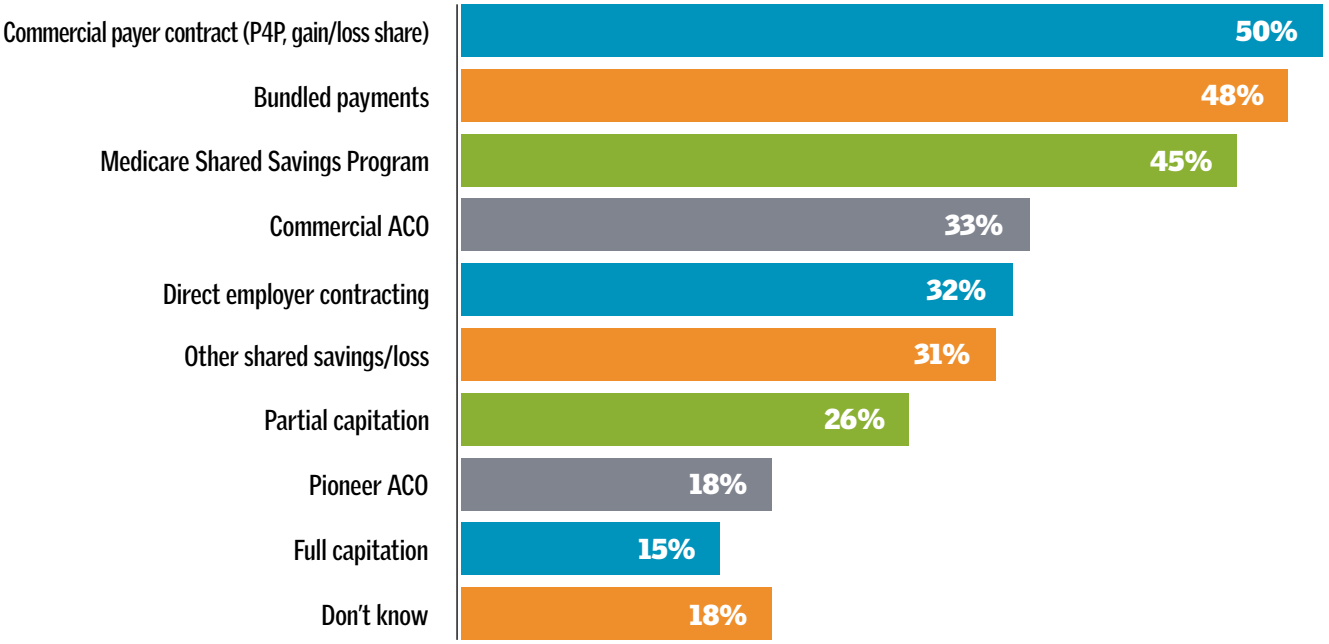
Pat McGuire, CFO at St. John Providence Health System in Detroit, says his system is undertaking some risk on its own and some with Blue Cross Blue Shield of Michigan, its largest payer, but at this point, the health system only shares in the upside. "We have two kinds of tracks that are capitated" in partnership with physicians, he says. One such partnership has about 50,000 lives, while the other has about 40,000 lives.

"But recently we are in discussions with Blue Cross about a gainshare arrangement where they will look at our attributed population and look at our cost per member per month against the statewide average trend," he says. "If we are performing better than the statewide average, then they will share that gain back with us 50/50."

St. John also plans to submit a proposal in response to a Blue Cross request. Under that plan, offered under the health insurance exchange in Michigan, the winning provider will create with Blue Cross a limited network product.

REIMBURSEMENT MODELS

What collaborative care reimbursement models does your organization expect to have in place within three years?



Multi-response

SOURCES: HealthLeaders Media Intelligence Report, *Collaborative Care: Hospitals Balance Risk and Revenue With Physicians and Payers,* April 2013.

"They are not wholly prescriptive in terms of what they're looking for in structure, but we think they want some type of a per-member per-month payment with some sharing with the plan both in upside and downside."

In some markets, hospitals and health systems seem more ready for risk than payers. Count Rick Hinds, CFO of UC Health in Cincinnati, among that group. He says commercial payers have been hesitant at best to offer providers opportunities to share in risk.

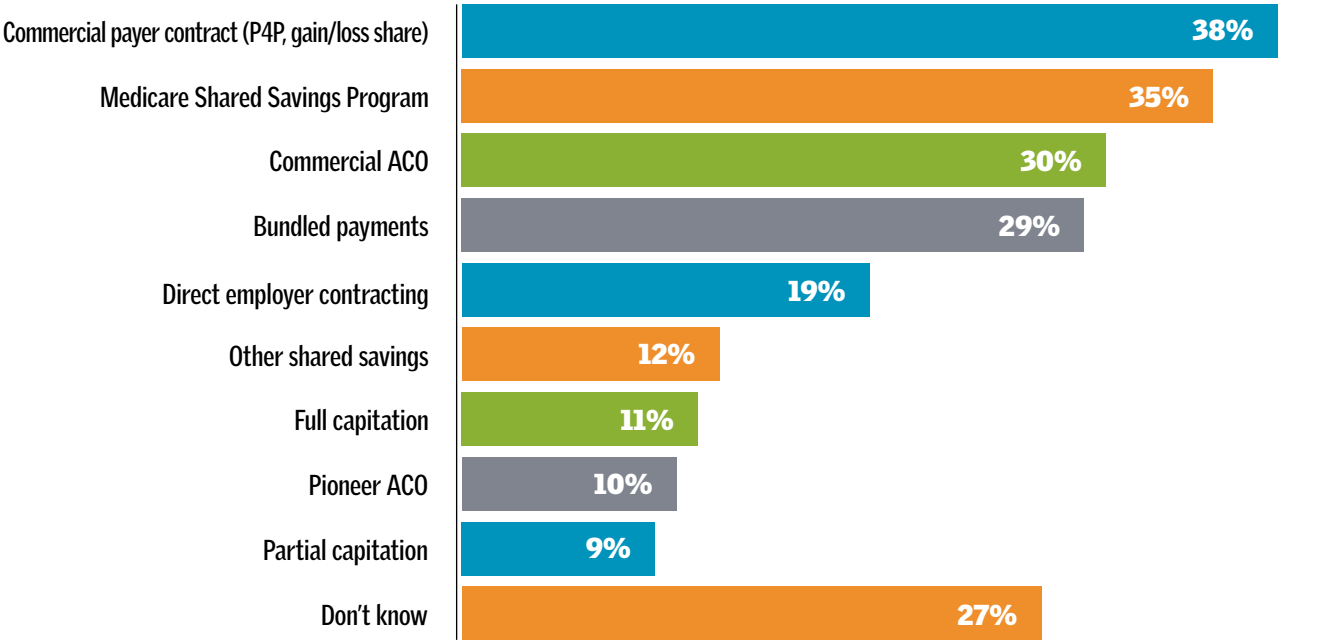
"There are some risk components based around outcomes that are in all of our big commercial contracts, but we've approached the payers about more significant risk sharing and they've really been hesitant in our market to move in that direction," he says. "What they tell us is they are limiting the amount of these that they do. We don't want to go all-in [on risk] but we know that's where it's heading, and we are having a tough time getting this established with the commercial payers."

Sharon Joy is part of an aggressive move by North Shore-LIJ Health System in Manhasset, N.Y., to take on risk. She serves as vice president for financial operations there, and says the health system has done a couple of deals with payers in the past year.

"We recently signed a risk-based deal with Emblem, which is one of the health system's larger payers," she says. "This plan includes 200,000 covered lives and allows for use of our full-time physicians, as well as some of our IPA physicians. In the first few years we have capped both the upside and the downside risk, which is tied to the medical loss ratio. This year, 2013, was the first year, so we don't have enough experience yet to report results."

REVENUE CONTRIBUTORS

Which collaborative care programs will be the top three revenue contributors in three years?



Multi-response

SOURCES: HealthLeaders Media Intelligence Report, *Collaborative Care: Hospitals Balance Risk and Revenue With Physicians and Payers,* April 2013.

Fred Savelsbergh, CFO at Baylor Scott & White Health in Dallas, says his organization is focused on establishing its North Texas ACO organization for which it is now completing infrastructure installation.

"It's called Baylor Quality Alliance. We currently have our own employees in the Baylor Quality Alliance as a learning initiative, and we have contracts with a few payers at this point in time for upside but no downside."

Mark Bogen, CFO of South Nassau Communities Hospital in Oceanside, N.Y., is concerned that his health system's risk will largely be out of its control.

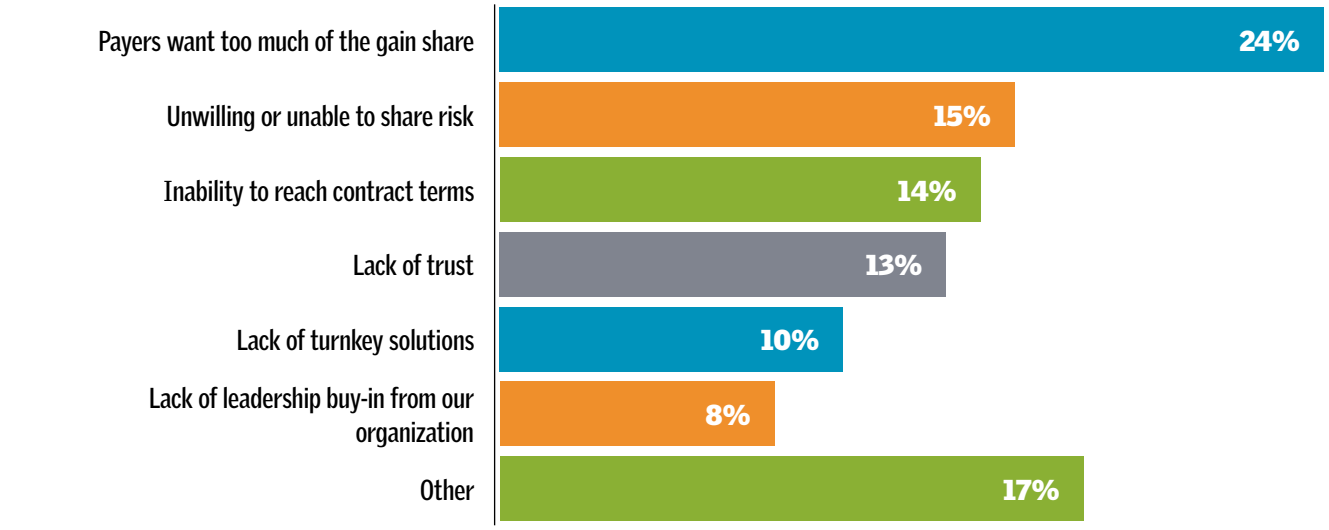
"Our concern is [that employers] will look at the ACA and decide it's cheaper to pay the penalty than it is

> We've done some things with Cigna, and we've increased patient satisfaction and patient care, but we're certainly not saving any money.
>
> CHARLIE HALL, CFO, PIEDMONT HEALTHCARE

DANA THOMAS

PAYER ROADBLOCKS

What is the primary roadblock your organization has faced with payers in its adoption of collaborative care?



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to provide employees with coverage. That would present us with a double whammy of having to take a lesser rate and then on top of that chase the high deductible patient as well."

McGuire, of Detroit's St. John Providence, shares those concerns.

"We're concerned about people moving from either small group or individual policies into an exchange-sold policy, and it's a lower rate. We're also concerned with large employers looking at the rates that are out there on the exchange now and having somebody do the math and say, 'Boy, it looks like if we just had all of our employees just buy insurance on the exchange, it would be a cheaper rate than we're paying for similar insurance,' and so we're concerned about the slippery slope."

Essentially, McGuire worries that the prices on the exchange will end up as the ceiling of the prices for the local market.

"We don't have an answer yet on how we keep that from happening."

Although operating a health plan as a provider does have some attractiveness, Baylor's Savelsbergh says if providers are going to get into health plans, then they really need to think about lessons learned from past experience owning such plans.

"When many of us were in it, we were there for the wrong reason," he says. "We were in there to protect our market share or to grow our market share in the hospital side, and that's the wrong reason to get into a plan. If you do it, you'd better hire somebody who knows how to run a health plan and not try to run it with hospital resources. And the hospital has to stay out of their strategy." EIR

Philip Betbeze is the senior leadership editor for HealthLeaders Media. He may be contacted at *pbetbeze@healthleadersmedia.com.*

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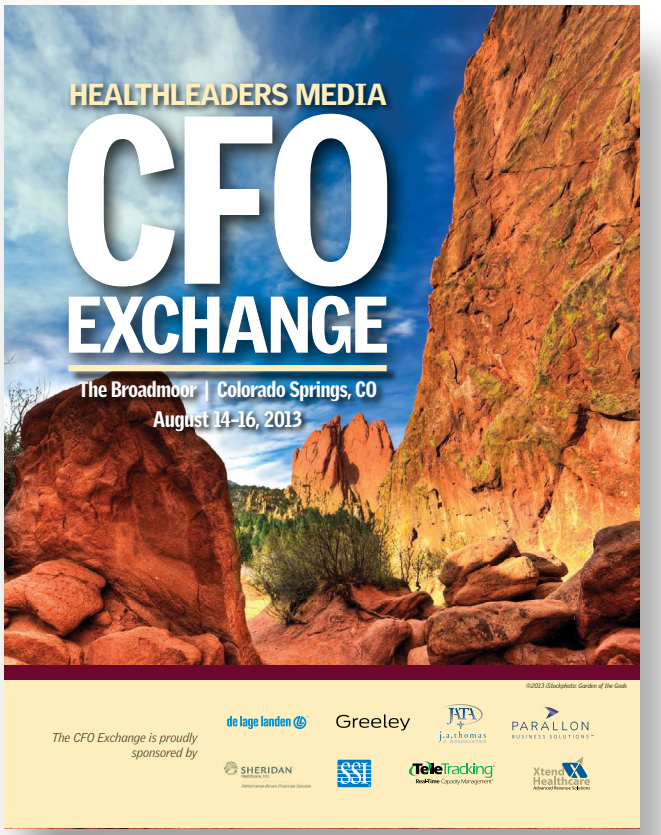

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