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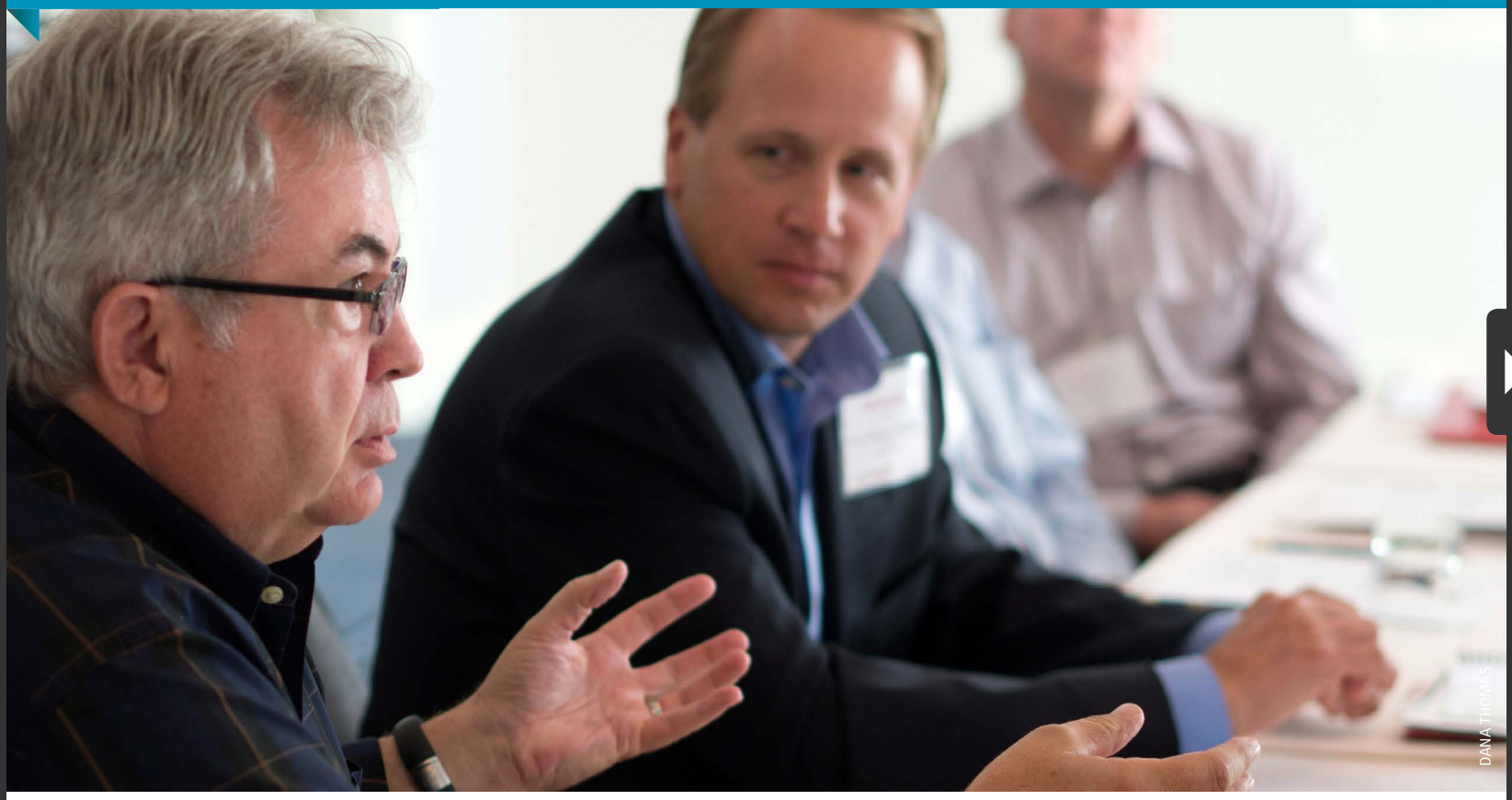
CEO EXCHANGE

Insights Report

April 2014 | Report 2 of 3



APPROACHING RISK

CHIEF EXECUTIVES ON EVOLVING PROVIDER-PAYER STRATEGIES

Analysis and in-depth discussions from healthcare CEOs taken from the HealthLeaders Media CEO Exchange in November 2013.

HealthLeaders Media

Analysis

DECISION-MAKING AND THE CHALLENGE OF TRANSITION

PHILIP BETBEZE
Senior Leadership Editor
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When? How much? How quickly? Leaders of healthcare organizations have been struggling for years to answer these questions about healthcare reform.

Of course, some hospital and healthcare CEOs have been vacillating about how quickly to try to transform their systems into coordinated, clinically integrated organizations when, with few exceptions, the ways they are paid have not led the transition. Such transformations are always fraught with uncertainty, but this one is especially so because leaders have found it difficult to gauge its speed, both nationally and locally.

At the annual HealthLeaders Media CEO Exchange, held in 2013 at the Boca Beach Club in Boca Raton, Fla., top executives got to meet and discuss such difficult issues, and learn from one another about what has worked and what has not. They shared ideas about how to respond strategically to what's coming in the next year, as health insurance exchanges ramp up and commercial payers dive more deeply into risk-based reimbursement.

Some healthcare provider organizations are no longer willing to wait for their business partners to transform and instead are leading the way. This report provides a window into the thinking of some of healthcare's most dynamic and innovative senior leaders surrounding these changes, and delves into their decision-making as they seek ways to design a safer, cheaper, and more seamless system of healthcare—and thrive under that transition. It helps that most are starting from a low bar.

They're interested in changing, they want what's best for their patients, and they're willing to take risk. So what's holding them back? Read on. EIR

Discussion

INVOLVEMENT WITH RISK-BASED REIMBURSEMENT VARIES WIDELY

PHILIP BETBEZE

Some hospitals and health systems are feeling the financial pinch from payers, whether government or commercial, forcing them to take risk in contracting through ACOs, narrow networks, or other risk-sharing reimbursement regimes where quality and outcomes measures form at least part of the equation that determines revenue and margin. Some are pioneering the process where payers seem reluctant to go there, and some simply aren't facing much pressure at all to change their business model.

Over the years, healthcare has arguably tended to evolve more cohesively, but given the level of crisis in healthcare inflation and spending in recent years, payers, providers, and even patients seem more interested in experimenting with injecting value into the financial part of the procurement of healthcare services. And the pace of change has never been faster.

Proving value

Jack Kolosky, chief operating officer at Moffitt Cancer Center, a nonprofit in Tampa, Fla., says his organization is learning about risk and taking it at the same time by developing what amounts to a shared savings program with Florida Blue, Florida's Blue Cross and Blue Shield company.

"Florida Blue Cross calls it an accountable care organization because it involves our hospital doctors and other providers," he says, "and we're in active discussions with several other payers about that sort of thing."

He says the new payment model has proven valuable for Moffitt in several ways. As a single-specialty organization, Moffitt has had to work out with Blue Cross how to determine when patients get accounted for during their course of care for quality measurement and payment purposes. But he says what makes this program so

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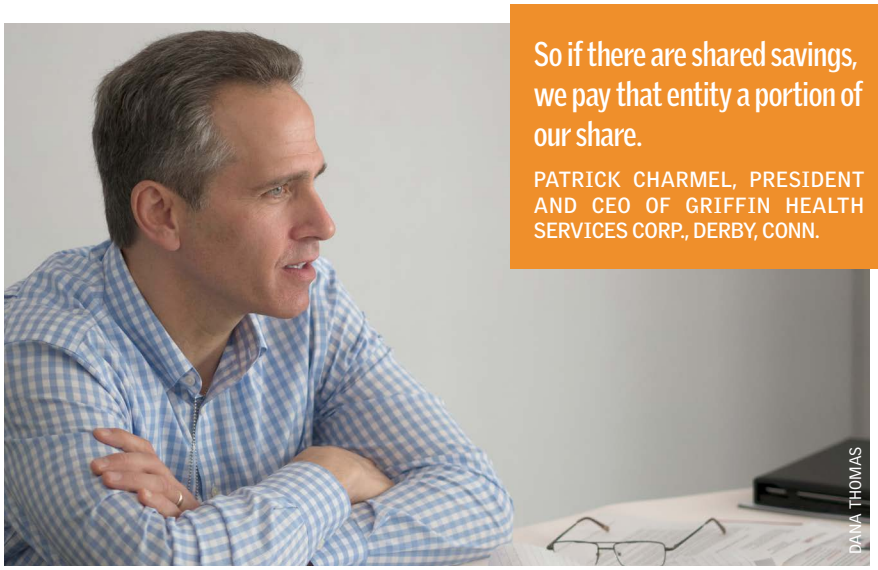
attractive at its initiation is that Moffitt gets to disprove certain assumptions payers and patients have about the cost of its care.

"We're perceived to be the most expensive or one of the most expensive organizations in the area, but as we analyze the data, we have found that we are not—and at least as importantly, they've found we are not—and it's mostly because of the way we manage our care," he says. "We're an integrated evidence-based model that in the long run will produce superior results, but we think in the short run will also produce cost savings."

Patrick Charmel, president and CEO of Griffin Health Services Corp., parent company of the nonprofit Griffin Hospital in Derby, Conn., says his organization has reached the end of its first year participating in the Medicare Shared Savings Program in an upside risk arrangement. What's interesting about the relatively small Griffin's participation in the program is that it is doing so in partnership with another entity in what Charmel calls a way to "rent infrastructure."

"So if there are shared savings, we pay that entity a portion of our share," he says. "In essence we are trying to leverage their infrastructure. They've been doing Medicare Advantage risk deals for about 12 years and have built the necessary care management infrastructure."

Two other Connecticut hospitals are also in the arrangement. Charmel hopes it will eventually morph into an alliance of what his team is internally calling "value hospitals: those that exhibit low cost and high quality."



> So if there are shared savings, we pay that entity a portion of our share.
>
> PATRICK CHARMEL, PRESIDENT AND CEO OF GRIFFIN HEALTH SERVICES CORP., DERBY, CONN.

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He says he hopes that eventually the group will be able to engage payers in discussions about creating products around that constellation of hospitals.

Coopetition?

Much of the work surrounding taking risk in healthcare contracting, at least from the hospital side, involves encroaching on territory previously completely controlled by payers.

David T. Brooks, FACHE, president of St. John Hospital & Medical Center in Detroit, a major hospital in the five-hospital St. John Providence Health System, says his organization is "in essence operating a health plan, if you want to think of it that way."

Brooks says the health system essentially formed its own health plan around its own nearly 12,000 employees.

"We look at utilization just like a health plan would look at it; we adjust benefits even like a health plan would do," he says. "That's a great learning lab in a lot of ways, but we haven't yet crossed the line to being our own commercial health plan."

Other innovative health systems feel the same pressure, but part of putting off forming an actual health plan is based on hesitancy about relationships with existing health plans.

"If we move to being viewed by them as a potential competitor, we've seen how dynamics can change both in metro Detroit and in other markets," says Brooks.

Michael Rowan, executive vice president and chief operating officer with Catholic Health Initiatives in Englewood, Colo., says his health

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system is gaining experience with taking risk through its ownership of Medicare Advantage plans in several markets.

"Part of our strategy with Medicare Advantage is the opportunity to build infrastructure skills and a national learning lab," he says. "Also, most of the payers do not seem to see that as a direct threat to their businesses."

Echoing Brooks on the advantages of behaving as a health plan to its own employees, Rowan says CHI has also taken on many qualities of a health plan in managing its own employees' health. With nearly 90,000 employees nationwide, managing the health of the entire company's workforce faces some scale hurdles locally, but it's a big group and the data is all theirs.

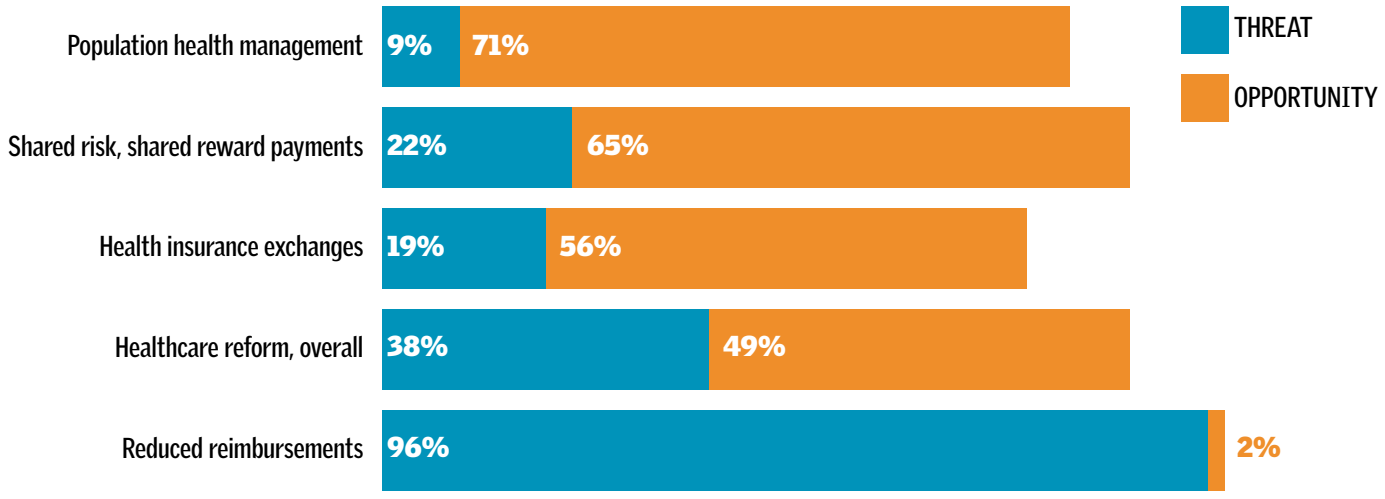
"The most obvious place for us to begin in terms of risk sharing is with our own employees. We started our efforts to change the behavior of our employees about four years ago in two key ways: by incentivizing healthy behaviors and by changing the benefit structure," Rowan says.

Adding (or retaining) pieces

John Popovich, president and CEO of Henry Ford Health System's flagship hospital in Detroit, says the advantages of having a captive health plan are coming full circle after more than a decade of health plan divestments among hospitals

THREAT OR OPPORTUNITY?

Does your organization consider each of the following to be a threat or an opportunity?



Multi-response
SOURCE: *HealthLeaders Media Industry Survey 2014, CEO Report: The Winners and Losers of Healthcare Reform,* January 2014

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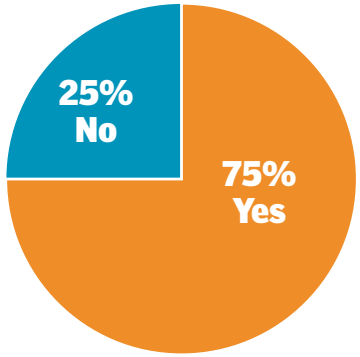
VOLUME TO VALUE

Do you believe the healthcare industry will make the switch from volume to value?



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and health systems that owned them during their heyday in the late 1990s. He says the health system's experience with capitation through its own Health Alliance plan has helped it prepare for risk-taking with other payers. He knows the pitfalls better than most.

"We've had full risk capitation in our medical group even with populations through the Health Alliance plan and then have gradually changed some of those relationships," Popovich says. "But where we had significant difficulties is that we couldn't have a large and extensive enough provider base through the medical group to care for even our own population within the health system. "

He says with nearly 24,000 Southeastern Michigan–based employees, Henry Ford has aggressively sought a mechanism under which it could create a narrow network with independent providers to incorporate such population health–based strategies.

"A few years ago we created an independent subsidiary corporation of the health system called the Henry Ford Physician Network, which is clinically integrated," Popovich says. "Its first large contract was the employees of the health system in which we had pretty strong penetration, and we've actually been able to hold the benefit cost to employees neutral from last year to 2014. Some of that was the network and some was probably based on benefit design."

Most important, the physician network has given the health system an opportunity to offer such integration in other contractual settings with commercial insurers.

> Part of our strategy with Medicare Advantage is the opportunity to build infrastructure skills and a national learning lab.
>
> MICHAEL T. ROWAN, PRESIDENT OF HEALTH SYSTEM DELIVERY AND CHIEF OPERATING OFFICER WITH CATHOLIC HEALTH INITIATIVES, ENGLEWOOD, COLO.

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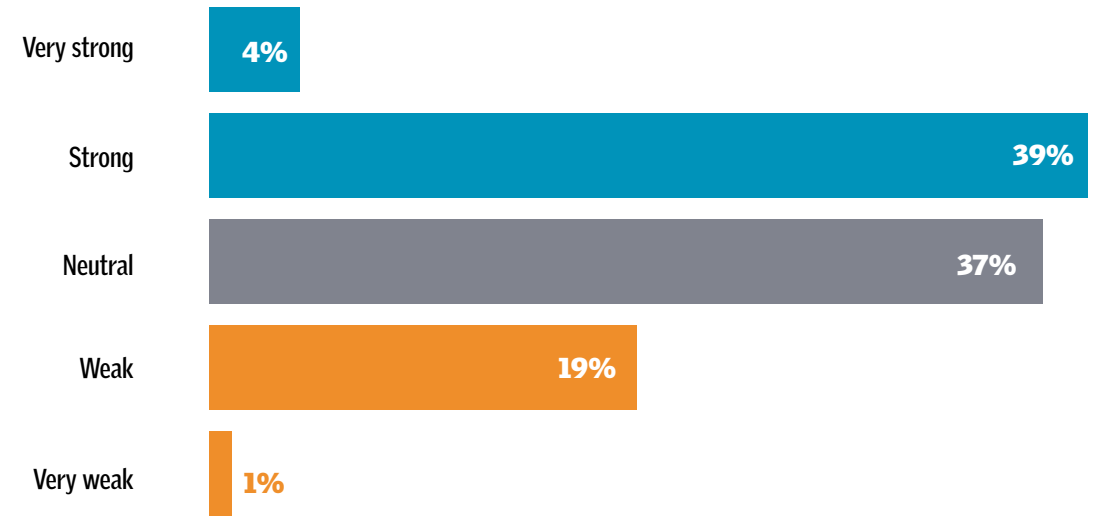
COLLABORATION/RELATIONSHIPS WITH PAYERS

How would you rate your organization's current performance regarding collaboration/relationships with payers?



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Challenges with data, control

"For those of us who don't own health plans, the challenge continues to be primarily with the payers not sharing the data," says Charles Stark, president and CEO of Columbus (Ga.) Regional Health System. "They view it as proprietary, and it is a disadvantage for us because if we had access to that for the full cost of care, we could begin to move the dial on improving care, clinical outcomes, and cost efficiency."

He says that leaves midsize organizations like his to attempt to create their own claims data system using vendor IT products.

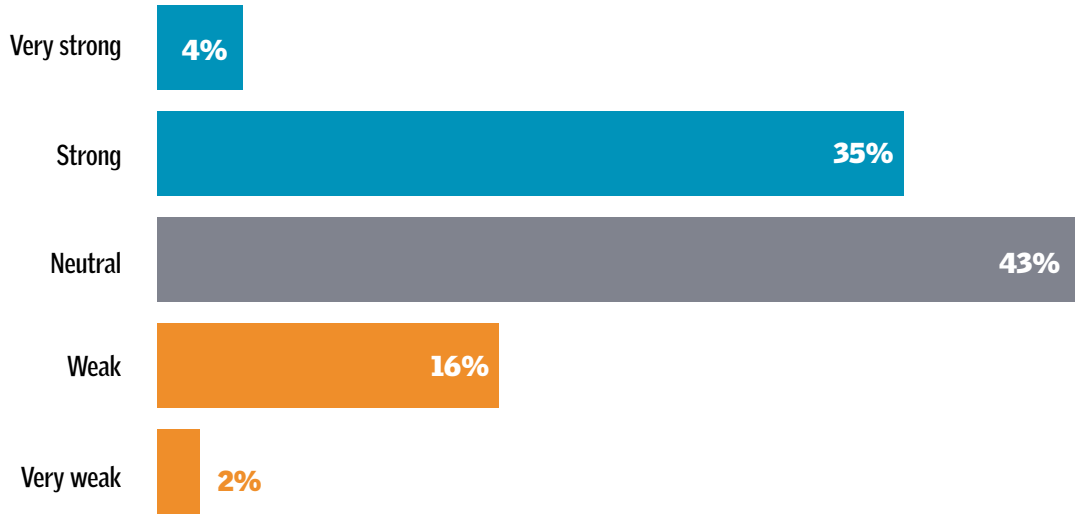
"So we'll create our own database, we'll move our own physicians, but we're only moving on the inside; we're not moving in the ambulatory setting, so we only have a glimpse of the big picture," he says. "But we have to identify the better-performing physicians and position everybody collectively for when we do move into

> Where we had significant difficulties is that we couldn't have a large and extensive enough provider base through the medical group to care for even our own population within the health system.
>
> JOHN POPOVICH, PRESIDENT AND CEO OF HENRY FORD HEALTH SYSTEM'S FLAGSHIP HOSPITAL, DETROIT


DANA THOMAS

PRICE TRANSPARENCY

How would you rate your organization's current performance regarding price transparency?



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accountable care or some sort of risk-sharing arrangement."

CHI's Rowan says in some of its markets, CHI has seen physicians try to commoditize the hospitals by taking risk on their own, without bringing in the hospital. They've essentially moved toward becoming the gatekeepers of care and, thus, spending. Some in the Denver market, for example, have figured out how to reduce admissions and have parlayed that into increasing the income of the members of their IPA by signing contracts with health plans that promise a piece of the savings if their group can reduce hospital admissions.

"Many leaders are trying to figure out how hospitals can address this issue by employing physicians." Rowan says. "But it's really about trying to figure out how we align with physicians or other providers, because if you look at all the money in the market, the biggest margins belong to the payers, and we need a portion of that margin to operate safely and successfully. And we need physicians to be aligned with us to do that."

Jerry Fedele, president and CEO of Boca Raton Regional Hospital in south Florida, says the same thing is happening in his market, especially with large independent physician groups. He says his market is not integrated, there are no large health systems, and most physicians are independent, particularly in the specialty realm.

"About seven years ago, single-specialty physician networks started coming together," he says, and now they "are evolving to multi-specialty groups with an eye toward taking a leadership role in managing care in a risk environment."

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

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