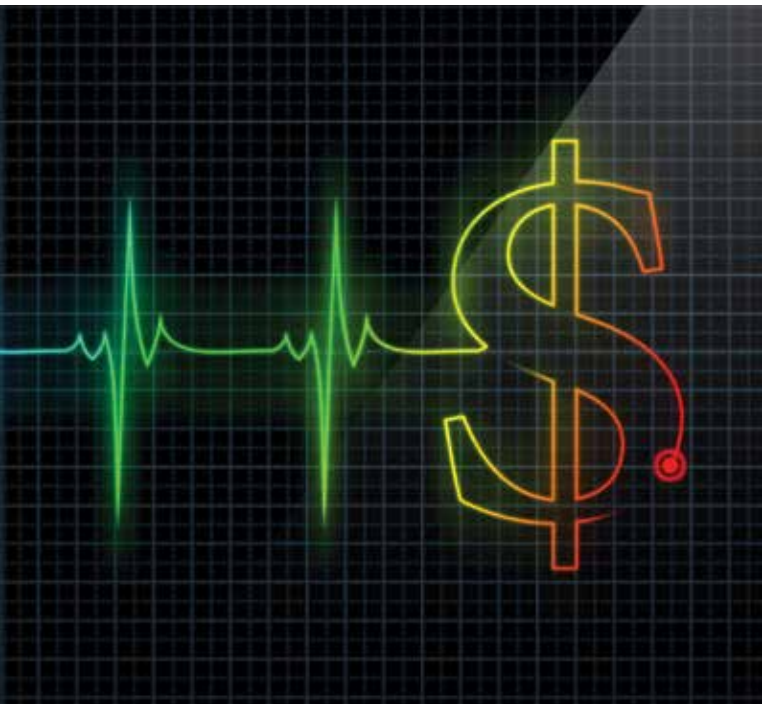
ROUNDTABLE

Bottom-Line Preservation in the Transition to Value-Based Care



Fee-for-service revenue remains dominant among healthcare provider organizations, but leaders expect a shift to value-based payment models over the next few years. They are testing models such as shared savings, bundled payments, and shared risk. The true degree of risk in these arrangements is unknown, as are the specific outcomes of the different models. Financial executives are challenged to make the right bets and to be sure their organizations have the necessary skills. The coming years are a bridge between the fee-for-service present and the pay-for-performance future, during which leaders must ensure their organizations' financial viability.

PANELIST PROFILES

DAN ENDERSON
Senior Vice President & CFO
Centura Health
Englewood, Colorado

CAROL KARP
CFO
Via Christi Health
Wichita, Kansas

KATHERINE SCHNEIDER, MD
President & CEO
Delaware Valley Accountable Care Organization
Philadelphia

LYNN WIATROWSKI
Executive Vice President, National Treasury Executive—Specialized Industries
Bank of America Merrill Lynch
Boston

EDWARD PREWITT (MODERATOR)
Editorial Director
HealthLeaders Media

Roundtable Highlights

HEALTHLEADERS MEDIA: *Where are you on this transition to value-based care? How much of your organization's revenue is fee-for-service?*

DAN ENDERSON: I would suggest 98%. Even the stuff that's flowing more into a value equation, we're still being paid fee-for-service. For example, Centura Health is part of a Medicare Shared Savings Program. We would consider that as a part of the value equation, but we're still being paid on fee-for-service and then adding everything up and doing the math to say what their overall shared savings is. It kind of comes down to your definition of value. ... We've got a total of about 210,000 lives that we're managing, out of over 5 million in Colorado and Kansas. You could derive a percentage that way.

HEALTHLEADERS: *That's a good point—some revenue can be put into different buckets.*

ENDERSON: Correct.

CAROL KARP: We are still primarily in a fee-for-service market. We have initiated some contracts before and in 2015 to start taking more risk, trying to be attributed for lives with some of our commercial payers. But it's small in number compared to the number we anticipate two to three years from now. We have to show value, and we have to be able to better define the value equation. And none of us are mature in this and are there yet. ...

We are one of the large players in the state of Kansas (not to say we don't have large competition). We're trying to be the proactive health system; we believe we know where healthcare needs to go, and we're trying to lead healthcare there in our market. The quandary we're finding ourselves in is that we might be getting ahead of the game. Are we getting ahead of where the payers' maturity is in our geographic region? Are we getting ahead of where the employers and the consumers are expecting their care to be provided and coordinated? But we're trying to be the leader and say, "We know healthcare is expensive. We know we can deliver better quality, cost-effective care and deliver a better patient experience at the same time."

LYNN WIATROWSKI: We have 2,500 clients nationally ... so I come at this with a vantage point of a very broad base of clients and prospective clients that we talk to in the market. ... Looking at our client base, there are few pockets where there are some innovative arrangements, either capitation or bundled payments. But the largest proportion is exactly where you all are: still very much fee-for-service, but an awful lot of conversations and some pretty creative ideas about how to go at value-based options. California is ahead with some models that are pretty progressive—Kaiser [Permanente] of course, adopted a value-based approach well before healthcare reform. Other parts of the West, Florida, and a few other markets are more advanced, with the South and Midwest somewhat less so. From the perspective of the bank's health benefits discussions, lots and lots of conversations are taking place around value-based options for our self-insured population. This includes everything from centers of excellence to bundled payments to risk-sharing.

> "Even the stuff that's flowing more into a value equation, **we're still being paid fee-for-service.**"

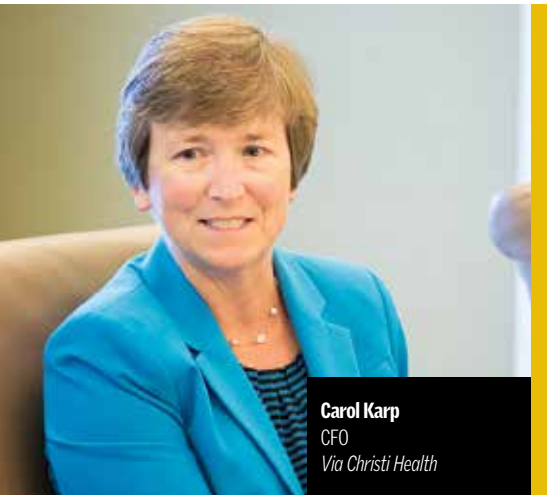
KATHERINE SCHNEIDER: The Delaware Valley Accountable Care Organization, which is actually in the greater Philadelphia area, is a joint venture of five health systems, all with very different cultures and interests, but all very committed to partnering through the ACO in a market that is still robustly fragmented. ...

Dan Enderson
Senior Vice President & CFO
Centura Health

To answer your question about what percentage of revenue is fee-for-service, obviously at the ACO level itself, we're 100% value-based because that is our business model. We are the layer that sits on top of the underlying fee-for-service. For our hospital owners ... the vast majority of our revenue is still fee-for-service. However, I think the conversation has shifted there, because when they start looking at operating margin and what's being left on the table on value-based arrangements, suddenly they see opportunity. Even when they're 98% fee-for-service, the bonus opportunity around value starts to look like a really big number compared to operating margin on the fee-for-service side. I think where it starts to really get folks' attention is, what is the actual cost to deliver on that value piece, as opposed to our traditional way of looking at volume?

In our PCP network, we have a very wide spectrum of capabilities along the transformation journey. For our most sophisticated primary care practices, some of them have crossed that 50% mark on revenue actually coming from value-based payments. I'm not talking about capitated risk-type payments, but actually patient-centered medical home incentives, quality payments, care coordination fees, and all of those capabilities that are really needed to manage population health. I see that most in the more sophisticated primary care practices. In specialists in the greater Philadelphia area, probably the vast majority are 100% fee-for-service. But some of the leading specialists are trying to be at the leading edge around value, doing bundled payments and some pretty innovative things. I think there's a ton of opportunity there.

HEALTHLEADERS: *What do you think the timetable is in your different markets for moving to value-based payment?*



Carol Karp
CFO
Via Christi Health

ENDERSON: I'm not sure there is [a timetable]. I think there's a lot of value-based discussion that's being pushed and prompted by consultants and writers. For the writers, it's something more interesting to talk about than historical fee-for-service. For consultants, it's if they can get me scared about something I don't know anything about, then I'll hire them to help me learn it. I get it. But I've heard of some CFOs nationally who have said, "We're not going there—period, end of story. We're not going to do it. It's a phase. It'll burn off. We're just going to hold our seat and ride it through, and the people who go run and do it are going to lose their shirts. They're going to spend a bunch of money, and they'll be no stronger in the end."

That's one view. It's not the view of Centura Health. We want to foster a leadership role in healthcare transformation and are dipping our toe in the water and playing. It is important to learn and modify our strategies to ensure we don't get left out of the game. So if the market really goes there [to value-based payment], we're ready and able to play.

"We have to reach out to our customers and really find out what is going to engage them in this healthcare product."

Five years from now, I've got a sneaky feeling it's not going to be what we think it will look like today. But the market has to go through a metamorphosis to get there. I think we as providers have a big role to play; how fast the market goes depends on how fast we're willing to take on a different risk model, and ... how fast the payers can modify their ability to pay claims in a different way. They love the concept, but when you really get down to the operational discussions, they don't have systems to adjudicate claims in the bundled payment environment.

KARP: Everybody is going down the next generation of capitation. So let's look back at the '90s. What did we learn, what did we do wrong? Let's not repeat those same mistakes. We're going to reduce cost, we're going to deliver care in the right venue, and we're going to incrementally increase our quality of care. ... We have to reach out to our customers and really find out what is going to engage them in this healthcare product. We can tell them all we want, "Come see your primary care physician twice a year, come do this, come do that." But until we engage them in their care and they want to take accountable actions toward working with us, it's still like the parent telling the child.

WIATROWSKI: I think the best thing that's happened with healthcare reform is that it has put the patient at the center and increased consumers' financial stake in their care. With increased the responsibility payment such as high deductibles, consumers think more carefully about their healthcare decisions. So what's driving some of the pace of change is pushing more ownership to the consumer. It has shifted the paradigm of how everybody is thinking about healthcare.

HEALTHLEADERS: *High-deductible health plans are a major driver forcing healthcare providers to consider value and different ways to meet patients/consumers. ... But no one knows what their impact will be. One impact is that self-paying patients become no-pay patients. But then people still continue to go to the ER. People self-ration, so volume could drop more. People go to the lowest-cost provider, which is the convenient care clinic on the corner. ... There's some real shake-up coming from the spread of high-deductible health plans.*

SCHNEIDER: High deductible is a gigantic hammer, and everything looks like a nail. But as a physician, I want to put in a plug for a little more innovation around benefit design. Why would we want to put barriers in someone's way of taking proper care of their diabetes

or whatever chronic conditions? ... We should be making it as easy as possible for people to do the right thing. We complain about patients being not adherent. Well, if someone who makes $15 an hour is expected to pay $300 a month in copays for their chronic disease medications because there are no generic alternatives that are appropriate, what do you expect? So when it comes to value-based benefit design, I think people should have skin in the game, but it can't be just of a broad-based, shotgun approach.

HEALTHLEADERS: *The economics have to work. You can ignore them only to such a degree. If you have a very large Medicare population that you're serving, at some point the Value-Based Modifier is going to really affect your revenue.*

KARP: Well, you're right—we're in this business to make money. You can't say that's a dirty phrase. We do have to carry out a margin to be in business tomorrow, three years, five years, 10 years from now. We do have to come back to the economics of the business we're in. ...

But I would say we lead with what is our mission—what is in essence the right thing to do. ... When you have that as your guiding light, then we do our darndest to make the economics make sense. I'm in a mission-based health system, and the mission drives a lot. ... We believe we're doing the right thing for the patient.

ENDERSON: When we went back and tracked Medicare readmission penalties (and we had been focusing on readmissions before the penalties came into play), of the 15 hospitals in our system, some hospitals were doing very good and had no penalty. Other hospitals had some penalty dollars. But the interesting thing about that metric was the hospitals that did really well and had no readmissions lost way more revenue in length of stay than the penalty they sidestepped. The best model would've been to be at 9% readmissions, just under the 10% threshold [for penalties]. That's the best place to be in economically. But we weren't focused on it. We just tried to do a good job at providing the best care for the patient and let the chips fall.

SCHNEIDER: You can't do ACO work without having a high tolerance for a lot of uncertainty—I assure you of that. But in changing the way we take care of patients, there is some low-hanging fruit that is going to deliver good outcomes regardless of the detail that plays out over the next couple of years. Reengineering how your health system approaches care management is a great example, and we're seeing that in a lot of places. Focusing on our own employees and really taking the purchaser view—there's a lot we can learn from that. I've seen many, many systems that say, "We are going to have to become a better care management organization than just a door-to-door organization. So let's do an inventory of where we are doing some kind of care coordination or care management." And they find it's in 12 different pockets, and they're not aligned, and so forth. So I think investing in foundational change that can start that broader continuum view is going to be a fundamental foundation that will serve you well—no matter what details start to flesh out in the numbers.

> "I've seen many, many systems that say, 'We are going to **have to become a better care management organization** than just a door-to-door organization.' "

HEALTHLEADERS: *A key question is, how much does this investment cost?*

ENDERSON: Centura Health has invested a lot in a bunch of different ways. We have our own ACO, working with close to 3,000 physicians and over 500 of them in primary care.

Our expectation—we call it our "second curve budget"—is that next year we're going to spend probably $18 million subsidizing these ACO second-curve learning strategies. Eighteen million dollars is a lot of money on a $3 billion net revenue budget. But we're spending money to hopefully learn and invest in the future.

Katherine Schneider, MD
President & CEO
Delaware Valley Accountable Care Organization

KARP: At Via Christi, we are trying to address the overall cost of care. When a patient comes into the hospital, we need to make sure they transition properly back into the community. So we are going to have a transitions clinic, we're going to make calls, we're going to make sure they see the primary care physician within a certain amount of time. And we have seen a favorable reduction to readmissions. That is [from] a continuum of care strategy we started to implement.

For our patients, we also have built the primary care medical home care model. We said, "We know the patients don't prefer to come in this inpatient door, so we're going to do everything we can and should over here on the outpatient side."

WIATROWSKI: I'm reminded, after 30 years in the healthcare finance

business, how much the dialogue has shifted to the preservice conversation. Even on collecting money, it's about educating patients to get that high deductible in advance or help them plan to be able to pay for it. And with respect to care delivery, the front end is such a bigger discussion. ... Large employers are investing money on the wellness side. ... And there's huge sensitivity to providing access to the venues that employees would want. It's not just about giving them the lowest-cost care; it's about getting them into the best environment to ensure the best outcomes, as well.

Lynn Wiatrowski
Executive Vice President
Bank of America Merrill Lynch

SCHNEIDER: That's the front-end wellness for the healthy or at-risk populations. But for those with chronic illness, the front end is not about readmissions; it's about admissions. One of my pet peeves is all the focus on readmissions. I understand it's because of the penalties in place. But the best predictor of a community's readmission rate is its admission rate. ... It's an indicator of the systems of care; organizations that have admissions be the "easy button" have high readmission rates as well. So the real question is not, "Are you doing a good job of hanging on to that person in the week after they walk out the back door?" It's "What are you doing to keep people out of the front door in general?" Not just around traditional wellness, but really around access to primary care and alternatives to hospitalization. Have you put those case managers in place—taken them off the floors where they work on the discharge plan and throughput—and actually put them at the front door in the ED? ... How threatening is it to move your care managers to the ED and potentially close a nursing unit two weeks later?

ENDERSON: It comes down to what does payback mean, and how do you measure a healthier, happier community.

HEALTHLEADERS: *That depends on time horizon and on your mission. If your organization has defined itself as being in the business of healthcare, which includes healthiness rather than simply the delivery of volume, then you can be successful, especially if you have a long time horizon.*

ENDERSON: I would suggest that population health doesn't always mean less volume. That's where I think we have to divide population health between use rates and volume. You can't just say volume; it comes down to use rates, too. Population health management should reduce use rates. If an organization is doing a really good job of providing value-based care, then the community should recognize that and want that brand of healthcare. That should be the biggest marketing play. Then volume for that institution should go up, and market shares should be following. Use rates may be going down, but the overall volume of the institution should be going up. That is where I think our board would find the value and the payback of spending money on value-based care programs: your success in the community, and the loyalty from the community because they see what you're trying to do for them.

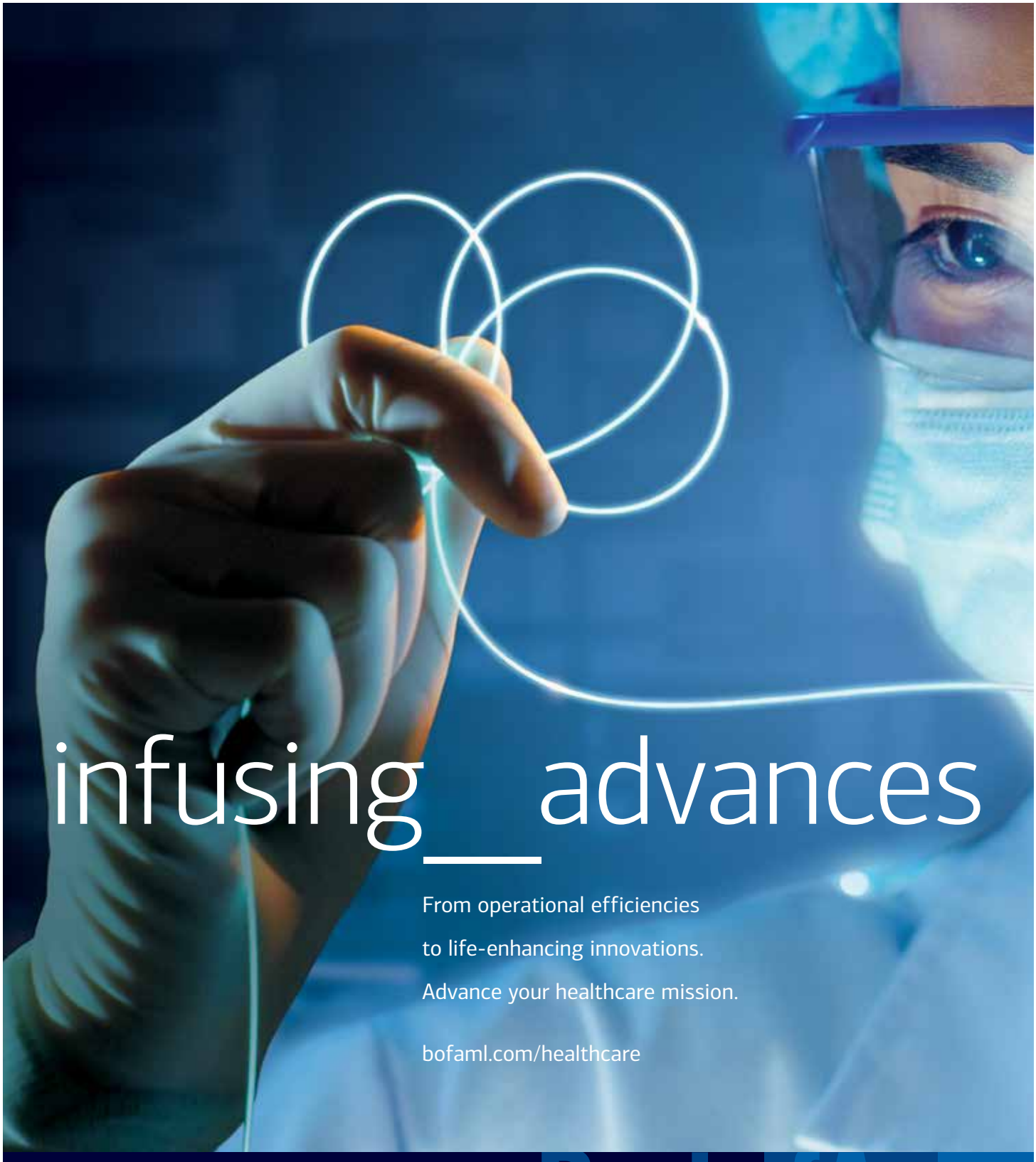
"Large employers are investing money on the wellness side. ... And there's huge sensitivity to providing access to the venues that employees would want."

SCHNEIDER: You bring up the elephant in the room in all of our conversations around cutting waste and improving value: There will be winners and losers. Not all the providers in the community [will be equal]. They're shifting market share, and there will be losers in that. My definition of waste is someone else's lunch and mortgage payment and kids' college tuition. But that's the reality if we're going to get 30% of waste out of the healthcare system, or even a fraction of that.

I think the potential to be a significant winner is quite substantial. Some folks are figuring that out and will become a magnet, will become a center of excellence. You can create stickiness. There's a win in volume and a win on the value side, too. But do you have to be the first in the market to actually get that advantage, or can you be a follower? I don't know the answer to that. I know where we're putting our bets.

WIATROWSKI: The good news is the amount of clinical data today that's available to measure and find the drivers for various outcomes. Also, the increased education of consumers, employers, and all the healthcare community is a factor. That's starting us on the journey to tackling population health. ... Healthcare remains very local, but we've got all the pieces now to begin to effect more comprehensive change.

Reprint HLR0815-5



Bank of America
Merrill Lynch

The power of global connections™