The Academy
The Health Management Academy

THE ACADEMY LUMERIS STRATEGIC SURVEY – TRACKING Q1 2018

HEALTH POLICY & THE EVOLVING PAYMENT MODEL

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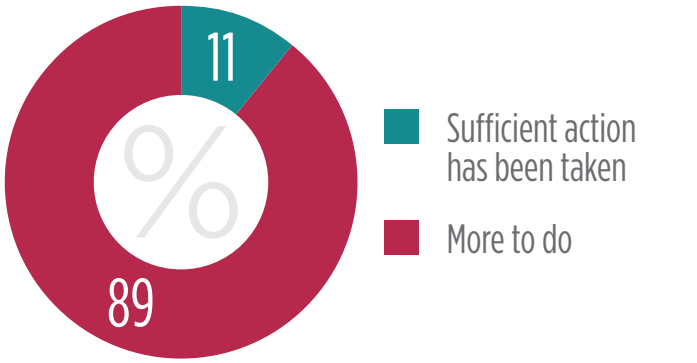
KEY FINDINGS

- The majority (89%) of Leading Health Systems believe that their organization has not yet taken sufficient action around price transparency to satisfy lawmakers in Congress and federal executives.
    - Many of these organizations are implementing strategies to improve price transparency for consumers.
- On average, health systems executives estimate that just over three-fourths (77%) of their care delivery is fee-for-service, and they do not anticipate that this proportion will change over the next year.
- In the first half of 2018, 33% of responding health systems are planning to take on additional risk through an Accountable Care Organization (ACO) and 22% are planning to take on additional risk in Medicare Advantage.

LEADING HEALTH SYSTEMS FACE POLITICAL PRESSURE AROUND PRICE TRANSPARENCY

There has been a high degree of recent interest from policymakers in Washington D.C. on pricing transparency in healthcare, both from Congress and from the administration. With this interest in mind, the vast majority (89%) of responding executives from Leading Health Systems believe that they have more work to do before their organization's actions around price transparency would satisfy lawmakers in Congress and federal executives (Figure 1).

FIGURE 1. DO YOU BELIEVE THE ACTIONS YOUR ORGANIZATION HAS TAKEN ON PRICE TRANSPARENCY WOULD SATISFY THE INTEREST OF POLICYMAKERS, OR DO YOU BELIEVE YOU HAVE MORE TO DO?



"While we have made strides in this direction, I absolutely think we have significant work to do around this topic in our marketplace." (CMO)

Multiple executives mentioned that they either currently have or plan to implement an online tool to help patients estimate the cost of a certain procedure or treatment. The tool's algorithm generally accounts for a patient's demographic information, medical history, and insurance.

"We have tools online where patients can calculate procedure costs." (COO)

Though many health systems have some sort of solution in place to makes pricing more transparent to consumers, some health systems found that these tools were much easier to implement for inpatient procedures and are struggling to fully implement a price estimation tool for the outpatient setting.

"We have some transparency on the inpatient side, but there is no transparency on outpatient side. We have a task force working to find a software tool that helps patients estimate prices. It really matters what insurance company pays – some systems can help the consumer navigate those." (COO)

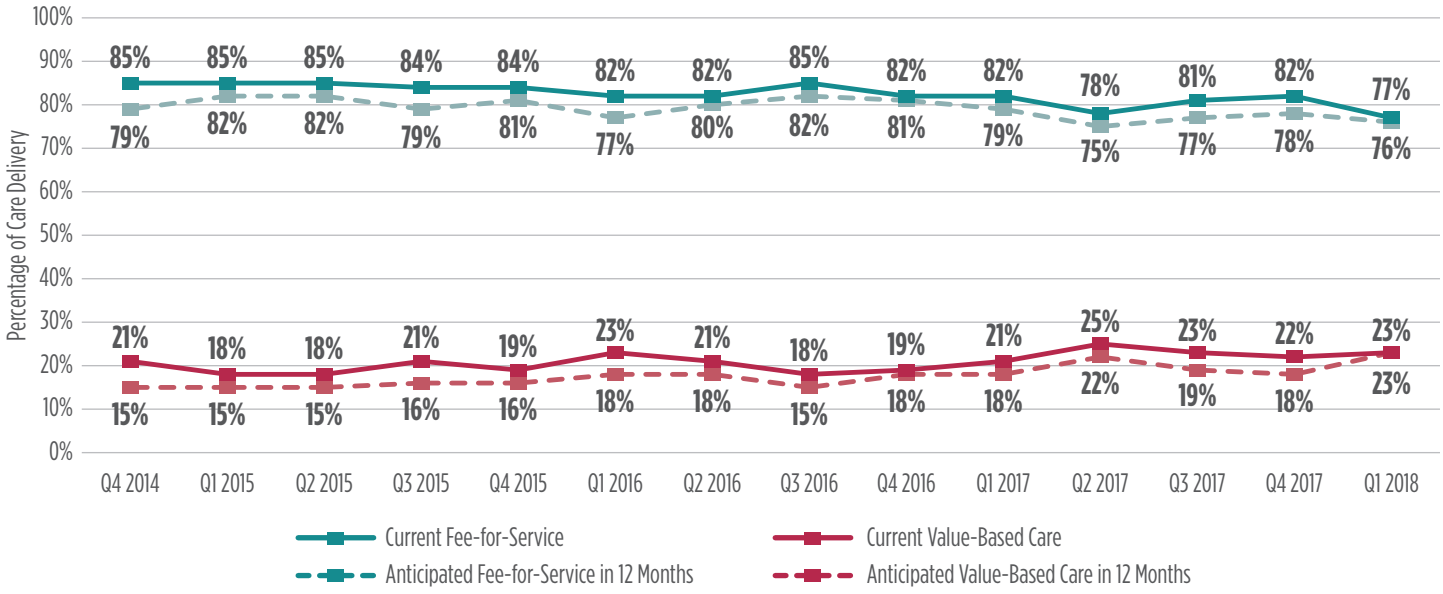
A common challenge for health systems implementing pricing tools is unanticipated insurance billing. The tools are most likely to convey incorrect information when there is an unexpected circumstance on the insurance side. Executives indicated that for these tools to be truly effective, they will require payer collaboration.

"Some have focused on the ability to provide patients with the 'price' to them based on their insurance plan – copays and deductibles. However, there really is not collaboration between the payor and the provider community at this point." (CMO)

THE EVOLVING PAYMENT MODEL

At Leading Health Systems, the shift to value-based reimbursement is slow, but steadily increasing. Fee-for-service payments still account for the majority (77%) of care reimbursement, though this percentage has decreased from the 82% reported in the same quarter last year (Figure 2).

FIGURE 2. CURRENTLY, WHAT PERCENT OF YOUR CARE DELIVERY IS FEE-FOR-SERVICE AND VALUE-BASED? WHAT DO YOU EXPECT YOUR CARE DELIVERY TO LOOK LIKE IN 12 MONTHS?

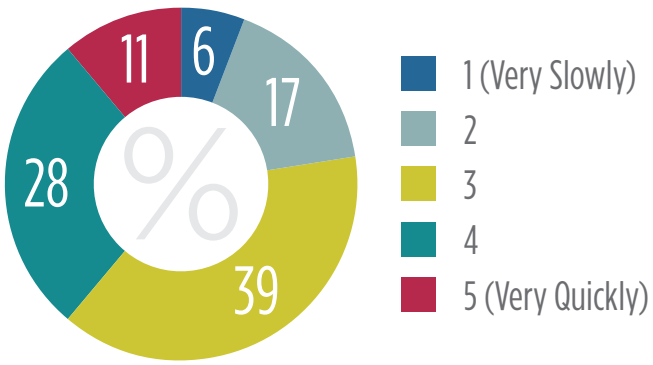


Note: Survey participants may vary by quarter.
For the purposes of this survey, fee-for-service is comprised of self-pay, Medicare DRGs, Medicaid, and commercial payments. Value-based payments include: shared savings ACO, Medicare Advantage, Medicare Shared Savings Program (MSSP), bundled payments, partial or full capitation products, Medical Home contracts, and commercial shared savings

Health system executives indicated that they expect these numbers to remain the same over the next 12 months, with very little movement in the shift toward value-based care. This aligns with health systems' self-reported pace of change towards value-based payment models, with just over one-third (39%) of systems reporting their pace of change a 4 or 5 on a scale from 1 (Very slowly) to 5 (Very Quickly) (Figure 3).

While the pace of change continues to be slow, executives reported a continued commitment to moving to value-based care, citing driving factors such as the potential to drastically reduce cost of care and to drive more innovative care models.

FIGURE 3. ON A SCALE OF 1-5, HOW WOULD YOU DESCRIBE THE PACE OF CHANGE TOWARDS VALUE-BASED PAYMENTS AT YOUR HEALTH SYSTEM?



"We think that as we continue to invest in value-based care within our system, we will see the medical cost in our community decrease overall. We are seriously considering moving to global capitation arrangement with our payers and assessing the acceptable amount of risk we're willing to take on." (CFO)

Many health system executives highlighted resistance from insurers as a challenge slowing the pace of change toward value-based care, as coordination with payers is a crucial component of implementing value-based care models.

"We are really waiting on the insurers. The switch from an open network model to a high performing narrow network model is not going as fast as we would like it to go. Securing the right value-based payment arrangements is difficult – we don't know what proportion of startup costs insurers are willing to share for the work involved in bringing down overall cost of care." (CFO)

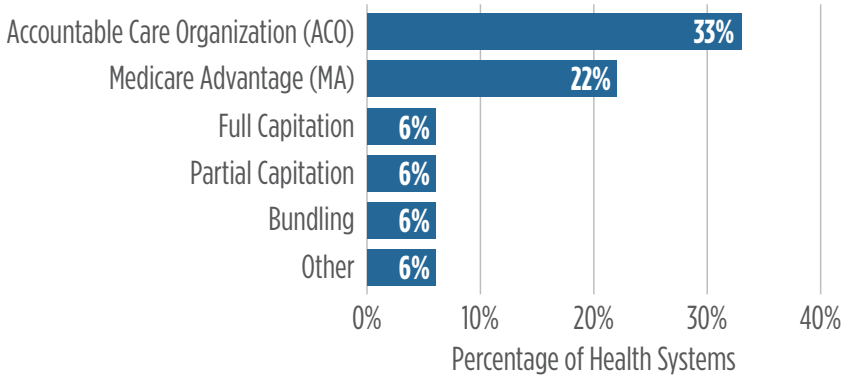
Providers also expressed that some of their hesitancy stems from uncertainty around government reimbursement, concerned that under-reimbursement may drive up costs in an unmanageable way.

"Not only are we experiencing a lack of interest on the payer side, but hesitancy around the fact that Medicaid and Medicare are significantly under-reimbursed. This cost must go somewhere, and simply becomes a tax on everyone else. We can't justify the value." (CFO)

Over Q1-Q2 2018, a minority of Leading Health Systems plan to take on additional risk, with 33% planning to add risk through an Accountable Care Organization (ACO) and 22% planning to add a risk through a Medicare Advantage (MA) plan (Figure 4).

"We already have a Medicare Advantage plan, and we launched a Medicare ACO in January. We are looking at partnering with health plans around partial and full capitation in the next 6 months, and we continue to move in that direction." (CNO)

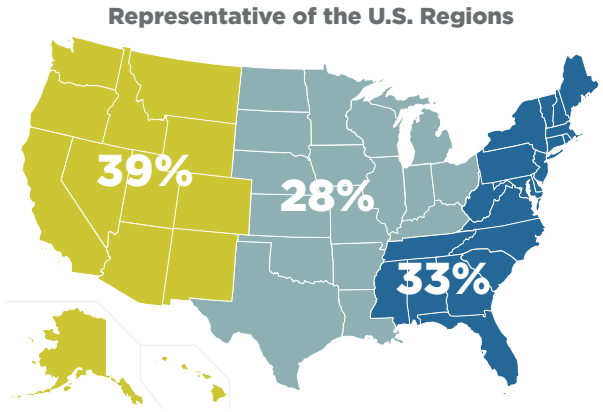
FIGURE 4. DOES YOUR HEALTH SYSTEM PLAN TO TAKE ON ANY ADDITIONAL RISK IN THE NEXT 6 MONTHS (Q1 – Q2 2018)?



Health system executives also noted that there are several challenges associated with taking on additional risk and deciding which value-based arrangements would be best for their specific organizations.

"We do have feasibility study around a potential Medicare Advantage (MA) plan, though we haven't reached a conclusion. We believe that the ACO model might be more lucrative than MA. It's hard to compare – there are substantial startup costs and actuarial risk in Medicare Advantage, and since the lives that are in MA can't be in a Medicare ACO, we lose out on the potential upside gains from an ACO if we go with MA." (COO)

PROFILE OF PARTICIPATING HEALTH SYSTEMS



AVERAGE NET PATIENT REVENUE

$4.75 BILLION

OWN OR OPERATE **296 HOSPITALS** WITH **54,026 BEDS**

PROVIDER OWNED HEALTH PLAN: **56%**

SINGLE-STATE SYSTEMS: **56%**

MULTI-STATE SYSTEMS: **44%**

PARTICIPATING HEALTH SYSTEMS

Advocate Health Care
Avera
Banner Health
BayCare
CONE HEALTH The Network for Exceptional Care
FAIRVIEW
HAWAI'I PACIFIC HEALTH Kapi'olani · Pali Momi · Straub · Wilcox
Indiana University Health
Intermountain Healthcare
KAISER PERMANENTE
Lehigh Valley Health Network
Northwell Health
Ochsner Health System
Piedmont HEALTHCARE
PRESBYTERIAN
Providence St. Joseph Health
UnityPoint Health
Yale NewHaven Health

METHODOLOGY

In March 2018, The Academy conducted the fourteenth round of its quarterly strategic survey among 18 senior health system executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs. The survey for the interview consisted of: (1) a tracking section that provides insight into trends around primary strategic areas; (2) a special topic area that allows for an in-depth look into a timely, developing issue. Innovation, consumer engagement, ambulatory and real estate strategies, physician alignment, bundling, data analytics, telehealth, pharmacy strategies, branding, health policy, cost reduction, cybersecurity, and disruption were topics of previous surveys.

THE HEALTH MANAGEMENT ACADEMY, "THE ACADEMY"

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.academynet.com.

LUMERIS

Lumeris serves as a long-term operating partner for organizations that are committed to the transition from volume-to value-based care and delivering extraordinary clinical and financial outcomes. We guide health systems and providers through seamless transitions from volume to value, enabling them to deliver improved and more affordable care across populations—with better outcomes. And, we work collaboratively with payers to align contracts and engage physicians in programs that drive high-quality, cost-effective care with satisfied consumers—and engaged physicians.

An industry recognized leader, Lumeris won the 2018 Best in KLAS award for value-based care managed services for helping clients deliver improved clinical and financial outcomes. This was the third year it received this distinguished award. For the past seven years, Essence Healthcare, Lumeris' inaugural client with more than 65,000 members in Missouri and Illinois, has received 4.5 to 5 Stars from the Centers for Medicare and Medicaid Services. Lumeris is committed to delivering these same results with its multi-payer/multi-population clients to meet their goals and missions.

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