# Expanded Business View Benefits Catholic Systems

By JOHN MORRISSEY

Mergers and partnerships among health care organizations have laid the groundwork for developing clinically integrated networks, managing populations efficiently and yielding value in better health status at lower-than-projected costs. But getting paid for that value depends on how amenable payers are to aligning health reform's aims with the claims.

In some cases, health systems are partnering with health plans to devise alignments that foster health care's "Triple Aim" — healthier people experiencing better care at a lower cost — and they share the cost savings. In other cases, health systems aren't waiting for payers to become so inclined. They are taking control of payer-provider alignment by acquiring or internally developing health plans of their own, asserting they can forge a transformation in care delivery faster and in the better interests of clinical care.

In Ohio, executives of Mercy Health talked to key payer partners in the state several years ago and "tried to move them into this space with us, because we wanted to move quickly," said Jennifer Atkins, vice president of payer contracting and engagement for the Cincinnati-based, Catholic system. "At the time, we really felt like the payers would eventually get there with us, but probably not as quickly as we wanted."

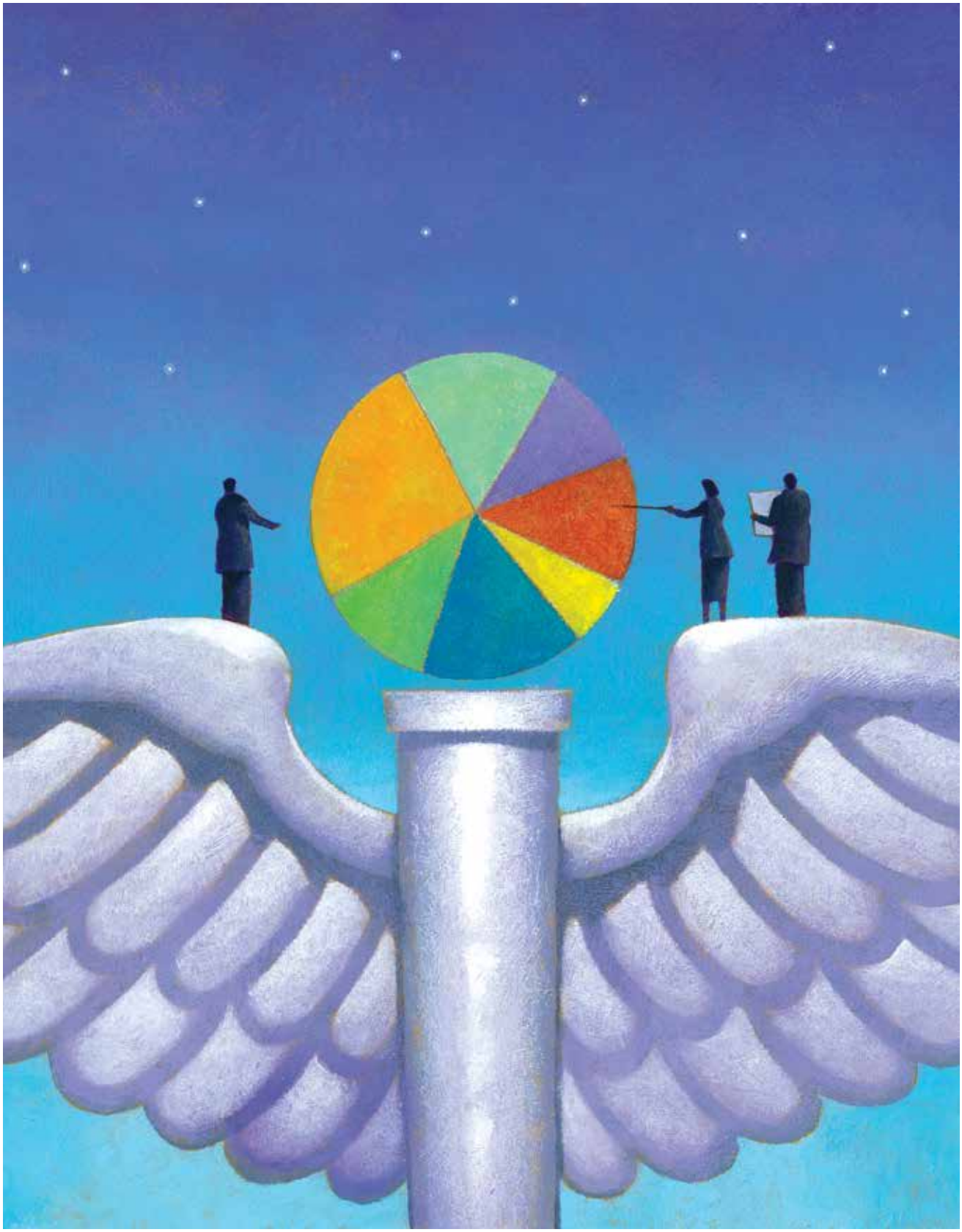
Since then, Mercy Health has partnered with a statewide health plan and launched headlong into value contracting.

A subsidiary of Catholic Health Initiatives acquired health plans in Arkansas and the Pacific Northwest in 2013 and 2014 and is expanding them into other areas where Englewood, Colorado-based CHI has a presence of health care networks. The strategic placements have created close alignment between providers and the licensed health plan, said Juan Serrano, CEO of the subsidiary, Prominence Health, and CHI's senior vice president for payer strategies and operations. "We're accelerating the process of unlocking synergies of value between these [provider and payer functions] in ways that are happening here and there in relationships with the traditional payers, but evolving very slowly."

The credit-rating firm Standard & Poor's, in a June 8, 2015, report, said provider-sponsored health plans (PSHPs) "are becoming increasingly prevalent" as changing dynamics in the U.S. health care delivery system spur efforts to make clinical integration, care coordination and accountability for populations financially viable through "accelerated development of desired risk sharing arrangements." The report also found a number of providers frustrated that "their traditional insurance partners are not willing to share risk with them," and that "provider frustration with this is one of the key reasons behind the development of PSHPs as they want to benefit from their efforts."[1]

The risk partnerships take many forms, with or without an insurer to help. Ultimately the goal is not so much to get into the health plan business as it is to supply the right payment incentives and returns.

In the Missouri cities of Springfield and Joplin, a regional arm of the Chesterfield, Missouri-based Mercy system has been inking one partnership after another directly with area employers during the past four years, relying on a delivery network practiced in reducing the need for employees to use expensive services. The deal: a money-back guarantee of sorts on a promise to reduce health care costs. The pitch: "We will give you basically a target and guarantee you less [cost] than where you'd expect to be in the next year," said David Cane, Mercy's regional vice



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president of payer relations and contracting. "And if we don't reach that, then at the end of the year, we'll just write you a check for the difference, up to where the target was."

The health system has yet to cut a check.

## COST CURVE CONTROL

From a business standpoint, the costly and inefficient norm of care delivery is ripe for reaping savings between the sizable year-to-year cost increases of the past and the level of cost curve-bending possible through well-designed models of care. The trick is to contract for an amount of revenue and then bring costs under that, or to project cost increases based on claims history and achieve a lower rate of increase. Providers then share with a payer the "arbitrage," or the difference between anticipated and actual cost.

"It's the Wild, Wild West right now in terms of opportunities to partner, acquire and joint-venture some ways to go after this arbitrage and compete in this value-based world," said Warren Skea, a director in the health enterprise growth practice of PricewaterhouseCoopers. "I think the stretches of your imagination are the limits here."

"Most of these conversations revolve around the business reasons, the economics, the realities of the marketplace — and quite appropriately so," said Serrano. "But by virtue of our being a Catholic health organization ... the foundational thinking behind all of this revolves around our commitment to serve our communities. And never more so than today are we are finding out that we need to expand our view of our business and how we serve people in the market in order to extend the legacy of care that we bring."

The showcase example of health care arbitrage is the Medicare Shared Savings Program (MSSP), under which health systems organized into accountable care organizations follow a government formula for taking cost out of the care of a Medicare population and then split the difference. But ACOs also are contracting with large, self-funded employers operating predominantly

## HOW A RISK CORRIDOR WORKS

Increases in health care costs were running 8 percent to 10 percent a year for Springfield Public Schools in Missouri, the latest group to negotiate a risk-corridor contract with the regional Mercy health system. The target increase for the coming year is 1 percent to 2 percent. "It's going to be a significant change for them," said David Cane, who heads up payer contracting, "and they would save a lot of money" if the target is achieved.

And Mercy would make a lot of money. In addition to providing the care, it would share with the schools a portion of every dollar above the first $2 million saved between projected and actual cost.

The public schools deal is typical of arrangements initiated about four years ago under which the health system calculates from claims history the potential for reducing an employer's spending on health care. The average spending per employee is about $10,000 per year, according to industry consultant surveys, and that leaves room to decrease costs, said Cane. If the average for a company works out to $6,000, the potential for getting under that trend level is less, and the guarantee is lowered accordingly.

The other big benefit is clarity in the business world, for health care providers as well as employers, said Alan Scarrow, MD, president of Mercy Springfield Communities. Doctors have to deal with two models of payment concurrently, with "not much clarity in how to manage patients," he said. "The more we shift from a volume proposition or a fee-for-service proposition over to a value proposition, the clearer the communication is between the leadership and the physicians: 'These are the rules, this is how it works. Here's a set of patients. Here's the bucket of money that we have. Here are the quality parameters that we have to hit. Now go out and do your thing.' That's a clear message."

Scarrow said area companies talk amongst themselves as they try to control health care cost, the No. 2 expense after wages, and they likely have some knowledge of the Mercy method "when we come in and say, 'Here's a proposition for you: We put some skin in the game, you put some skin in the game, if we do well, you do well." Mercy reps explain that "by focusing on quality, we drive down price, and we're not just going to say that, we're going to put our money where our mouth is at. That's a pretty good strategy for getting companies on board, because this is a way to predict and limit their costs."

Mercy today cares for 488,000 people in the Springfield communities, and some type of gain-sharing or risk-sharing arrangement applies to 43 percent of that population, Scarrow said.

in one region, said James Smith, a senior vice president with the Camden Group, a health care business advisory firm.

"ACO/health plan partnerships are now putting products together to address those large employers' needs, and they are very specific," Smith said. Provider organizations benefit from both the expertise of health plans and the creativity of corporations that operate outside the bounds of ERISA, a federal statute regulating pensions and commercial health plans. "Large employers that have been ERISA-exempt and responsible for their employees' health for long periods of time have done some remarkable things in that space," he said.

Mercy Springfield has been doing direct contracting for nearly 20 years, supplying the contingent of inpatient, outpatient and other facilities and services that comprise the list of in-network providers, instead of having a health plan perform that organizing function. For the last four years, it has offered the risk arrangement as an alternative to the traditional discount, said Cane. The network has no insurance adjunct, and it limits risk to a certain range, called a corridor, above which a self-funded employer has to re-assume financial liability. (See sidebar on page 14.)

Collectively, the direct-to-employer business is the health system's single largest contract group, bigger than any commercial payer contract in southwest Missouri, he said. Employer partners include the City of Springfield, local utilities, the Springfield headquarters of Bass Pro Shops and other large entities.

## HEALTH SYSTEM CATALYST

Mercy Springfield learned how to coordinate care throughout its provider network through successful participation in a Medicare physician group practice demonstration that began back in 2006. It built a prototypical ACO, transformed the network accordingly, and earned about $30 million as its share of cost savings, said Cane. Then it began using that model with employers in its direct-contracting business. "We have gotten pretty confident in our ability to save money for employers by improving their quality," he said. "We get the quality up, and that automatically helps us to bring the cost down."

The processes and methods, polished over many years of reorienting care priorities in response to its shared savings ventures with the government and private sector, center on controlling chronic illness, keeping small problems from turning into big ones and generally preventing the medical mishaps that drive up health care costs. That starts by getting people to go to the primary-care doctor instead of the emergency department, to reduce visits per 1,000 people, and also getting inpatient admissions down, Cane said. Other examples include helping diabetics to get their disease under control, "so we don't have somebody lose a foot or go blind." All those initiatives yield "better quality, but they save a lot of money, too," he said.

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By acquiring the ability and latitude to present their providers with the right incentives, health systems that are acquiring or developing health plans hope to create much the same value-oriented conditions of participation for their hospitals and physician groups.

"The primary motivation behind CHI moving into the health plan/health insurance space is to accelerate and catalyze a restructuring of how we serve our community," said Serrano. As the organization moves into population health management, and as federal government and commercial insurers hand them more economic risk, "we have to become more adept at performing this work and being accountable for the value we deliver. . . . Oftentimes simply desiring to be the organization that's doing that isn't sufficient without having a network product and economic alignment that supports the entire equation."

Part of that equation involves breaking providers of their long-rewarded focus on productivity defined as delivering more services, often at high-cost hospitals. Providers have to move beyond that, Serrano said, "to embrace the notion that we need to not only deliver superior services at the right cost and with the right outcomes, but we also need to have an eye toward where it makes sense

to embrace alternate sites of care, care coordination, discharge planning and re-hospitalization prevention; sponsoring pathways to the home so that in effect we're helping people adhere to their care plan and not end up back in the emergency department."

A fully aligned health plan rewards the health system's providers for such initiative, he said, which then increases the attractiveness of the health plan with employers seeking effective, efficient options. "As we have developed these health insurance markets, we've located them predominantly around our health system in order to encourage our forging of new value-added ways to bring these products to market."

That helps explain CHI's acquisition of a Medicare Advantage plan called Soundpath Health, based near Tacoma, Washington, and a full-service commercial plan, QualChoice, based in Little Rock, Arkansas.

Medicare Advantage operations require expertise in meeting government regulations and effectively managing chronic illnesses, and CHI plans to leverage the acumen of Soundpath to expand in 2015 into Nebraska, Tennessee, Kentucky and metropolitan Cincinnati — markets where it has a physician and post-acute network that can support a care continuum, and where Medicare reimbursement, variable by region, makes sense, said Serrano.

QualChoice is Arkansas' second-largest health plan and a participant in the state's health insurance marketplace, which presents a good place to get an operational foothold and then take it elsewhere. Initially the health plan is expanding into CHI regions that have built clinically integrated networks capable of managing populations and aligning with the health plan on care management activities, he said.

By partnering with or acquiring an insurer, provider organizations are looking at lowering the risk of entry with an entity that has been in the market for a long time and has the resources — financial and human — to operate a health plan, Smith explained.

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### HEALTHSPAN IN OHIO

HealthSpan is a new partner in the fully insured business, but Mercy Health has operated a PPO network for self-insured companies for nearly 20 years, also under the HealthSpan name. Two years ago, the Mercy Health system began working with HealthSpan to increase its reach across Ohio so it could support Mercy Health's value-based network, said Atkins. In early 2014, HealthSpan filed with the state insurance department to sell fully insured business and be able to sell on the state insurance exchange.

As the "most highly aligned payer partner," HealthSpan will do a lot for Mercy Health as a health system to transform payment in its current markets as well as areas in which Mercy Health does not have a presence, such as Columbus, Atkins said. But maintaining healthy relationships with its other payer partners remains important, even as HealthSpan competes with them. The environment of coexistence has required some explaining.

"For the most part, where it has come up, we have done our best to remind them of the conversations that our executive leadership team had, several years ago now, saying that we needed to move into this space, and we came to all of them first and said this is what our strategy was going to be," Atkins related. "I can't tell you that it's been without comment; a couple of the plans have mentioned it, but really, there's a way for us all to exist in this space."

The message to plan partners is that "we have HealthSpan for very specific reasons; we also know that it's not going to be the full supporter of the health system. So we're still going to need to have highly aligned payer partners that are not HealthSpan to fuel our systems." That includes national-in-scope health plans that can bring national accounts to the negotiating table. "There's a way to strike a balance there, and the payers for the most part understand it," Atkins said.

Serrano sees the rollout of health plan business as a way to prove to other commercial insurers

that the CHI health system is serious about the payment-model shift and that they should take it up, too. In conversations with other insurers in the marketplace that are curious about what this means down the road, "what it means is we think we'll be a much better partner, a much better network in health care delivery for each of the insurers as we become more adept at doing this work," he said. "Our goal is to forge progressively more aligned, more integrated relationships with all of the payers in the community. It's much easier to have that conversation and advance that model when we're already doing it."

## MEDICARE-FIRST STRATEGY

Mercy Health in Ohio has forged the beginnings of new-era business arrangements with commercial insurers, initially by enrolling in the MSSP in the Cincinnati area to support clinical integration activities there. Once the required network-building materialized, Mercy Health viewed its Medicare capacity as "a catalyst for moving those clinical integration activities throughout our system," said Atkins. "The Medicare program continues to provide opportunities for us to move our strategy along, with a sizable book of business."

Spreading to all markets in Ohio under the same clinical integration umbrella, the Medicare initiative enabled physicians and their leadership "to have something real and tangible to work with, so it's not just an esoteric conversation about what a contract might look like. These are real patients who are affected by that [clinical approach]," she said. The system's ACO is taking accountability for more than 70,000 lives under the federal shared savings program.

The same clinical structure developed for that ACO, called Mercy Health Select, was additionally deployed to manage risk in other venues. All Mercy Health employees are now in Mercy Health Select, as are enrollees in a mushrooming Medicare Advantage business into which HealthSpan moved in 2014. Besides developing new government contracts with HealthSpan, the Medicare initiatives also have opened up an avenue to initiate the long-awaited partnership with other commercial insurers who have "the highest comfort level in moving into risk-based contracts with us in the Medicare Advantage space," Atkins said. The Mercy Health Select network is managing 190,000 lives and counting, including Medicare Advantage contracts.

The track record with payers on Medicare business has the potential to change their attitudes about risk on the commercial side. Or vice versa. A partnership with Aetna, for example, began with a commercial risk-sharing arrangement, and now that it's off the ground, said Atkins, Aetna is moving into Medicare business with Mercy Health. "But it's still using the same clinical integration resources we have that support MSSP, that support our employees, support Medicare Advantage, support HealthSpan," she said.

## SATISFYING MISSION GOALS

Whether through acquisition or finding another way to align, "everybody is moving in a little different direction, but being able to have the capability of managing populations in our individual markets is what's really important and, ultimately, what satisfies our mission: being able to improve the health of the communities and achieve the triple aim," Atkins summarized.

Buying existing, market-tested plans instead of starting up one helped jump-start the CHI strategy, enabling it to expand from that base into new areas and new types of coverage, said Serrano. "For folks who are looking at these developments with interest and may be thinking about doing the same types of things, a deep partnership with somebody who is already in this space, or perhaps acquiring an interest in a health plan, could be a good way to get started," he said.

These varied approaches also enable providers, not just insurers, to set the rules of engagement. "Remember the health plans are always going to come with their best foot forward for what's going to be best for them," Atkins said. Catholic health systems tend to take "a little different attitude and a little different bent on the best thing to do for our communities," she said. Thus for Catholic systems nationwide, "staying on the sidelines is probably not the way to go."

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### NOTE

1. Standard & Poor's, "The Growing and Evolving Role of Provider-Sponsored Health Plans in U.S. Health Care," June 8, 2015. www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1402787&SctArtId=320508&from=CM&nsl_code=LIME&sourceObjectId=9177496&sourceRevId=2&fee_ind=N&exp_date=20250608-21:28:37.

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