SOCIETY FOR
Healthcare Strategy & Market Development℠
of the American Hospital Association

CREATIVE AFFILIATIONS FOR SUCCESS IN HEALTHCARE'S NEW ERA

In association with Kaufman, Hall & Associates, LLC

Report from the SHSMD
2015 Thought Leader Forum

Oct. 11, 2015
Washington, D.C.

About the Society for Healthcare Strategy & Market Development

The Society for Healthcare Strategy & Market Development (SHSMD), a personal membership group of the American Hospital Association, is the largest and most prominent voice and resource for healthcare strategists, planners, marketers, and communications and public relations professionals nationwide. SHSMD is committed to helping its members meet the future with greater knowledge and opportunity as their organizations work to improve health status and quality of life in their communities. For more information, visit www.shsmd.org.

About Kaufman, Hall & Associates, LLC

Kaufman Hall provides management consulting services and enterprise performance management software that help organizations realize sustained success amid changing market conditions. Since 1985, we have been a trusted advisor to boards and executive management teams, helping them incorporate proven methods into their strategic planning and financial management processes, and quantify the financial impact of their plans to consistently achieve their goals.

Kaufman Hall's extensive industry expertise and tailored solutions for healthcare, financial institutions, higher education, and other key industries enable clients to take advantage of proven best practices and realize faster time to value. For more information, visit www.kaufmanhall.com.

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Foreword

The Society for Healthcare Strategy & Market Development held the fourth Thought Leader Forum on October 11, 2015, at its annual conference in Washington, D.C. The event originated in 2012 as the result of a brief survey in which SHSMD asked its strategic planning members to identify their most pressing concerns. The survey results revealed that planners' biggest challenge is addressing current financial realities while preparing for future financial models.

SHSMD convened its first Thought Leader Forum in September 2012, with the goal of exploring this issue through a dialogue of members and other healthcare leaders. Due to its successful reception, that dialogue continued with the 2013 Thought Leader Forum titled "New Rules, New Tools: A Discussion of How Planners, Marketers, and Communications Professionals Can Lead Their Organizations Through a Changing Environment," and the 2014 Thought Leader Forum titled "Redefining the 'H': How Health Systems Must Evolve to Grow and Thrive."

The theme of the 2015 Thought Leader Forum was "Creative Affiliations for Success in Healthcare's New Era." A diverse panel of professionals in healthcare strategy, planning, and business development were invited to share their perspectives. Ryan Gish, managing director of Kaufman, Hall & Associates, LLC, moderated the session for the fourth consecutive year. The discussion involved a high degree of audience participation covering a range of topics, including:

- Criteria for selecting the right partner
- Examples of creative affiliations, factors driving their creation, and future goals
- Challenges and limitations of non-merger arrangements, including data sharing, antitrust issues, and care coordination
- Communicating partnership initiatives to stakeholders

This report provides a summary of panelists' insights on partnerships and their responses to specific issues during a question-and-answer session. The panelists' comments focus on important strategic and financial considerations facing healthcare organizations today, and provide examples from key industry players on how they are pursuing nontraditional partnerships.

comments focus on important strategic and financial considerations facing healthcare organizations today

Executive Summary

Healthcare's transition to new care delivery models is driving merger and acquisition activity among hospitals, health systems, and other healthcare organizations. For those organizations wishing to maintain their independence, however, a creative affiliation may be a pathway for creating value for communities and realizing some of the benefits of scale of a partnership, without fully combining assets and governance structures.

Numerous examples have emerged around the country, spurred by factors such as intense cost pressures and federal and state mandates to shift Medicare and Medicaid populations to managed care programs. Some examples include:

» *Trivergent Health Alliance* was formed in May 2014 and placed into operation in July 2014 to provide regional services for three Maryland health systems under a management services organization. The partners invested a combined $3 million in the Alliance to manage approximately $250 million in aggregate costs for the membership, which aims to increase operational efficiencies, reduce costs, and enhance care quality in the region. Trivergent achieved $10 million in savings its first year through multiple initiatives, including implementation of a single, shared drug formulary that significantly reduced costs, accounting for about 25 percent of the overall first-year savings.

» *TriHealth* formed in 1995 between two Cincinnati hospitals. The $1.8 billion integrated health system has a market share of about 22 percent. The system has a distributed primary care network, and it is developing the ability to assume risk and manage population health. In 2012, TriHealth partnered with the sole acute care provider in northern Kentucky, St. Elizabeth Healthcare, to jointly enter into risk-based contracts with employers and payers. The partnership—Healthcare Solutions Network—has aligned quality data between the two systems and is moving forward with coordinated managed care contracts.

» *The Illinois Partnership for Health* (IPH), a Medicaid managed care organization with about 40,000 members, includes nine health systems and a health plan covering central Illinois. The partnership has aggressively worked to build a population Healthcare model, and has made significant progress in coordinating clinical leadership of best practices. The partners ultimately plan to move to a full risk payment model.

» *Good Shepherd Penn Partners* is an affiliation between Penn Medicine and Good Shepherd, a rehabilitation hospital in Allentown, Pa. Penn Medicine sought a partner with a solid track record in rehabilitation to manage its physical therapy program. The program has had great success, with increased therapy levels at all of its outpatient centers, as well as the opening of new facilities.

Because these and other non-merger affiliations lack the "glue" of more integrated partnerships, having the staunch support of executive leadership across all partners is critical to success.

Addressing regulatory requirements

While such affiliations allow organizations to share certain information and resources, there are regulatory and antitrust limitations related to data sharing and other issues.

Trivergent Health Alliance, for example, maintains separate databases at its member health systems, and any shared data are de-identified before data are consolidated. Data use agreements are in place that allow for information sharing only for specific patients seeking care across multiple alliance facilities. To address antitrust concerns, the three Trivergent hospitals share best practices, but do not collectively engage in facility planning. The partners also are careful about negotiating contracts on behalf of multiple hospitals for materials or services.

TriHealth shares aggregated clinical data between its members to analyze performance and quality improvement opportunities, but no claims data is shared without a shared-risk agreement. The partners cannot share fee schedules or coordinate physician payments.

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Executive Summary Cont'd.

Communicating the benefits of a creative affiliation to the community also can be a challenge. It is important that organizations ensure communication with all stakeholders, especially physicians, and tailor those communications to the different audiences. Organizations may choose to accentuate a particular partner based on its brand dominance in a particular service line or community, or develop a new brand name altogether.

Finding the right partner

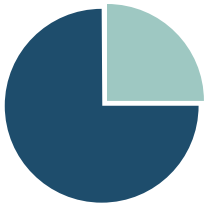
In entering into an affiliation, healthcare leaders should look for a partner that brings the best value relative to established organizational objectives. Partnership decisions should be based on each hospital's unique situation, rather than established relationships. Compatible culture, values, and leadership are essential to a successful affiliation.

Opinions differ on whether such partnerships will yield the level of savings that the Centers for Medicare & Medicaid Services is seeking long-term. While some feel that more integrated structures ultimately will be required, others believe non-merger arrangements offer abundant cost-reduction opportunities.

In seeking to coordinate care and move closer to a population health model, some creative affiliations are using care coordinators to help high-risk patients manage their care. The Illinois Partnership for Health, for example, stratifies patients' risk levels up front. Established care coordinators then work with high-risk patients at the local level.

Organizations entering into non-traditional partnerships need to have patience and recognize that change takes time. Healthcare leaders should focus on identifying the right partner(s) and ensure that accountability is built into the arrangement through clear and effective leadership. Ensuring patient involvement will be essential in the success of creative affiliations as they evolve over time to a value-based care delivery and business model.

Perspectives on Partnerships



Maryland: 44 hospitals & health systems
10 are not merged, affiliated, or acquired

Lower capita Medicare cost saving $330 million over the next five years

$40 million in potential savings over 3 years

Overview of Partnership Activity Occurring Nationwide

Ryan Gish, Managing Director of Kaufman, Hall & Associates, LLC

The merger and acquisition market remains very active, reflecting organizational repositioning for healthcare's transformation to a new business model. We're seeing a new generation of system-to-system mergers, whose partners are looking to transform their individual market. At the same time, stand-alone hospitals, in particular, are thinking about where they fit into the delivery system mix in their regions.

The benefits of scale have been well documented. They include growth of intellectual capital, economies of shared infrastructure, enhanced purchasing power, ability to create or participate in narrow networks, and increased ability to assume risk arrangements related to managing population health. Yet, many organizations don't want to merge for various reasons. For example, they may have concerns related to culture and taking on risk, or they've built very strong businesses and organizations in their local market and want to retain their independence.

Numerous creative affiliations are being formed around the country as a result, as organizations develop new ways to add value in their communities while remaining independent. Such affiliations are the topic of our discussion today.

Driving Value Through a Management Services Organization

Raymond Grahe, Chief Executive Officer of Trivergent Health Alliance MSO

Trivergent Health Alliance is a management services organization (MSO) brought into operation in July 2014 after two years of planning to provide regional services to Frederick Memorial Hospital in Frederick, Md., Western Maryland Health System in Cumberland, Md., and Meritus Health in Hagerstown, Md. Together, the organizations have $1.2 billion in revenue and about 250 employed physicians. The Alliance is based in Hagerstown, Md. Its mission is to increase operational efficiencies, reduce costs, and enhance quality of care in the communities it serves.

Maryland has 44 hospitals and health systems, only 10 of which have not merged, affiliated, or been acquired—including the three health systems in Trivergent. Cost reduction pressures are uniquely intense in the state, which is highly rate-regulated with global budgets and revenue caps for all hospitals. Those cost pressures are intensifying as the state has promised the Centers for Medicare & Medicaid Services that it will lower its per capita Medicare cost, saving $330 million over the next five years. It's a grand experiment moving at warp speed from volume to value.

The chief executive officers (CEOs) of the three health systems that make up Trivergent began talks in October 2012, seeking to form a collaborative that would allow them to generate savings without giving up control of their organizations. They identified about $40 million in potential savings over three years.

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Perspectives on Partnerships Cont'd.

Alliance achieved $10 million in savings, nearly double its first–year goal of $5.6 million.

Implementation of a single drug formulary reduced costs and contributed about 25 percent of overall first–year savings.

206 recommended changes related primarily to antibiotic stewardship, 96 percent of which were accepted.

Following approval and a five-year commitment from each of the members' boards, Trivergent launched in July 2014 as a limited liability company. Its 1,200 employees were drawn from the health systems, which invested a total of $3 million into the corporation to manage $250 million in costs for the Alliance.

Today, Trivergent has six divisions: human resources, information technology (IT), laboratory services, materials management, pharmacy, and revenue cycle. In its first year, the Alliance achieved $10 million in savings, nearly double its goal of $5.6 million. The partners are pursuing several major initiatives the second year, including moving to a single IT platform, employee benefit structure, and revenue cycle function.

Ryan Gish: Please describe the three members of the Trivergent Health Alliance and how they came together. What have been some of the successes to date, and are there plans for expansion?

Raymond Grahe: All of the health systems in the Alliance are sole community hospitals, but they are culturally different and serve very different populations. Frederick Memorial Hospital is close to metropolitan D.C. and covers a population that is generally younger and more ethnically diverse, with a higher per capita income. Meritus Health in Washington County covers a primarily working-class population in a county with a lot of industry (i.e., a Volvo manufacturing plant and several trucking companies) and high obesity rates. Western Maryland Health System in Allegheny County covers an older, lower-income population in a rural and mountainous area.

Managing with three different cultures can be a challenge. The Alliance would not be as successful as it is without the total commitment of the organizations' CEOs and chief financial officers (CFOs). One example of a success to date is implementation of a single, shared drug formulary across the three hospitals that significantly reduced costs, accounting for about 25 percent of overall first–year savings. Medical staffs at each of the hospitals vote on any changes to the formulary. In the first year, there were 206 recommended changes related primarily to antibiotic stewardship, 96 percent of which were accepted.

Bringing the medical staffs together presents opportunities for new cross-referrals to Alliance hospitals and collaborating on quality of care and cost reduction initiatives. For example, to reduce unnecessary care, the three hospitals contract with the same group for emergency care.

Trivergent could expand with new members or with additional divisions, so the model could be scalable. But we want to move forward cautiously and build a solid foundation before inviting expansion.

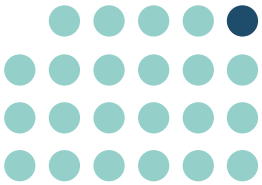
Perspectives on Partnerships Cont'd.

Of $1.8 billion

$1 billion is in hospitals

$200 million in non-hospital clinical services

& $600 million is in the physician component



TriHealth has expanded from 25 employed physicians to 550

Assuming Risk Through Joint Operating Agreements

Will Groneman, Executive Vice President for System Development for TriHealth (also involved with Healthcare Solutions Network and Midwest Health Collaborative)

TriHealth is a $1.8 billion integrated health system based in Cincinnati that has a long history of partnership and affiliations. About $1 billion of that $1.8 billion is in hospitals, $200 million is in non-hospital clinical services, and $600 million is in the physician component.

TriHealth formed as an operating company in 1995. It is a creative affiliation between Good Samaritan Hospital (part of Catholic Health Initiatives) and Bethesda Hospital, both of which are based in Cincinnati. The organizations have separate sponsors and separate balance sheets, but nearly everything else is operated jointly (e.g., electronic health records, budgeting process, capital allocation process, etc.).

Three smaller hospitals have since joined, and TriHealth has expanded from 25 employed physicians to 550. TriHealth currently has an approximately 22 percent market share. The company is pursuing population health, has distributed primary care networks, and is looking to assume risk.

In 2012, TriHealth partnered with St. Elizabeth Healthcare in northern Kentucky to create the Healthcare Solutions Network (HSN) under a joint operating agreement. St. Elizabeth is the sole acute care provider for northern Kentucky, which has the state's largest population base and a vibrant and growing economy. The organizations want to contract with employers and payers, assume risk together, and jointly go to market to provide a single experience for patients across state lines, without becoming an integrated system.

During its first two years, HSN focused on aligning critical functions. One initiative, for example, established common definitions for data coming from the partners' two separate electronic health record systems to enable aligned quality data/indicators. For phase two of the joint operating agreement, a newly hired CEO is pursuing further alignments, including coordinated managed care contracting. HSN has one managed care contract for 2016 and expects to have three managed Medicare contracts by 2017, along with several commercial contracts.

Future initiatives include care coordination programs and a unified population health IT system. Ongoing incremental value to each of the systems is what will keep Healthcare Solutions Network together.

Perspectives on Partnerships Cont'd.

IPH has approximately 40,000 members and capacity to manage 120,000 Medicaid covered lives through more than 60 facilities and 7,000 physicians/clinicians.

Partnering to Manage Healthcare for the Medicaid Population

Terri Welter, Principal at ECG Management Consultants and Strategic Advisor to the Illinois Partnership for Health

In 2011, Illinois issued a mandate for 50 percent of Medicaid beneficiaries to be moved into managed care organizations over a multiyear period. Shortly after, the state formed accountable care entities, a program modeled after CMS accountable care organizations (ACOs). Initially, the plan allowed organizations to get paid per member per month (PMPM) for care management, and become a Medicaid managed care organization within three years.

The Illinois Partnership for Health (IPH) was formed as an accountable care entity in 2014, and it immediately began work toward becoming a Medicaid managed care organization. The partnership includes nine health systems (currently four founding organizations and five affiliates) covering central Illinois and the Health Alliance Medical Plans (owned by the provider, the Carle Foundation), with which each system had long-term relationships.

IPH has approximately 40,000 members and capacity to manage 120,000 Medicaid covered lives through more than 60 facilities and 7,000 physicians/clinicians. The partnership began enrolling members in August 2014, receiving $9 PMPM for the traditional Medicaid population and $20 PMPM for the ACO adult population.

A major focus for the partnership has been building a viable care model through consolidation of best practices. Its hybrid model for care management, led by clinical leadership, is driving change across the network. Services are centralized for activities such as assessing a population's risk, with information then sent to individual practices where nurse navigators can use it in providing care locally.

IPH's members have agreed ultimately to accept risk, which provides the opportunity for them to get closer to the premium dollar in a state that receives lower Medicaid payments than most. Key to success with risk assumption by IPH is having a strong health plan partner (Health Alliance) that is willing to share the savings from reduced spending.

Ryan Gish: Terri, can you discuss some major challenges for the IPH and how the partnership has worked to overcome these challenges?

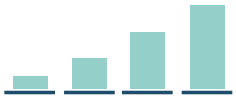
Terri Welter: A big challenge for the partnership is its coverage of such a wide geographic area by the participating health systems. Both a board and a clinical leadership committee were established with equal representation from each of the health systems. They spent a lot of time together developing trust, which really is the partnership's glue. They are working on continued communication of board/committee decisions across the organizations.

Another challenge came in April 2015, when the then-new Illinois governor, Bruce Rauner, decided to expedite the transition of much of the state's Medicaid population to managed care. Suddenly, IPH had to become a managed care organization in a matter of months rather than years. Having a strong health plan partner allowed the partnership to quickly establish a plan to move its Medicaid members to Health Alliance and provide care management for those members. The partnership with Health Alliance was critical to success. The health plan's culture had already evolved toward looking at providers to manage care.

Perspectives on Partnerships Cont'd.

Developing Unique Service Line and Infrastructure Ventures

Robert Bauer, Executive Vice President of Navvis and Company



Therapy levels at all of their outpatient centers have increased dramatically

Lower healthcare costs in the three years post-completion

There are four ways to create or energize service line programs through unique relationships that don't require a merger.

No. 1: It can be difficult for organizations to focus on more than three to five service lines and to develop a strong business plan that is efficiently executed in each.

Penn Medicine, for example, is a top-notch organization that's a leader in National Institutes of Health funding and a worldwide leader in gene therapy. In considering its physical therapy program, Penn's leaders realized that it would not get attention and focus as a high-priority service line for the organization, despite being a much-needed service. So Penn established a joint venture with Good Shepherd, a rehabilitation hospital in Allentown, which had similar values and a strong reputation for running a high-quality program in that service area.

The partners formed Good Shepherd Penn Partners, with Penn holding a minority ownership interest, but turning over the management and control of this service line to Good Shepherd. The program has had tremendous success. Therapy levels at all of their outpatient centers have increased dramatically, and new long-term acute care and inpatient rehabilitation units have been established at a hospital Penn acquired.

No. 2: Some programs today work in the current fee-for-service environment *and* also build success for the future population health management (PHM) environment. I call these "sweet spot" programs, which hospitals and health systems should consider developing.

For example, traditional cardiac rehab programs typically lose money because patients tend to go only for a short time and then drop out. In an effort to improve results, CMS created Intensive Cardiac Rehab (ICR) about five years ago. ICR is a multi-modality program that includes exercise, nutrition, stress therapy, counseling, and other services, so patients tend to stay longer than with a traditional program that is only exercise focused. CMS permits twice as many allowable visits and provides reasonable payment rates. Medicare Advantage plans have to cover it, and ICR receives good coverage from commercial insurers as well.

To date, CMS has approved three ICR programs: the Benson-Henry Institute Cardiac Wellness Program (Harvard), Pritikin Program, and The Ornish Program for Reversing Heart Disease. Studies show that people who complete the program have significantly lower healthcare costs in the three years post-completion.

No. 3: The infrastructure that organizations need for population health management, which could be gained through creative partnership arrangements, includes:

- A digital engagement platform
- Strength and competency around behavior change and modifying lifestyle risks
- Capabilities to manage medical care costs of high-risk patients
- Ability to provide care across the continuum

Developing these competencies in an entity like a "population health services organization" can allow for involvement of multiple organizations, which enables more cost effective development and deployment of services at scale.

No. 4: Lastly, organizations must consider whether they are organized for success under a PHM model. This is the biggest challenge. A lot of organizations have many ongoing activities—such as those involving discharge planning, pay-for-quality programs, a Medicare Shared Savings Program ACO, and care management through an independent physician association—but efforts aren't coordinated.

Organizations need to have a focused effort and a department or company in charge of the overall PHM strategy.

All of these needs can be filled through means other than mergers.

Audience Questions and Answers

1. How can data be aggregated in these types of non-merger partnerships? What are the possibilities and the limitations on how that data can be shared?

Raymond Grahe: For Trivergent Health Alliance, each hospital system has its own database. We take the data from each, de-identify, and then consolidate the data. The Alliance has data use agreements in anticipation of sharing specific data on patients who may be seeking care across the geographic region, but data that are proprietary to one hospital remain proprietary.

Will Groneman: Unless we have a shared-risk agreement, we shouldn't be sharing claims data. We share some information around certain outcome measures (e.g., HCC scores), but not the data, even in a highly aggregated form. We treat each other as competitors except for data for those specific patients who are under a shared-risk contract through the Healthcare Solutions Network.

On the clinical data side, we share aggregated data between systems to assess overall population health and quality. That includes analyzing performance and opportunities for improvement on quality indicators by group or by practice.

2. What issues have you faced related to antitrust concerns, and how have those shaped your thinking about the structure of your partnerships?

Raymond Grahe: The three Trivergent Health Alliance MSO hospitals are prohibited from coming together to develop strategies such as determining where service centers such as urgent care centers should be placed in the overall market, for example. We can talk about best practices and how to staff facilities, but going beyond that to try to coordinate the locations would violate antitrust laws. Essentially, the MSO can facilitate strategy that the three hospitals have *independently* generated, but the three hospitals cannot come together and develop a collective strategy. We also have to be careful negotiating contracts on behalf of multiple hospitals for materials or services.

Will Groneman: TriHealth had antitrust counsel from the start, since we are all still competitors legally. You can't share fee schedules or coordinate the prices you pay physicians recruited to the organizations, unless you have some formal clinical integration or shared-risk arrangement. Our separate risk-based contracts have different fee schedules that we have negotiated individually.

Not being able to share information on claims and finances can be challenging because we want to take risk together, yet we aren't allowed to really see how that works. However, it's not an insurmountable impediment. More latitude exists around sharing data for joint quality improvement initiatives.

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Audience Questions and Answers Cont'd.

3. How can an organization, often with numerous types of partnership arrangements (e.g., with a children's hospital for specialty services, an academic medical center for an ACO, etc.) communicate the benefits of those partnerships to the marketplace in a way that makes sense and resolves confusion?

Bob Bauer: It really is about brand equity. Where are you going to try to project your organization's brand recognition into a new market? Or where might another organization have a strong brand reputation that you want to maintain and benefit from a halo effect, while not diluting your own brand? Obviously, the equity equation and communication challenges become more complex as you enter into additional relationships.

Terri Welter: Ensuring communication with all stakeholders, tailoring communications to the different audiences, and timing them appropriately are critical. Communicating early with primary care physicians was particularly important for the Illinois Medicaid partnership because physicians experienced changes quickly within their practices. The IPH held webinars and other forums, and created information sheets in an effort to spread key information the providers needed to know.

Raymond Grahe: You may want to promote/accentuate the predominant player in a space, rather than trying to give everyone equal billing. Healthcare leaders have to ask: What is the principal player's program whose strengths we are trying to communicate? In our case, we don't promote the Trivergent name, we promote the hospitals and their programs instead. Our employees' badges name their hospital; the employment relationship with Trivergent is less prominent. We don't want to confuse people.

Another option is using the "empty vessel concept" by developing and using a name that is not yet trademarked anywhere. You can then build meaning around that new name and help to shape the community's relationship with a fresh brand. Some example names are the "Meritus" or "Inova" health systems.

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Ensuring communication with all stakeholders, tailoring communications to the different audiences, and timing them appropriately are critical.

– Terri Welter

Webinars, forums & information sheets to spread key information the providers needed to know

Audience Questions and Answers Cont'd.

4. As you entered into these different affiliations, what were the criteria for choosing the right partner(s) for your organizations?

Bob Bauer: The first step is to develop a business plan that guides the organization in looking for a partner or partners that provide the best value relative to that plan. So value is the first criteria. You can't just go out and find organizations you have prior relationships with. You have to consider what the market wants/needs and which organizations are competent and able to enhance your organization's position to meet those needs.

Cultural compatibility is critical. You have to evaluate how different organizations view the world. How do they make decisions? What values do they apply to their decision making? There also has to be some chemistry between the CEOs. They have to be able to work together to keep their staffs moving forward, even when the work is challenging.

Terri Welter: I agree. Culture and a high level of agreement among the senior leadership teams around the vision to create a better system are important considerations. Where there are differences in competencies between the partnering organizations, it is important to create a common thread.

With the Illinois Partnership for Health, we recognized variability in the competencies of partners, but the group agreed that they all had the same vision to create a more coordinated and better managed system for Medicaid patients, ultimately moving the systems toward bearing financial risk. All partners recognize that they each bring something different to the table, and they are willing to learn from one another.

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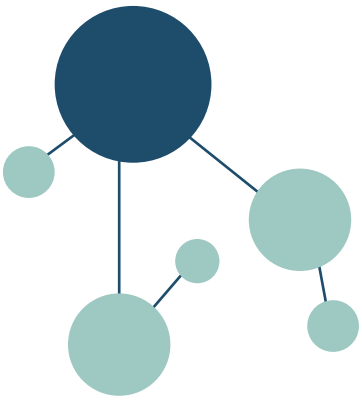
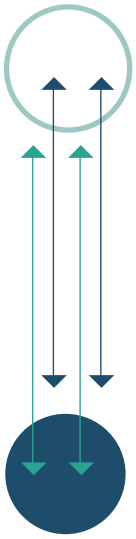
Cultural compatibility is critical. You have to evaluate how different organizations view the world.

– Bob Bauer



First step is to develop a business plan consider what the market wants/needs

Audience Questions and Answers Cont'd.



Reduce unnecessary hospital admissions and readmissions

5. Do you think these creative models can achieve the kind of savings that CMS is looking for once the low-hanging cost reduction fruit has been removed? Or are these arrangements precursors to more integration and maybe even mergers to achieve the level of success that will be expected in a value-based world?

Bob Bauer: Getting to the next level of cost reduction is going to require much harder decisions, and I don't think these structures will do well for these harder decisions. The really tough issues we all face, such as rationalizing service delivery, will require a more integrated structure.

Raymond Grahe: There's no end of cost-reduction opportunity—the challenge is execution. The dual eligible market (individuals who qualify for both Medicare and Medicaid), for example, has a wealth of opportunity. The pharmacy cost alone for these patients is equivalent to the total cost of care in the regular Medicaid market. Also, the care of nursing home patients typically isn't managed optimally, so opportunities exist to reduce unnecessary hospital admissions and readmissions.

Ultimately, CMS needs to align incentives and change the way physicians are paid. Under the current system, physicians don't receive payment for behavioral health or bringing in a care manager to help better coordinate care. Physician payment must better align with a value-based model.

6. Would you please comment on the issue of care coordination and how this is accomplished given the different partnership models?

Terri Welter: With the Medicaid care/payment model, which is centralized, the organizations in the Illinois Partnership for Health focused on risk stratification at the first level of contact with a new member, to determine whether patients were in high-, medium-, or low-risk categories. At the local level, organizations already had nurse navigators managing the high-risk patients across different payers, so these resources were used for IPH Medicaid patients as well, along with hiring additional local resources.

Raymond Grahe: I don't think you can focus on a single payer with care management. If you're using a care manager in a physician practice, the individual should manage the care of all patients, independent of their payers.

Will Groneman: Care coordinators really are needed for the 1 percent or 2 percent of patients who have complex care needs. Rather than put care coordinators in each service area, organizations will need to focus on the hard work of defining care pathways for patients who have conditions that are not common, but also are not unusual. This work is core to being an integrated system.

Closing Comments

Bob Bauer: To me, the biggest challenge is the issue of organization. Many partnering entities have multiple initiatives occurring simultaneously. As a result, efforts are disjointed, not coordinated. Hospitals and health systems need to have someone in charge of the entire effort.

Terri Welter: You need to know what the desired end state of the partnership is, and recognize that you're not going to achieve your goals overnight, but must take one step at a time. Organizations should have an incremental plan to get there, whether it's changing the way you're paid, or changing the care delivery model.

Will Groneman: Working with other organizations is a lot harder than working within your organization. Before you pursue a partnership, make sure your goals for that arrangement are truly high priorities, and make sure the arrangement has a high likelihood of being successful.

Raymond Grahe: Patient engagement will be key. We have to get patient involvement in this process in order to make these partnerships successful.

Ryan Gish: It is clear that many organizations will continue to pursue these types of creative partnerships as a series of experiments is occurring nationally. We expect some of these creative partnerships to dissolve as organizational priorities change or goals are not fully achieved, while others may prove durable over time. The successful partnerships will have three elements in common: a shared commitment to a clearly articulated set of goals, an underlying business model that aligns incentives to support achievement of these goals, and compatible cultures.

Considerations for Strategic Planners

1. **Ensure alignment of executive management teams.** Successful partnerships require the total commitment and support of the CEOs and other top leaders from each participating organization.
2. **Engage key stakeholders.** Because of their critical role in providing managed care, it is especially important to engage physicians and clinicians. Make certain they are aware of and involved in the development of partnership initiatives.
3. **Seek expert counsel.** Expertise is needed related to creating aligned partnerships and alliances. Further, antitrust laws and other regulations place limitations on the ways in which non-merger partners can collaborate and/or share information and resources.
4. **Develop a thorough communication plan.** Consider your communications strategy carefully in determining how best to inform the local community about a partnership. Healthcare leaders should decide which brand strategy best serves the goals of the affiliation, without diluting their organization's brand.
5. **Choose the right partner.** Successful affiliations cannot be built solely on historic relationships. Organizations should seek arrangements after first developing a solid business plan. They should look for potential partners that are culturally compatible and that share the same organizational values.
6. **Recognize the value of your differences.** Many nontraditional partnerships are occurring among different types of entities. Organizations should acknowledge their differences and be eager to learn from one another.

Forum Participant Biographies

Ryan Gish, Managing Director, Kaufman, Hall & Associates, LLC

Ryan Gish is a managing director of Kaufman Hall and a member of the firm's strategy practice. Mr. Gish works with executive leadership teams and boards of all types of hospitals and health systems nationwide. The strategic advisory focus is on helping organizations address the most pressing industry challenges through defining and implementing resilient strategies for the changing healthcare landscape. The result for clients is a platform for their ongoing strategic and financial success.

Mr. Gish has authored numerous articles published in healthcare professional journals, including *hfm* magazine, *BoardRoom Press*, and *Trustee*. Additionally, Mr. Gish was a contributing author for *Healthcare Strategy for Uncertain Times*, published by AHA Press/Jossey Bass. Mr. Gish is a frequent presenter at national conferences of the American College of Healthcare Executives, The Governance Institute, Healthcare Financial Management Association, and the Society for Healthcare Strategy & Market Development (SHSMD). Additionally, he has served as guest faculty at Harvard University, Washington University in St. Louis, and The University of Southern California. Prior to joining Kaufman Hall, Mr. Gish worked for Jennings Ryan & Kolb and Baxter Healthcare Corporation.

Mr. Gish has an MBA, with honors, from the John M. Olin School of Business at Washington University in St. Louis and a BS, *cum laude*, also from Washington University.

Mr. Gish currently is serving a three-year term on the SHSMD Board of Directors.

Forum Participant Biographies Cont'd.

Robert Bauer, Executive Vice President of Navvis and Company

Bob Bauer has more than 30 years of consulting and executive leadership experience in the healthcare industry. He has served as the vice president of finance/CFO for community, multi-hospital, teaching, and faith-based health systems. Mr. Bauer is known for his strategic approach to financial leadership and has led numerous acquisition, affiliation, and financing transactions.

Mr. Bauer has extensive experience in the development of clinically integrated networks, PHOs, and ACOs. He works extensively in the area of service line performance improvement through specialty physician integration strategies. He has served as Senior Vice President/ COO for a network of 10 hospitals and their respective PHOs or IPAs involved in risk-based managed care contracting. Mr. Bauer also is an innovator in ambulatory care strategies. He created the nationally recognized Health and Wellness Center by Doylestown Hospital, an experimentally designed comprehensive outpatient campus.

Mr. Bauer graduated *summa cum laude* from Villanova University with a B.S. in accounting. He is a member of the Healthcare Financial Management Association and the Pennsylvania Institute of Certified Public Accountants, where he has served on the statewide Health Care Committee.

Raymond Grahe, CEO of Trivergent Health Alliance MSO and Chairman of the Board of Maryland Physicians Care

Raymond A. Grahe is the chief executive officer of the Trivergent Health Alliance MSO, a $250 million organization with 1,150 employees serving Frederick Memorial Hospital, Western Maryland Health System and Meritus Medical Center. Formerly, he was the senior vice president – chief financial officer and treasurer of the Meritus Medical Center, Inc. and was responsible for all financial services of Meritus Health Inc. He joined the administrative staff of Washington County Hospital in 1979.

Mr. Grahe is a member of the American Institute of Certified Public Accountants and the Maryland Association of Certified Public Accountants, and a Fellow of the Healthcare Financial Management Association. He is chairman of the Board of Directors of Maryland Physicians Care, a Medicaid HMO with 200,000 members statewide. Mr. Grahe is a past member of The Columbia Bank Board, chairman of the Colonial Regional Alliance Board of Managers, and treasurer of the TriState Health Partners Inc. Board of Directors.

Mr. Grahe has been a member of various committees of the Maryland Hospital Association for many years, largely on the finance committee and the rate negotiation committees. He received a BS from the University of Maryland and an MBA from Loyola College.

Forum Participant Biographies Cont'd.

Will Groneman, Executive Vice President for System Development at TriHealth

Will Groneman is the executive vice president for System Development for TriHealth, a $1.8 billion, integrated delivery system in Cincinnati. TriHealth includes two tertiary teaching hospitals, three smaller community hospitals, and numerous ambulatory centers and community-based services. The system operates a 550-doctor, multi-specialty physician group and a Physician Hospital Organization.

Recently, TriHealth has entered into collaborative agreements to extend its geographic coverage for value-based contracting and enhance its infrastructure for population health management. Healthcare Solutions Network (HSN) is a collaboration with St. Elizabeth Health System, the largest provider of health services in northern Kentucky. HSN was formed as a vehicle for TriHealth and St. Elizabeth to develop a clinically integrated health network with broad coverage to cover the Greater Cincinnati region.

TriHealth has also entered into a collaborative arrangement with five other Ohio integrated health systems (the Cleveland Clinic, Ohio Health, ProMedica, Premeir, and Aultman Health System) to address statewide opportunities for value-based contracts.

A native of Cincinnati, Mr. Groneman has served in various positions in Grand Rapids, Mich., Chicago, and Colorado Springs, Colo. He returned to Cincinnati in 1987. Mr. Groneman received his bachelor's degree from Brown University and his MHA from Xavier University in Cincinnati. In 1994, he was recognized by the American College of Healthcare Executives as the Robert S. Hudgen's Young Healthcare Executive of the Year.

Terri Welter, Principal at ECG Management Consultants and Strategic Advisor to the Illinois Partnership for Health

Terri Welter leads ECG's contracting and reimbursement practice. Since 1996, she has helped hospitals and health systems improve revenues under their payer contracts. Ms. Welter has recently been deeply involved with assisting providers and health plans with developing and executing the types of arrangements needed to successfully react to healthcare reform and to establish contracting structures that facilitate hospital/physician alignment and clinical integration.

Ms. Welter has extensive experience in the area of managed care, including strategy development, reimbursement, contract negotiations, innovative payment reform, and operations. Her experience includes hospital, health system, health plan, and medical group reimbursement strategy development, contract negotiations for commercial, Medicare Advantage, and Medicaid arrangements, risk contract payment design and negotiations, development of innovative payment approaches, contract modeling and financial performance review, managed care structure, function, and department design, rate benchmarking, and contract language review.

Ms. Welter has been published in several healthcare journals, and been the featured speaker on managed care and provider reimbursement for a variety of national professional associations, including the Healthcare Financial Management Association and the Medical Group Management Association. She has an MS in Healthcare Administration from Villanova University, and a BA from the University of Notre Dame.

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