ROUNDTABLE

Straddling and Surviving Two Payment Systems

After years of talking about the transition from fee-for-service to value-based payment, most provider organizations are still waiting for the tipping point. Increasingly, the future revenue picture looks like a combination of both payment models, with some revenue coming through value-based arrangements, but much fee-for-service remaining. This will pose an enormous challenge for healthcare leaders, who must figure out how to evolve and thrive at the same time—how to ensure their organizations get paid enough, how fast they should shift to ambulatory and outpatient care, and how best to restructure toward accountable care and population health management.

PANELIST PROFILES

JIM DIETSCHE
Executive Vice President and Chief Financial Officer
Bellin Health
Green Bay, Wisconsin

JOHN GRIGSON
Senior Vice President and Chief Financial Officer
Covenant Health System
Lubbock, Texas

RHONDA PERRY
Executive Vice President and Chief Financial Officer
Navicent Health
Macon, Georgia

ANTHONY OLIVA, DO
Vice President and National Medical Director
Nuance Healthcare

EDWARD PREWITT (MODERATOR)
Editorial Director
HealthLeaders Media

Roundtable Highlights

HEALTHLEADERS MEDIA: *How are your organizations faring with two different payment systems?*

JOHN GRIGSON: I don't know how to balance fee-for-service and value. I don't think it's ever going to totally switch. I know we will always be in both worlds because west Texas has such a large territory that we're never going to be managing the lives of people 150 miles away. We can't reach that far. Lubbock is 250,000 people, and in our referral area the population is about 1.5 million, so the other 1.2 million are all driving into Lubbock for a lot of their healthcare, and some of them are driving 150 miles for primary care visits. So our dilemma is that we are always going to be in a fee-for-service world for the outlying region, and then we're trying to be in this value world for our metropolitan area.

ANTHONY OLIVA: The major disconnect is that we're still using the fee-for-service side to measure the value-based side. … I've talked to some CFOs that are getting out of the ACO market, and it's because we achieved a ton of savings, but we didn't get any shared savings dollars. … That's a tough pill to swallow.

HEALTHLEADERS MEDIA: *What do you think the situation is going to be a few years down the road, after Medicare really tightens the screws on value-based payment in 2018?*

GRIGSON: I have a hard time seeing us even getting to a 50-50 ratio between payment models in the foreseeable future because the markets are just moving slower than we anticipated. The insurance companies are moving slower. We talked to Blue Cross two years ago about a full-risk deal, and they said no. They knew what we were doing was going to save them money, [but] they didn't want to give us the profits that we would be generating from our population health efforts. You know, insurance companies are not in the business to manage the health of members; they manage financial risk. A lot of them have been very profitable in the risk game. Why would they want to give up that to us? To me, they're not pushing it as quickly as we all thought they would. We thought once Medicare started, all the payers would just go to risk-based payments. No, they didn't. They started figuring out how to maximize their bottom line with it.

RHONDA PERRY: Nobody has a crystal ball, but I will agree that payers are not ready. They also, I sense, don't really want to share their cleansed data or information either, so I think the data will have to be addressed eventually. If you move to risk with these payers, you've got to have some sharing of the data, other than what we have within our own system. All the payers are talking a little bit about shared savings or some type of risk model, but we've seen nothing substantial at all, and the ones that are talking a little more have very little of the market share as well, so not a big impact to us if that came.

Our system did some really good things in the mid-'90s, and they're all just kind of sitting out there now. … We're at the point where we've really got to think about what we are and where we're moving. We're looking at … really driving the cost down. We have lots of pieces of the continuum. We believe if we can get the system of care put together as the market evolves toward risk, we will be better off.

JIM DIETSCHE: It's clear that we're pushing the payers in our market in what they come to the table with. Honestly, for the investments that you need to make as an organization … what they put on the table is peanuts for what your investment is and what you expect the return to be. … You want to be rewarded on outcome measures. But all the payers have their own quality metrics, and they're process measures; they're not real outcome measures.

As to where it's headed—Wisconsin is a very strong market in terms of provider-sponsored plans. We're part of a network across the state of Wisconsin that is clinically integrated. So not only are we locally clinically integrated, we're clinically integrated statewide. We have a clinically integrated network with seven other health systems, prominent health systems that deliver a differential in terms of quality and cost. That's been documented. The network is called About Health. …

Jim Dietsche
EVP and CFO
Bellin Health

Where it's going to go is the health systems are going to take advantage of the provider-sponsored plans in the state. … People have taken notice of that [About Health] network. I think with those provider-sponsored health plans, if we can take advantage of their assets that they have and introduce those into our market, that's how we're going to compete. We're competing with the payers already, even though they're not providing direct care. At the end of the day, we're competing with them, and the ones that want to partner with us, we're willing to talk with them, but they've got to bring something substantial to the table. … We are going to work with a payer or payers that have

lives in our communities ... and we are going to go to them as a clinically integrated statewide network and say, "Here's how we want to work with you. We're going to seek this differentiation." ... How quickly that will come, I think we're probably four, five, six years away from that yet. ... I think we'll still have fee-for-service to some degree, but there will be more dollars at risk that will make it worthwhile.

GRIGSON: You've got to define that risk. Are you really at risk for a premium, or are you at risk for your fee-for-service payments? I think there's going to be a lot more of being at risk for your fee-for-service payments.

DIETSCHE: Our goal is to be at risk for the premium. That's where we clearly want to go. Where we can't quite get there, we want to be at risk with at least fee-for-service, but it has to be two-sided. It's not going to just be upside only because there's not enough in it.

John Grigson
SVP and CFO
Covenant Health System

HEALTHLEADERS MEDIA: *I have heard for years that the transition to value-based payment is four, five, six years out. The target is always several years out.*

GRIGSON: It is still years away. Even with our own health plan, it's just been shocking to me how hard it is to get the administrative team of the health plan to work with the administrative team of our ACO. They ought to be helping each other, right? If it's that hard with our own health plan, you can imagine what it's like with the other health plans.

PERRY: Our PHO had a shared savings contract this year and really did return a good bit to the doctors. But it left $500,000 or $600,000 on the table, so that has gotten their attention. The issue was they could not get timely data. ... There's a lot of data feeds, [but] making it usable and meaningful and timely is difficult. I think it will be a challenge for us, probably for years, to be able to digest that.

HEALTHLEADERS MEDIA: *Everybody knows they need better data, but ... you can never get to the best data. Somebody can always pick holes in it.*

OLIVA: Most of [the industry's] data right now is still claims based, and that's a challenge. Until we can get past claims-based data and get to big data connections, I think that's where we're going to continue to struggle. Claims-based data is fraught with issues.

GRIGSON: The biggest issue we're battling is data. We just recently made the decision to switch off the platform we were on to a platform that has much more flexibility. We will be dumping all member claims data into our new data repository along with all the lab feeds and pharmacy. We're also dumping electronic medical record information from the hospital system, from our employed physician group, and from our affiliated physicians who have electronic medical records (and yes, we are still working on getting some of our affiliated physicians to get off their paper systems). We are beginning to build on top of that the reporting mechanism we need to provide the monthly real-time reporting that is required to manage populations.

HEALTHLEADERS MEDIA: *Jim, you talked about pushing downside risk, how it's not just enough to have the upside risk. ... Do people really need to get into shared risk in order to effect the changes in behavior that are needed to move a lot of markets toward true value-based payment?*

DIETSCHE: I think you hit the nail on the head. That is absolutely right. ... The conversation changes dramatically when you're sitting at the table ... considering an arrangement that has both upside and downside risk. First off, when it's upside only, what they want to give you on the upside is extremely small. When you're looking at a risk-based arrangement that's upside and downside, the opportunity is greater, and the conversation changes about how you minimize that downside risk. If it's on medical expense ratio, what are the quality indicators? Are there any indicators for the specialists, like surgical-site infections? Some of the indicators are hospital-based as well—readmissions and things of that nature. The conversation changes, and the attention among the individuals in the room, and then the linkage to the quality side of how they have to come to the table, changes dramatically.

That is one of the reasons why we don't want to sit in that upside-only world—because you're not effectively changing anything. You're just getting peanuts. We know where Medicare is going; they've already told us that. So we better start figuring out risk faster or sooner than later, because we know we'll find ourselves in a bad place if we wait.

PERRY: In our system, one of the biggest issues that has hampered us [in moving to risk-based payment] is that we've been very successful financially. So for the hospital and the doctors, there's not been a burning platform.

HEALTHLEADERS MEDIA: *Bundled payments are coming for orthopedics. ... Is that going to create change in your markets?*

OLIVA: It's such a small piece. ... Even the bundled payment for total hips and total knees, where it seems pretty

straightforward, the problem is that it's difficult to figure out the downstream risks of a patient. ...

And after hips, what's the next one to go to? Doctors are certainly not going to touch something like CHF. I'm not going to check CABG.

GRIGSON: Because of the way CMS designed the Comprehensive Joint Replacement program, the hospital has to take all the risk. The way to effect change is have the physicians and the postacute care facilities have some skin in the game. We can't force them to have skin in the game. We've talked about requiring our physicians to take some risk to be able to operate at our hospitals. Guess what? They said, "We'll just go across the street. See you."

HEALTHLEADERS MEDIA: *How does the ongoing shift to outpatient services affect your ability to move to value-based payment? A lot of it seems simply a volume shift.*

PERRY: You have to differentiate between the medical side and the procedural side. Where we feel the pain, as far as loss of revenue, is the procedural side. A doctor can say, "We want to open [an outpatient center] and see the patients where we can make money." The rest still go to the hospital. We're having the procedures leave quicker than we're figuring out the problems of cost and penalties on the medical side. It's like the problem is doubling up on us.

GRIGSON: Are you asking the question from an ACO perspective or a hospital perspective? The outpatient shift is a good thing for the health system because our inpatient service lines in totality lose money. So our entire system profit is in the outpatient arena. We have some profitable inpatient service lines, but totaling them all up, they're a loss. From an ACO perspective, it is also good because there's more cost efficiency in the outpatient arena. The problem, though, is that as more procedures move to outpatient facilities, you have more entrants into the market wanting to compete with you for the profitable market segments, such as physician-owned ER centers.

So the hospital is getting its profitable business cherry-picked, and it's starting to hurt the hospital. On the ACO side, since we are at risk for quality and cost outcomes, we're okay with the cherry-picking. When these other joint ventures and entities come in and create these outpatient facilities, they're pricing at a lot lower than the medical center prices its outpatient procedures. So we've gotten into internal discussions about, Should we refer to the freestanding place that's a lot cheaper or refer to our own health system outpatient services? Which hat do we put on? ... It's just a crazy dilemma.

OLIVA: What about the retail competitors? They have so much money behind them, the Walmarts and CVSs and Walgreens, so they're going in and picking off 10 diagnoses. That's pretty straightforward, but I'm thinking their vision is a little bit bigger than that. When do they become urgent care centers and when do they become bigger players in the market? That's scary for hospitals because [the retail competitors] are doing everything based on customer experience.

"You need four or five outpatients to make up for the loss of one inpatient."

PERRY: We have to accept that we're going to have competition. We have to try to find ways to be there for the other services that they don't provide. ...

With good data, you may be able to explain that a $600 charge [at the hospital] is just as good as the $500 outpatient charge if the quality or the outcome of the [hospital] scan is better. But in a consumer-driven world ... it doesn't matter that we can read it 15 ways. Especially the younger generation, if they can go lower out of pocket, they're going.

Rhonda Perry
EVP and CFO
Navicent Health

You need four or five outpatients to make up for the loss of one inpatient. And then you've got pop-up for-profits, selective ventures in the outpatient side, and yet you're trying to maintain your cash position to invest to move to the next level. It's a dilemma.

DIETSCHE: We developed our own brand of retail clinics, and we're actually the largest provider franchise of what are called FastCare Clinics in the nation. They're all over about 30 states right now. Walgreens has become partners now with local health systems because they realize the stand-alone model is not sustainable.

The way we have dealt with [retail clinics] is to develop a relationship with a patient that retains them for whatever they need. ... You have to develop that, because that's what's going to create a relationship with that patient who says, "I don't care about all this noise that's going on around us. This is my provider and my health system of choice."

HEALTHLEADERS MEDIA: *Is FastCare fee-for-service?*

DIETSCHE: In essence, it is. But we have strategic partners where if we don't lower their overall healthcare spend or moderate the increases, our FastCare primary care services are free. And with some strategic partners, we've embedded this site of service in their plan that their visits to FastCare are free. So if their employer has an incentive for them to go to FastCare first, there's no out of pocket, no copay, no deductible. There are ways to incent that kind of behavior, and it's been positive.

Anthony Oliva, DO
VP and National Medical Director
Nuance Healthcare

GRIGSON: We have completely centralized all of our care management activities systemwide. In most of our population health value-based contracts, we pull off a per-member-per-month fee for care coordination and care management. It's two or three dollars, so we're actually hiring the coordinators and the navigators to deal with the population we have been contracted to manage. We have patients coming through our health system who are under these contracts, and then there are the normal fee-for-service patients coming through. As we've built our care coordination navigation programs and people see what good it's doing, they're saying, "Hey, I need you to navigate this patient for me because of social issues," and we say, "That patient's not under a value-based contract." This is another dilemma of living in both worlds.

PERRY: Health systems are being asked more and more to deal with the social aspects of care. ... As an example, we had a diabetic who would swear she's taking her insulin, she's doing everything, and yet she's right back in our emergency room. We went to her home and found she didn't have the money to completely pay her power bills every month, so she wasn't refrigerating her insulin. We have stepped in and we're helping pay her power bill to avoid that huge EC bill. Those are the social aspects of care. ... Who fills those gaps? It is a real issue.

HEALTHLEADERS MEDIA: *A lot of hospitals are very mission-based. They're going to suck up the costs [of social services]. It's incredible that you have to pay somebody's power bill, but I've heard many other examples like that around the country.*

DIETSCHE: We have a freestanding inpatient behavioral health facility. ... We're really the only one in our community, and it's been very successful. We have begun moving that clinical care out and embedding that service with primary care. ... Especially in the Medicare population, when you're looking at chronic condition management and they're screened with depression, you've got to treat the mental side of their illness because that can help the physical side. ... It's early on, but we've seen a lot of success, at least from an outcome perspective. ... [Treatment] has to get out of the stigma of mental health and just get mainstreamed into primary care.

OLIVA: With primary care docs, we're okay with the minor to moderate depression. But you bring in that patient who's on multiple antipsychotics, and they can only get into the psychiatrist once every three months, and they're expecting [a PCP] to take care of them. It's just not the world of the primary care docs. Finding ways to get education or support into the office could be the basis to solve that problem.

HEALTHLEADERS MEDIA: *Physician alignment is a big issue. How do you get physicians on board with this shift?*

DIETSCHE: We have a governance structure for both our primary care group and the specialty care group. When it comes to compensation review, if we want to change the model, they get a say in that. When it comes to quality measures, they get a say in that. That governance process has been in place since we started primary care. As we started employing specialty physicians, we created a separate group just so that we could deal with specialist issues. Now we have brought the two groups together, and I think that has helped immensely in developing trust.

OLIVA: I see it as absolutely required to set up an alternative governance structure to how physicians have governed themselves forever, which is the medical staff model. That is completely antiquated in the current world. The medical staff model needs to be torn up, thrown away, and restructured.

PERRY: The person who is leading our employed group now said, "You will never stop these battles" without changing governance. [Otherwise] it's administration versus clinicians. While we've got a long way to go, I can see so much difference in [physicians] owning it. When there's an issue, we can go to them and say, "Don't yell at us. Tell us how you want to work through it and fix it." That has been great.

OLIVA: I think [physician alignment] is multifactorial. There's not one quick answer. Governance has power. ... Giving physicians some say will always drive a level of alignment. ... If they feel powerless, they're not going to do anything. The second piece is what's in it for them. Medicine has got to have some value to [physicians]. They're still driven by the patient.

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