

Health Care Industry Report 2014

New horizons

Voyage to value

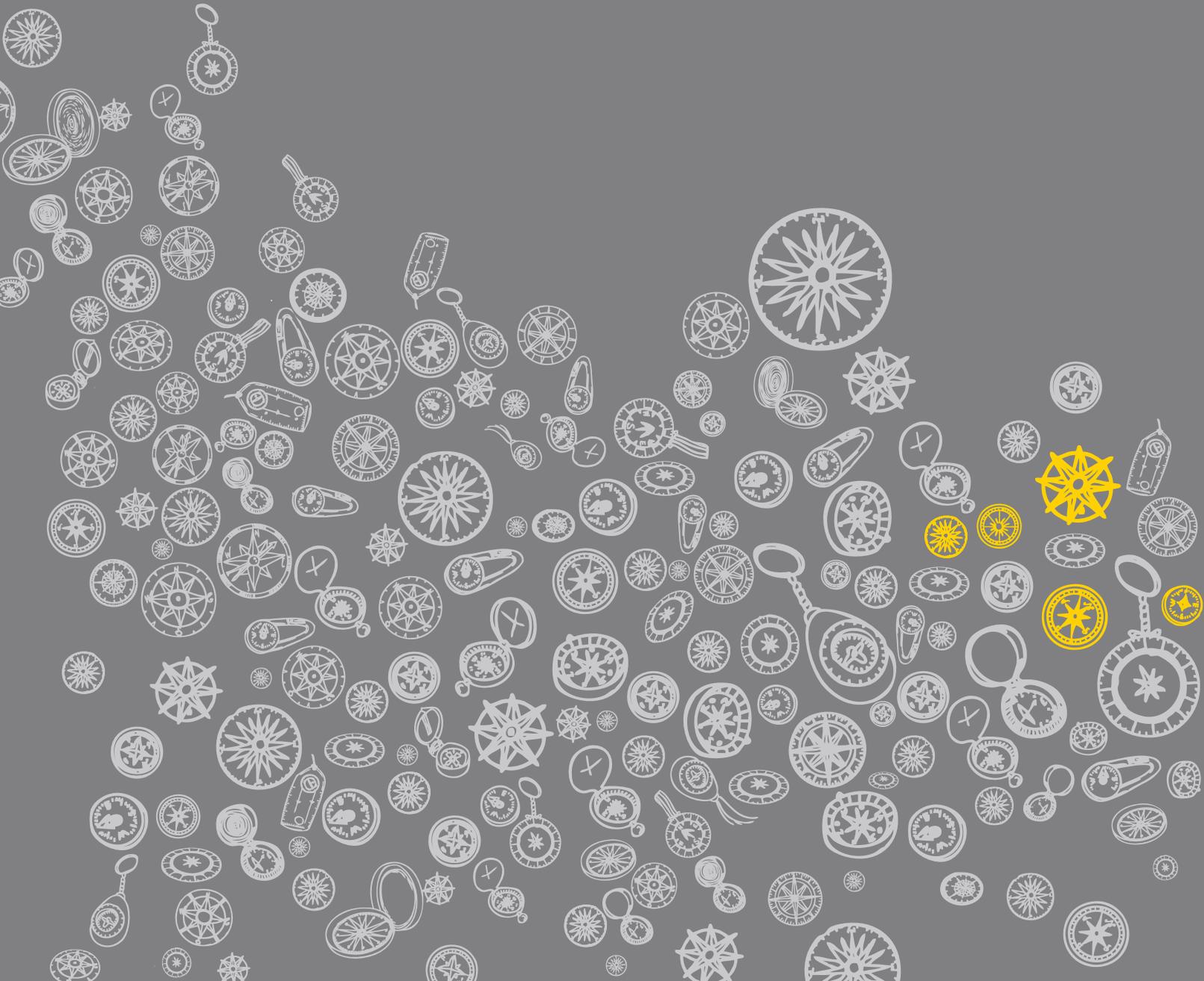
Featuring exclusive interviews with

the International Consortium for Health Outcomes Measurement,
the Center for Healthcare Quality and Payment Reform
and the Robert Wood Johnson Foundation



**Building a better
working world**

To our clients and other friends



A profound tidal shift is under way in the US health care system. In the wake of uneven quality and unsustainable spending, the old volume-driven model is being jettisoned. A new tide is rolling in to transform how care is delivered and paid for, rewarding those who improve patient outcomes and do so at lower costs. The ultimate destination is a more efficient, higher-quality, consumer-focused health care system – one firmly anchored in value.

“Like sailboats at sea, health care organizations will need to steer confidently through the shifting winds and changing currents that continue to challenge their course.”

The journey forward is an arduous one. Ongoing implementation of the Affordable Care Act, emerging health insurance exchanges, mounting pressures for price transparency, a heightened focus on population health, massive investments in health information technology,

an increased impetus to gain scale and market share, a growing call to engage patients in their care – these are among the converging forces the industry must deftly navigate.

And they are only the beginning. In the years ahead, health care providers and payers can expect rising pressures from every direction. Like sailboats at sea, they will need to steer confidently through the shifting winds and changing currents that continue to challenge their course.

This edition of *New horizons* is focused on how health care organizations can best find their way on the voyage to value. Along with an overview of recent industry developments, we include brief profiles of several organizations and programs that are in the vanguard of value creation. Questions are also provided to serve as a gauge of today's initiatives – and tomorrow's imperatives.

As your organization sails toward the new horizon, we hope this report will help inform your discussions and enrich your decisions. If you have any questions about the issues explored in *New horizons*, please contact your local EY executive.



A handwritten signature in black ink that reads "Jon Weaver".

Jonathan G. Weaver
EY Americas Health Care Sector Leader



A handwritten signature in black ink that reads "Jim E. Costanzo".

Jim Costanzo
National Practice Leader
EY Health Care Advisory Services



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Value and viability

Setting sail

Feature

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measuring outcomes that
matter to patients

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"To reach a port we must set sail – sail, not tie
at anchor; sail, not drift."

Franklin D. Roosevelt, *32nd US President*

Prelude

Value and viability

Setting sail

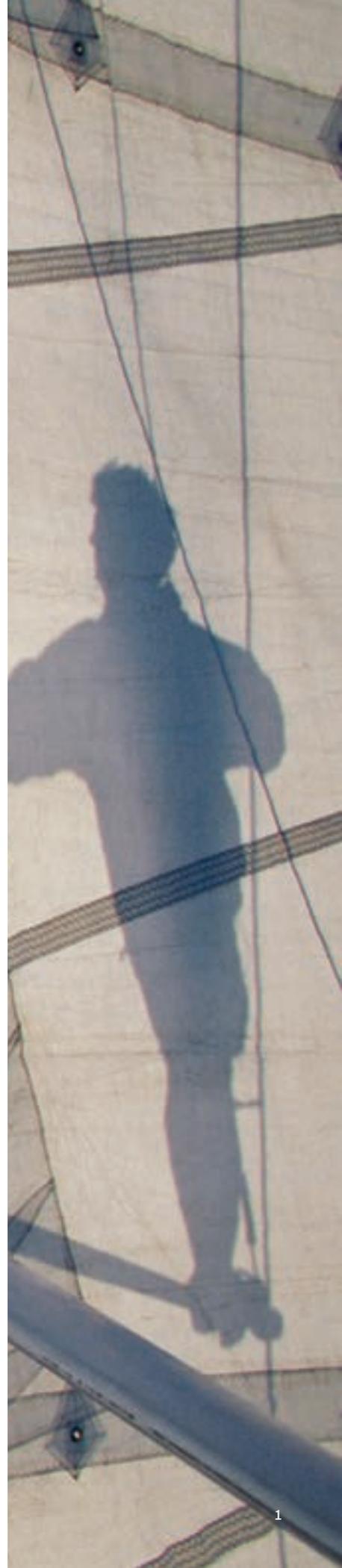
The demand to derive greater value from health care, producing the best patient outcomes at the lowest cost, is pervasive and urgent. Compared with the rest of the world, the US spends the most money for health care. Yet our overall health is not improving, especially within the most costly patient populations – those with chronic diseases.

$$\text{Value} = \frac{\text{Outcomes}}{\text{Cost}}$$

To close the value gap, the health care industry today has set sail on a new course. Since passage in 2010 of the Patient Protection and Affordable Care Act (ACA), where the term “value” appears prominently, the pursuit of value-based care has rapidly emerged in industry and policy discussions. The ultimate goal on the “voyage to value” is to create an economically sustainable approach to how care is delivered and how it is paid for. Advocates maintain that costs can best be controlled by re-engineering care delivery and rewarding improved value: keeping people healthy, using medical interventions appropriately, and preventing and managing the chronic illnesses that consume a large part of our health care dollars.

“Value is the only goal that unites the interests of all the parties in the healthcare system.”

Michael E. Porter, PhD
*Bishop William Lawrence University Professor
The Institute for Strategy and Competitiveness
Harvard Business School*



In the consumer world, value is a familiar concept. Consumers tend to equate good value with products of the highest quality for the lowest price. When applied to health care, however, value is more complex, as the consumer – from patients and providers to payers and purchasers, and the product – patient outcomes, can vary widely. According to the Institute of Medicine (IOM), an organization that has studied the issue closely, value is in the eye of the beholder, representing different things to different stakeholders.

Value for health care providers, for example, hinges on making decisions based on appropriateness of care. For payers, it means using evidence-based interventions and paying based on outcomes. For employers, value is keeping workers and their families healthy and more productive at lower costs. And for patients, value is having a high-quality relationship with care providers, meeting personal health goals and being assured that out-of-pocket payments are targeted to these

goals. Reconciling stakeholder perspectives in a way that creates value for all is a challenge requiring thoughtful discussion, diligent focus and unified action.

Driven by the value challenge, industry stakeholders are pursuing a variety of strategies. Health care providers are embracing payer incentives to deliver high-value care through such models as pay-for-performance, bundled-payment, global budgets and financial-risk-sharing within accountable care organizations (ACOs). Payers are finding new ways to partner with providers to add value to the patient experience. Employers are striving to rein in rising health care premiums while pursuing affordable, high-value products and services that enhance employee health and productivity. Product manufacturers are investing in innovations that deliver value by improving quality of life. Patients are looking to access tools and transparent information that help them make the most informed value-based decisions.

In this edition of *New horizons*, we look at the voyage to value in health care and the course ahead in delivering on the value promise. Throughout, “Value vignettes” profile real-world examples of how payers, providers and industry groups are pursuing value. “Viewfinder” questions at the end of each chapter offer considerations for your board and leadership team as you pursue value initiatives within your organizations and with partners across the continuum of care.

Our launching point is a conversation with Dr. Jens Deerberg-Wittram, who leads the International Consortium for Health Outcomes Measurement. His organization has been instrumental in defining and driving the adoption of a global set of outcome measures for a full range of medical conditions. In focusing on the outcomes that matter most to patients – the center of the health care universe – these efforts are helping the industry set sail toward the full potential of value-based care.



Feature

Value-based health care: measuring outcomes that matter to patients

A conversation with
Jens Deerberg-Wittram, MD,
President, the International Consortium for Health Outcomes Measurement (ICHOM)
(www.ichom.org)

Dr. Deerberg-Wittram leads ICHOM, a global organization cofounded by Professor Michael Porter of the Institute for Strategy and Competitiveness at Harvard Business School, the Karolinska Institute in Sweden and the Boston Consulting Group to help advance value-based health care. We talked with Dr. Deerberg-Wittram about the concept of value and the importance of measuring outcomes that matter to patients.



You've observed health care systems around the world. What does value mean, from your perspective? Why has it been so difficult to consistently deliver health care value – and measure it?

The term “value” was best defined for health care by Professor Michael Porter of the Harvard Business School: the outcomes we achieve for the money we spend. The term “outcome” hasn't been clearly defined in the past. If we look at different sources that deal with outcome measurement, what is called an outcome is really an output. An outcome from our perspective is only one thing: the results that matter to a patient after a care delivery process. It's an exciting formula because it offers a new perspective on value with a different measure of success.

“An outcome from our perspective is only one thing: the results that matter to a patient after a care delivery process.”

Although physicians are striving to improve patients' health, historically, the more broad measures of health care system outcomes have not been aligned with specific patient health outcomes. In an outcomes-based world focused on patients' health, we say: “Let's do this differently. Let's move away from volume and measure value based on the results that matter to patients. To what extent can we achieve these results? And how much money do we need to get there?”

Let's look at an example. If you have a patient who is suffering from prostate cancer, and you ask physicians what kind of outcomes they are measuring, they will tell you that they measure a lot of things – for example, length of stay, appropriate MRI scans, PSA level, number of procedures and patient satisfaction. All these kinds of measures may be interesting, but not relevant. They are not what matter to patients.

If you ask patients their definition of an outcome, they will tell you clearly and consistently. Michael Porter has rendered these responses as an outcome measures hierarchy (see diagram on the next page).

The first tier is the health status achieved or retained. Do I survive as a patient who is suffering from cancer? What will be the status of my health or degree of my recovery? Will my quality of life be good? Will I be in pain? Will I be able to sleep? What about anxiety?

The second tier is the process of recovery. How much time will it take to return to normal activities? What difficulties and complications might I face in my care or treatment?

The third tier is health sustainability. Will my illness recur? Will my treatment have any long-term consequences? For example, a patient with cancer treated with beam radiotherapy may see great results for a year, but two or three years later may be complaining about complications caused by the treatment.

We believe that if you want to determine value, you need to measure the outcome of every medical condition from the patient perspective. Standardized outcomes can help clinicians decide on treatments that improve patients' quality of life.

What is the process for obtaining these outcomes that matter to patients?

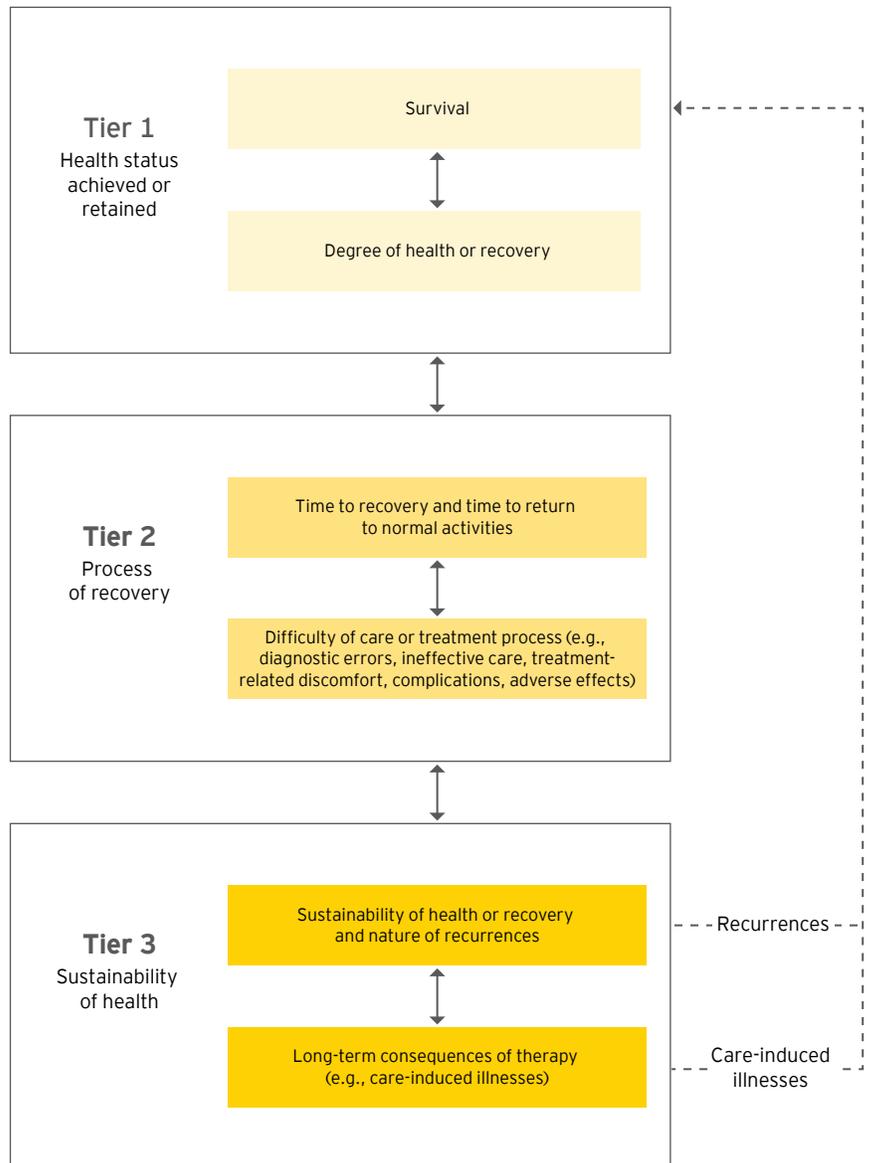
Measuring outcomes systematically requires having the right data sources. Some outcomes can be determined only by asking the patient directly – for example, “Do you have pain?” and “How would you rate your quality of life?” We call these “patient-reported outcomes,” and they are an essential part of outcomes measurement. Yet patients can’t report on a number of other outcomes that matter to them, such as complications that happen during surgery. You have to ask the physician about that, because the patient doesn’t know. These are “physician-reported outcomes.” One of the most difficult outcomes to measure is mortality – a patient with cancer who dies two years after treatment, for instance. The patient by definition is not able to report. In this case it might be helpful to get access to the national death registry, if it is available.

At ICHOM, in defining health outcomes, we directly involve patients in the process. All of our patient representatives have been treated for the condition being evaluated. We also bring together leading physicians from across the globe who specialize in treating this condition. As patients and physicians discuss and reach consensus on the outcomes that matter most to them, the ICHOM team serves as facilitator.

What role does technology play in this process?

We’re looking more and more at technology solutions to collect meaningful outcomes data. For example, a key resource is mobile devices. If you want to measure the mobility of a patient after orthopedic surgery,

The outcome measures hierarchy



Source: Professor Michael Porter, “What is value in health care?” *New England Journal of Medicine*, December 23, 2010. Used with permission.

it's probably much easier to look at GPS data on his or her mobile phone than to ask how many miles or meters were walked this week. This new measuring and reporting capability is a huge step forward and one that will help greatly in collecting more relevant data on outcomes.

However, in the outcome measurement field today, we've found that large information technology vendors are not the drivers of innovation. Numerous smaller companies are making the greatest strides in this space, developing ready-to-use plug-and-play apps for outcomes collection. The challenge will be to integrate their solutions into larger systems.

Tell us more about the mission of ICHOM. How did your organization come together? What are your plans for the future?

In the early '90s, Michael Porter began writing the first paper about creating value-based competition in health care. In 2006, he published a book on this topic, *Redefining Health Care*. It provides the argument for using health outcomes data to redefine the nature of competition in the industry. Over the past eight years, we have offered many courses at Harvard and other institutions worldwide where we teach the value concept to providers, payers, pharmaceutical companies and medical technology companies.

People quickly "got it." They agreed we needed to move to value as the new definition of success in health care.

Further discussions led to the idea of standardization. It doesn't make sense to tell surgeons around the world that they should measure incontinence, for example – and then find years later they're all measuring it in a different way. We would have no chance to compare outcomes. We concluded we needed a standard set of measures ready to use, simple to handle and comprehensive enough to cover the relevant aspects of a patient's condition from a patient's perspective – but not too complex to overstretch organizations. And, we needed to offer these measures for free. In the summer of 2012, we launched ICHOM as a nonprofit organization and started our work.

Our first goal was to show that it's possible to define meaningful patient outcome standards and test them in the field. We agreed to begin with four medical conditions, and for these reasons:

1. **Coronary artery disease**, which is the number one cause of death globally and also one of the most costly conditions to treat. But it's also preventable through patients' lifestyle changes.
2. **Localized prostate cancer**, one of the most common types of cancer in men. It has different ways of being treated – from active surveillance to radical prostatectomy – and can produce wide variations in outcomes that matter to patients. For example, the average incontinence level one year after prostate surgery in Germany and Sweden is around 50%,

while organizations performing best in this procedure worldwide show a post-surgery incontinence level of 5% – a tenfold difference.

3. **Cataracts**, a health issue found in patients around the globe. Cost for treatment shows wide variations. In India, for example, the cost is 1% of what it is in the most expensive centers in the US.
4. **Low back pain**, a condition that is one of the greatest causes of sick leave in the workforce and has a huge impact on global economies. It is also a condition involving different medical specialties and many different treatments. We need to better understand which options offer patients the best long-term outcomes.

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"Our five-year goal is to cover 50 medical conditions that represent about 70% of the disease burden in industrialized countries."
.....

Within a year, we completed four Standard Sets of outcomes for our first four medical conditions. In November 2013, we unveiled these at a Harvard conference drawing health care leaders from more than 20 countries. These standards have also been submitted to leading journals and are in the process of being published. In 2014, we're studying more medical conditions

and plan to have Standard Sets for 12 more conditions by the end of the year. Our five-year goal is to cover 50 medical conditions that represent about 70% of the disease burden in industrialized countries.

You've had the opportunity to observe health care value in many countries around the world. How does the US measure up?

I would say the US has a long way to go but is definitely on its way. Historically, it's been a nation willing to try new approaches. We see lots of interest and energy to move forward and improve. The momentum is coming from providers – from small organizations that want to begin measuring value, to well-known leaders that have the bandwidth and funding for pilot testing. It's also coming from payer organizations that want to reimburse based on outcomes, and from the ACA itself, which has opened many opportunities to measure and pay for outcomes.

You've had considerable experience as a hospital executive and understand the unique challenges faced by C-suites and board members. How can executive leadership best support outcomes measurement in their own organizations?

Perhaps my personal experience can shed some light. For eight years, I ran a 4,800-bed for-profit system and was also a health care consultant. I saw firsthand the impact outcomes can have on managing health

care costs, and I came to believe that health care should be organized around improving outcomes and value.

Before this realization, I tried everything I could to change clinician behavior in a systematic way, from clinical pathways to lean management. But it didn't work. If you tell a physician, "The antibiotics you use cost 25% more than those of your colleagues," they may not care. If you say, "I have a clinical pathway in my computer that tells me what to do," they may not take it. They'll say, "I'm not a technician. I'm a physician."

.....
"I have found the only thing that works – and drives organizational change – is providing outcomes information."
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I have found that the only thing that works – and drives organizational change – is providing outcomes information. This is something you must believe or experience as a health care executive. Then you will take the right steps.

The first step is to commit yourself to outcomes measurement. Walk the walk. Tell your people, "I want you to measure outcomes. I want you to know how to do this, and I want to discuss with you how we can do better from a patient perspective."

Second, don't wait for a big-bang information technology fix. It isn't coming.

Third, try to find payer partners who are ready to tie money to outcomes. The ACA gives most organizations room to do just that.

Last, seek out the "evangelists" in your organization who are already measuring outcomes. Give them the bandwidth, support and funds to run pilots. Celebrate their successes. In the new world of value-based health care systems, one successful pilot can position your organization for lasting leadership.



Considerations for your board and executive leaders

- ▶ Is value the “wind in the sails” of your organization’s mission and leadership?
- ▶ Have you defined your organization’s core value proposition and overarching strategy to succeed in a value-based world?
- ▶ How are you building your reputation in the community as a provider of value?
- ▶ Have you developed a culture of collaboration and accountability to support value-based approaches? In what ways are your employees at every level empowered to deliver value in their daily work?
- ▶ What tools have you built into your processes for continuous feedback and action to support the voyage from volume to value?
- ▶ How do you know you are delivering the outcomes that matter to patients?



“Price is what you pay. Value is what you get.”

Warren Buffett, *20th-century American investment entrepreneur*

Value in payment

Making headway

Voyage to value

In pursuing value-based health care, payers are partnering with providers to create high-value payment systems that reward quality over quantity. Varied routes are being tried to shape the payment model of the future, from changing payment incentives to adopting performance measurements. Value-based payments can spur the health care system to make delivery more efficient, steer clear of waste and reward providers for helping patients stay healthy.

Meanwhile, with mounting financial pressures, health care organizations are “battening down the hatches” through a range of methods designed to streamline operations and better manage their bottom lines. This dual focus – looking externally to leverage new payment opportunities and internally to curtail costs – is a promising approach in making headway toward the value destination.



Government and market forces are propelling the health care industry in a new direction – one that moves away from paying for volume and toward paying for value. In these deep currents of change, health care providers and payers must pilot a variety of financial decisions, new business processes and strategic opportunities. In this chapter, we look at payment systems driven by policy and by the market. We also explore several approaches health care organizations are taking to lower their costs in a world of reduced margins and value-driven operations.

Value-based payment models: considering the options

The move toward value-based payment, in motion for many years, has been accelerated by the Affordable Care Act. The law includes several financial incentives for providers to better coordinate health care delivery. Different payment methodologies have been proposed as the prime solution for stimulating delivery system change. A range of government initiatives are in play to improve quality through payment models (see Exhibit 1-1 on page 13). Commercial payers, too, are pairing payment incentives with changes aimed at producing better-coordinated, higher-quality and more-efficient care. According to Catalyst for Payment Reform, a national organization for health care purchasers, 10.9% of commercial payments today are value-oriented, designed to either improve performance or cut waste.

This marks a significant leap from 2010, when 1%-3% of payments were value-based.

Exhibit 1-2 on page 14 illustrates the continuum of value-based payment models, from lowest to highest risk, accompanied by a discussion of how these models are being pursued today.

Fee-for-service (FFS)

Paying health care providers on an FFS basis has been cited as a key contributor to the nation's cost and quality challenges. In the FFS system, each procedure or service is billed and paid for separately. These payments may encourage the use of more, and more expensive, services and fail to reward high-quality care. FFS also makes coordination of care across multiple providers and varied settings difficult and burdensome for patients, as they receive different bills from different clinicians and may not have a designated care manager to help them with treatment decisions.

Pay-for-performance (P4P)

The P4P model typically pays fees for individual services, with some form of a financial incentive payment to physicians based on their performance compared with a set of performance metrics. While early P4P programs used quality and access measures to determine incentive awards, current models often include measures of physician practice efficiency, such as use of lower-cost generic pharmaceuticals.

In the government sector, the P4P model is implemented through hospital value-based purchasing, penalties for readmissions and penalties for hospital-acquired infections (see Exhibit 1-1 on page 13). In the private payer sector, P4P is evident in a wide range of quality-based commercial contracts.

.....
"The way we price health care cannot be understood by a human being of average intelligence and limited patience."

Michael Leavitt
*Former Secretary
US Department of Health and Human
Services (HHS)*
.....

Care management fees

In this model, health plans pay providers, typically organized as patient-centered medical homes, for better care coordination. Payments are intended to provide an investment in practice functions that traditionally have not been reimbursed, such as educating patients in self-management.

Exhibit 1-1. Government initiatives in the shift from volume-driven to value-driven payment

- ▶ **Bundled Payment for Care Initiative (BPCI).** A total of 299 hospitals and 166 post-acute care organizations are part of BPCI, a Medicare pilot program. Providers are reimbursed for certain care episodes through single case rates and can participate in gainsharing.
 - ▶ **Comprehensive Primary Care Initiative (CPCI).** A four-year public-private partnership, CPCI is designed to test a model of improved access to quality health care at lower cost. A total of 500 primary care practices in eight states are participating. CMS is paying primary care practices a care management fee to coordinate services for Medicare fee-for-service beneficiaries.
 - ▶ **Hospital Acquired Condition (HAC) Reduction Program.** Beginning October 1, 2014, the HAC Reduction Program, mandated by the ACA, requires the Centers for Medicare & Medicaid Services (CMS) to reduce hospital payments by 1% for hospitals that rank among the lowest-performing 25% in HACs.
 - ▶ **Hospital Value-Based Purchasing (HVBP) Program.** Created under the ACA and launched in October 2012, the HVBP Program lays the groundwork for Medicare to become a value-based purchaser of health care services.
- Payment adjustments, up or down by as much as 1.25%, are based on hospital performance across two dozen measures of clinical processes, patient satisfaction and outcomes.
- ▶ **Medicare Hospital Readmissions Reduction Program.** Under this program, the government is looking at the number of heart attack, heart failure and pneumonia patients who return to the hospital within 30 days of discharge. The program will be expanded in October 2014 to add two additional conditions, elective hip or knee replacements and chronic obstructive pulmonary disease. Hospitals with more readmissions than Medicare expected given their mix of patients were penalized by losing up to 1% of their regular payments during the program's first year, fiscal 2013. The maximum penalty ramped up to 2% beginning October 2013 and is 3% beginning October 2014 – rising to 8% in 2017.
 - ▶ **Medicare Shared Savings Program (MSSP) ACOs.** In December 2013, CMS named 123 new ACOs as members of its MSSP, the largest group announced since the program started in 2012. These ACOs will cover 1.5 million Medicare beneficiaries. CMS will begin accepting applications for its 2015 class of MSSP participants in the summer of 2014.
 - ▶ **Pioneer ACOs.** In July 2013, CMS released the first-year results from the Pioneer program, sponsored by the Center for Medicare & Medicaid Innovation. All 32 Pioneer ACOs improved quality, but only 13 were able to save enough money to share in the savings with Medicare. In the wake of these results, nine Pioneers announced they were dropping out of the program. Seven of those ACOs planned to transition to the lower-risk MSSP, while two left the sea of Medicare ACOs entirely. CMS is considering opening the application process to allow more organizations to join the program.
 - ▶ **Value-Based Physician Payment Modifier (VBPPM).** Applied by CMS to physician performance, the VBPPM is a method for paying physicians differentially based on the quality and cost of their care, as reported through Medicare's Physician Quality Reporting System. Using quality and cost data reported for 2013, differential payment is scheduled to begin in 2015 for large group practices and in 2017 will be applied to most or all physicians who submit claims under the Medicare physician fee schedule.

Source: CMS, 2014.

Since mid-2011, when the Obama Administration began promoting the medical home model, the number of medical home practices has been growing rapidly (see Chapter 2, page 34). According to *Modern Healthcare*, Medicare and 43 other payers, including commercial plans and state Medicaid programs, are supporting 500 medical home practices with per-member, per-month, care management fees.

Bundled payments

Under the bundled payment model, sometimes referred to as an “episode of care” payment, instead of being paid separately for each individual service, providers receive one payment for all

services delivered to a patient during a single episode of care – for example, a hip replacement or a coronary artery bypass graft. The payment is made for all services that the patient is expected to use, from physician and hospital services to post-discharge services such as home health and rehabilitation. Bundled payments are also applied to treating such chronic conditions as diabetes, with payments made in anticipation of all services to be received in treating the condition over a defined timeframe.

If the costs of care are less than the bundled payment amount, participating providers keep the difference. If costs exceed payment, they absorb the loss.

Bundled payments give participating providers an incentive to coordinate their activities, eliminate unnecessary services and avoid complications that require additional services.

In the government payer sector, CMS has piloted bundled payments through its Acute Care Episode Demonstration project and Bundled Payment for Care Initiative (see Exhibit 1-1 on page 13). In 2012, bundled payments made their way into the state-driven Medicaid sector with the Arkansas Health Care Payment Improvement Initiative. Currently the country’s only Medicaid bundled payment model, it is mandated for state providers within five episodes of care.

Exhibit 1-2. Spectrum of payment models

| | Fee-for-service | Pay-for-performance | Care management fees | Bundled payments | Shared savings and shared loss | Global payments | Provider-sponsored health plans |
|--------------------|--|---|---|--|---|---|--|
| Providers are paid | A specific price for each service rendered | Fee-for-service payments plus incentive payments for quality and efficiency | Per-member, per-month fees – typically for providers organized as patient-centered medical homes – to fund investments in care coordination | One lump sum for all services rendered to a patient during a hospitalization or episode of care – or to treat a particular disease for a defined time period | Payments closely tied to controlling the overall cost of the care that patients receive while achieving quality targets – sharing in savings if costs are less than target and sharing in losses if costs are greater than target | A fixed dollar amount, usually prepaid monthly, designed to account for most or all of the expected cost of care for a group of patients for a defined time period; may be supplemented with incentive payments for achieving quality goals | Through ownership of the provider’s own health plan, assuming 100% of the financial risk for insuring a patient population |
| | ← Less risk, less value | | | More risk, more value → | | | |

Source: EY analysis, 2014.

Value vignette

Employers Centers of Excellence Network: bundling payments for value

Beginning January 1, 2014, a first-of-its-kind coalition of large US employers – including Lowe's and Walmart – began offering knee- and hip-replacement surgeries to more than 1.5 million employees and their dependents. The companies joined the Pacific Business Group on Health (PBGH) Negotiating Alliance to create the Employers Centers of Excellence Network (ECEN).

According to PBGH, these elective surgeries represent a growing portion of employer health care spending. Prices can vary between \$15k and \$125k, without correlation to quality. As of early 2014, the network is offering these procedures at four US health care systems:

- ▶ Johns Hopkins Bayview Medical Center in Baltimore, MD
- ▶ Kaiser Permanente Orange County-Irvine Medical Center in Irvine, CA
- ▶ Mercy Hospital in Springfield, MO
- ▶ Virginia Mason Medical Center in Seattle, WA

ECEN assists members that want their employees to have high-quality elective surgical care by providing information on which surgeons perform best on these procedures. The network evaluates and selects centers of excellence (COEs), negotiates bundled payments and encourages member organizations to promote use of these COEs to their employees. According to ECEN, each COE is committed to the highest-quality standards and has performed far better than national norms for complications, reoperations and patient experience. In addition to total hip and knee replacements, other elective surgeries such as spine/low back and cardiac surgeries will be added. Participating employers receive discounted rates for care.

For employees, participation in ECEN is voluntary. Those who take part receive 100% coverage for their surgical care, with no deductibles or co-pays, as well as travel, lodging and living expenses for the patient and a caregiver. Each employee

is assigned to a patient advocate, who schedules the surgery and selects the center. After surgery, the same advocate assists with insurance claims, as well as the transition back to the patient's home physician. The COE also assigns a patient navigator to guide the patient while he or she is on-site.

.....
“[ECEN] is designed to serve as a model for delivering high-quality health care with transparent and predictable costs.”

David Lansky
PBGH President and CEO

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Lowe's and Walmart have tested the waters before with bundled payments. Lowe's entered into a bundled-payment agreement with Cleveland Clinic for cardiac surgery, and Walmart and six hospitals, including Cleveland Clinic and Mayo Clinic, have launched bundled payments for workers' cardiac and spinal surgeries.

Sources: PBGH website; Walmart website; “Wal-Mart, Lowe's, PBGH form network for ‘no-cost’ knee/hip replacements,” San Francisco Business Times, October 8, 2013, via The Business Journals, www.bizjournal.com; “Wal-Mart, Lowe's to offer employees leg up on knee and hip work – at certain systems,” Modern Healthcare, October 8, 2013.

The private payer sector also reflects a wide range of bundled payment initiatives. For example:

- ▶ Geisinger Health System in Danville, PA, developed its ProvenCare as a bundled payment model for coronary artery bypass graft surgery and has since added additional bundles.
- ▶ Horizon Healthcare Services, Inc., New Jersey's oldest and largest health insurer, started its bundled payment program with total joint replacements

and has expanded to include such episodes of care as pregnancy and adjuvant breast cancer treatment.

- ▶ The PROMETHEUS Payment model, launched in 2006 with the support of the Robert Wood Johnson Foundation, now includes 21 bundles with the potential to affect payment for almost 30% of the insured adult population.
- ▶ Several major national employers have started their own bundled payment arrangements with hospitals (see Value vignette above).

Shared savings and shared loss

In the shared savings and shared loss model – the payment strategy for such structures as ACOs – providers are paid based on achieving defined performance goals. Those that meet or exceed certain quality and cost performance benchmarks can share in any resulting cost savings. Those that do not meet goals will share in losses.

The concept behind ACOs is that by linking provider payment to cost and quality outcomes, the provision of unnecessary treatments and services is discouraged while prevention, care coordination, quality and value are emphasized.

Along with the Medicare Shared Savings Program and Pioneer ACO program in the public sector, several commercial ACO contracts have emerged. Current estimates (Leavitt Partners, May 2014) put the number of ACOs in the US at 626; 329 have government contracts, 210 have commercial contracts and 74 have both government and commercial contracts. The remaining 13 ACOs have not yet made specific announcements about their contracts or are still in the process of finalizing them. Among recent developments:

- ▶ Anthem Blue Cross and Blue Shield plans to form an ACO with Franciscan Alliance, a Catholic health care system in Indiana.
- ▶ Memorial Healthcare and Florida Blue have formed a new ACO, Memorial Health Networks. The ACO marks the tenth accountable care arrangement between Florida Blue and hospital systems throughout the state – and the fifth in south Florida.
- ▶ UnitedHealthcare, the Minnetonka, MN-based health insurer subsidiary of UnitedHealth Group, plans to more than double its accountable care health plan contracts with hospitals and physicians over the next four years. UnitedHealthcare currently ties \$20 billion of its contract payments to quality and cost efficiency, and plans to allocate \$50 billion by 2017.

Global payments

A comprehensive payment to a group of providers, global payments are meant to account for most or all of the expected cost of care for a group of patients for a defined

timeframe. These agreements pay on a per-member, per-month basis. The model offers providers incentives to keep their patient populations healthy and maintain low utilization of clinical services.

While generally synonymous with the term “capitation,” the term “global payment” is preferred by advocates to distinguish it from early capitation models, under which some providers suffered financial losses.

Today, global payments have evolved considerably compared with earlier efforts. For example, some payers are using risk-adjustment methods to account for the relative illness burden of the population and risk sharing to protect the provider if costs are higher than anticipated. This way, providers are not facing potential catastrophic financial losses – or an incentive to curtail care, a common concern with early versions of capitation arrangements. A leading

example of a global payment model is the Alternative Quality Contract (AQC) from Blue Cross Blue Shield of Massachusetts (see Value vignette below).

“Ending fee-for-service payment in favor of accountable care organizations and bundled payment once and for all is unlikely to be feasible for quite some time, but gradually increasing disincentives for providers that do not participate in reformed payment approaches is a practical way to move forward.”

Paul B. Ginsburg
President
Center for Studying Health System Change
“Achieving health care cost containment through provider payment reform that engages patients and providers”
Health Affairs, May 2013

Value vignette

The Alternative Quality Contract: increasing value through accountability

The Alternative Quality Contract, a payment model from Blue Cross Blue Shield of Massachusetts (BCBSMA), illustrates current trends in payer-provider cost-saving initiatives. Launched in 2009, the AQC is one of the largest commercial payment reform initiatives in the US. It includes more than three-quarters of BCBSMA’s overall network of contracted primary care providers and specialists who care for nearly 700,000 BCBS members. BCBSMA notes that the AQC arrangement is a five-year agreement that encourages providers to invest in long-term initiatives – significantly longer than BCBSMA’s traditional contracts, which are typically

three years for hospitals and one year for physicians.

The model combines a per-patient global budget with significant performance incentives based on nationally endorsed quality measures. BCBSMA links its contracts with providers to dozens of quality metrics that track whether patients get the right screenings and exams, whether physicians and hospitals prescribe the correct drug and whether patients are satisfied with their care. A study finds that this approach improved quality of care while cutting costs as much as 10% below their fee-for-service level.

Source: BCBSMA, <http://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html>

Provider-sponsored health plans

As many health care providers are assuming risk through new contracts with payers, others are taking risk-bearing to a higher level by becoming provider-sponsored health plans. Financial pressures, the wave of new entrants in the insurance market and the move toward population health have spurred several health systems to launch their own health insurance plans.

Now isn't the first time providers have taken on the payer side of business. The most notable example of provider initiatives in the payer space is California's Kaiser Permanente, which started as a hospital in the 1930s and has since grown to nearly 8.9 million health plan members – making it the largest US health plan by medical enrollment. Today's four largest provider-sponsored health plans after Kaiser, according to data from *AIS's Directory of Health Plans: 2013*, were also early risk-bearing pioneers: University of Pittsburgh Medical Center (UPMC) Health Plan (founded 1998), Healthfirst (founded 1993), Henry Ford Health System's Health Alliance Plan (founded 1960) and Spectrum's Priority Health (founded 1992).

Since the shift to value-based care, the concept is again attractive to many providers, who are finding that creating and offering their own health plans is a route to achieving competitive advantage. According to the American Hospital Association, about one in eight hospitals – primarily not-for-profit health systems and nonacademic systems – operated health plans in 2011.

Recent activity reflects the growing trend. For example:

- ▶ In Massachusetts, Partners Healthcare in Boston, the state's largest hospital and physician organization, acquired Neighborhood Health Plan, a nonprofit organization insuring more than 240,000 mostly low-income residents across the state.

Exhibit 1-3. Potential benefits and risks for providers considering health plan formation

| Potential benefits | Potential risks |
|--|---|
| <ul style="list-style-type: none"> ▶ Greater financial rewards. With a projected drop in inpatient service utilization, forming a health plan can help providers hedge against potential revenue loss. ▶ Improved market share. Incentives are created to keep patients within the system, providing the opportunity for deeper market penetration. ▶ Better population health management. Critical decisions around what care to provide and what to pay for are under the provider's control. With more tightly integrated clinical and financial performance data and metrics, health systems may be better positioned to improve outcomes and lower costs around specific patient populations. | <ul style="list-style-type: none"> ▶ High start-up costs. Providers need to have enough funds to cover start-up costs and regulatorily required capital thresholds, and enough potential covered lives to absorb actuarial and other risks. ▶ Payer pull-outs. Hospitals that start their own health plans will be competing with other plans in their markets. Commercial payers may choose to end contracts, posing a new set of challenges for hospitals. ▶ New responsibilities. Changing from being a provider to being a provider-payer will require a different mindset, skill set and knowledge base with a corresponding learning curve. |

Source: EY analysis, 2014.

- ▶ In New York, North Shore–Long Island Jewish Health System – with 16 hospitals and more than 300 outpatient centers – has launched its own health plan, CareConnect, on the state health insurance exchange (HIX).
- ▶ In Ohio, Cincinnati-based Catholic Health Partners is selling health plans through its subsidiary, HealthSpan, on the Ohio exchange.
- ▶ In Texas, Baylor Scott & White recently expanded the nonprofit Scott & White Health Plan to portions of Baylor's market area, covering more than 240,000 members across 71 counties in the central part of the state.
- ▶ In Virginia, Falls Church-based Inova Health System has partnered with Aetna to establish a 50-50 ownership joint venture, the Innovation Health insurance plan.

Providers that are considering forming a health plan need to carefully weigh the benefits against the risks (see Exhibit 1-3).

The quest for efficiency: controlling costs in a value-driven world

Regardless of which payment model organizations adopt or where they are in their voyage to value, increasing efficiencies and reducing operating costs are always worthwhile goals. A survey from the Health Information Management Systems Society and AVIA (*The 2013 Healthcare Provider Innovation Survey*) reveals that while providers have numerous priorities – from reducing medical errors to improving patient satisfaction – cutting costs is still at the top of the list. As margins tighten for US hospitals, especially for

those with higher levels of Medicaid and Medicare patients (see Exhibit 1-4), hospital executives are using a range of strategies to control costs. Highlighted below are prevalent approaches.

Readmission reduction

Nearly one in five Medicare patients returns to the hospital within a month of discharge. From the government's vantage point, readmissions are a leading symptom of inadequate quality and a costly, uncoordinated system. The ACA charged the Department of Health and Human Services (HHS) with creating

the Hospital Readmissions Reduction Program, effective for discharges beginning October 1, 2012. With an initial penalty rate of 1% of Medicare payments for failure to substantially reduce readmission rates, the penalty continues to rise (see page 13). CMS reports an estimated 2,225 hospitals were penalized \$227 million in 2013 because of excess readmissions.

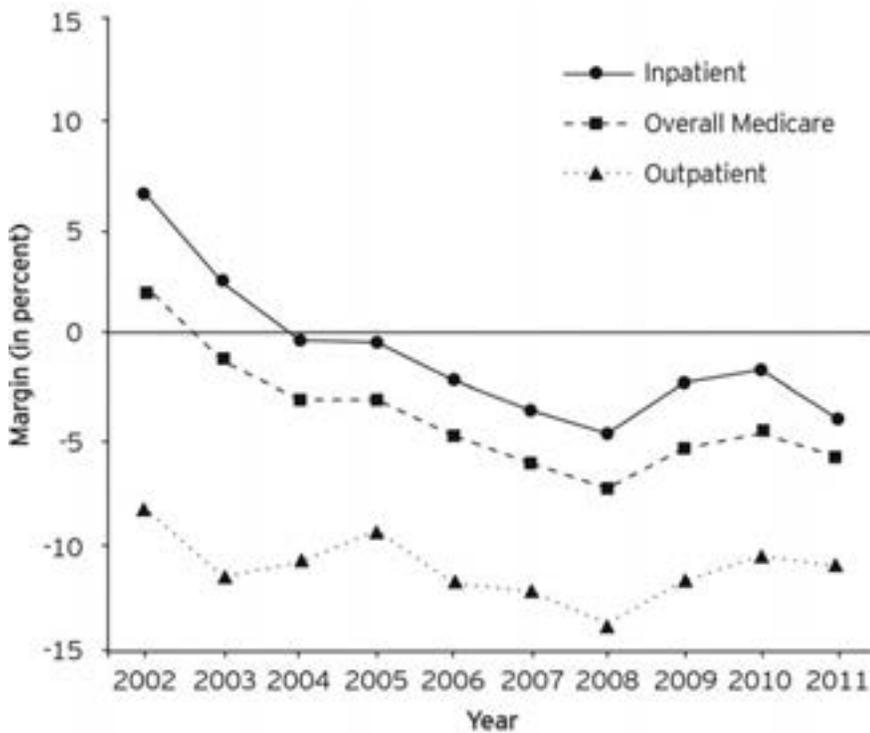
What are the causes of unnecessary readmissions? A seminal report from the Robert Wood Johnson Foundation highlights a variety of catalysts (see Exhibit 1-5 on page 20).

A scan of the health care horizon finds a range of cost-effective solutions to reduce readmission rates. For example:

- ▶ In California, Napa's Queen of the Valley Medical Center uses the Case Management, Advocacy, Resource/Referral, Education (CARE) Network, through which a social worker and nurse visit patient homes to make sure the patient understands post-discharge care plans. Over a one-year span, the CARE program yielded a 60% reduction in ED visits and a 40% reduction in hospitalizations for the patient population.
- ▶ In Ohio, Cincinnati's Mercy Health has used nurses specially trained to act as patient guides through the discharge process. In less than a year, the program has yielded savings in avoided readmissions of about \$495,000 and a 15% drop in all-cause readmission rates for heart failure, acute myocardial infarction and pneumonia.
- ▶ In Utah, Salt Lake City's University of Utah Health Care hired a hospital-based transitions navigator to help patients transition safely from hospital to medical home. Over three months, the program yielded a 23% reduction in the hospital's 30-day readmission rate.

To prevent hospital-acquired infections (HAIs), a major cause of readmission, many providers are implementing automated infection control and patient surveillance systems. These systems provide real-time alerts, pushing time-sensitive patient information directly to the treating physician to act quickly in reducing adverse events. Studies have found 10%-70% of HAIs could be prevented through systematic surveillance and standard preventive guidelines.

Exhibit 1-4. Trending of Medicare margins



Source: Medicare Payment Advisory Commission (MedPAC) report, March 2013.



Exhibit 1-5. What leads to needless hospital readmissions?

1. Some patients leave the hospital with a treatment plan for one illness when other problems of equal importance are ignored.
2. Many patients are discharged without understanding their illnesses or treatment plans or they inadvertently discontinue the medicines needed to stay well.
3. Family members who may be the patient's central caregivers are often not included in discharge planning.
4. The physicians caring for the patient may not communicate with each other or may not develop a coordinated plan for care after discharge.
5. Patients may not have the right prescriptions or cannot fill them.
6. Appointments with primary care clinicians or with specialists may not occur soon enough after discharge. Missed clinician visits lead to missed opportunities to recognize that the patient is not improving.
7. Information about a patient's hospital stay does not always go to the appropriate community clinicians.
8. Clarity is lacking on which clinician is responsible for care after patient discharge; accountability is spread among hospital staff, community physicians and nurses, skilled nursing facilities and families. Without clear accountability, problems that could be prevented are missed, leading to ED visits and repeat hospitalizations.

Source: The Revolving Door: A Report on U.S. Hospital Readmissions, RWJF, February 2013.

Patient flow improvement

Regardless of how many hospital beds are available, inefficient processes, inadequate care transitions and a fleet of other challenges can lead to poor use of capacity. Patient-flow problems not only create operational bottlenecks, but they often set the course for patients' perceptions of their entire stays. If the hospital encounter starts with a long wait to get a bed, the hospital may already have lost the battle for delivering a positive patient experience.

Providers nationwide are taking action to address the patient-flow challenge. For example:

- ▶ In Connecticut, Yale-New Haven Hospital implemented process changes that led to an 84% improvement in discharges by 11:00 a.m., a decreased length of stay from 5.23 to 5.05 days and the ability to accommodate 45 additional patients each day.
- ▶ In Ohio, Cincinnati Children's Hospital Medical Center improved surgical scheduling practices, resulting in fewer delays and cancellations of elective surgeries because beds were not available, as well as a more predictable flow of patients through the intensive care unit. The changes also saved the facility \$100 million in capital costs by eliminating the need for 75 new beds.
- ▶ In Washington, at Seattle-based Virginia Mason Health System, nurses analyzed their workflows and took steps to improve efficiency. A key change was reorganizing nurses' care patterns on the hospital floor so that they could care for patients who were in groups of rooms rather than spread across a unit. In areas where this change has been implemented, Virginia Mason reports its nurses now spend 90% of their time on direct patient care and attend to patients' needs faster and more effectively.

A key area of focus for improving patient-flow is the Emergency Department. Automated patient-flow solutions are helping relieve ED overcrowding by speeding up throughput processes. To reduce heavy patient volumes in the ED, some health care systems have also created transfer centers – hubs for patient referrals between the system and all the clinics, hospitals and physician offices in the region. These centers enable referring providers to make one phone call to send their patients directly from their facilities to the appropriate level of acute care, bypassing an unnecessary ED visit. Patients can readily receive the care they need, while hospitals can decrease the number of patients entering the hospital through the ED.

Supply chain retooling

On average, the supply chain represents the second-highest component of a hospital's operating costs – eclipsed only by the cost of labor. More and more hospitals are recognizing the value that the supply chain can bring to their organizations and have moved to add supply chain strategic initiatives to their overall goals. Approaches range from rightsizing inventory, to joining purchasing collaboratives for best-price negotiation, to building and automating warehouses and ordering directly from manufacturers. For example:

- ▶ In Arizona, Phoenix-based Banner Health saved \$226 million in five years by aligning supply chain management with efforts to improve quality, remove waste and disseminate best practices.
- ▶ In Florida, University of Florida and Shands Teaching Hospital in Gainesville are collaborating with Orlando Health in joint supply purchasing decisions – resulting in millions of dollars in savings for both organizations.
- ▶ In Mississippi, Meridian's Anderson Regional Medical Center rightsized its inventory levels and gained savings of \$1.5 million.

By the numbers

Many hospitals have found the most effective way to reduce costs for those supplies over which physicians have the greatest influence, such as implants, medical devices and high-cost pharmaceuticals, is to involve them vigorously in cost-saving initiatives.

“Hospitals have got to start engaging the right executives and physicians and share data with them. They’re scientists by nature. You’ve got to give doctors input on what is being used.”

Brent Johnson
Vice President of Supply Chain & Support Services
Intermountain Healthcare
Healthcare Finance News, September 2013

Revenue cycle re-engineering

From offering online scheduling to issuing easy-to-understand bills, the revenue cycle presents a distinct opportunity to make the transactional side of health care more financially sound for providers – and more satisfying for patients. The goal is to transform the process from reactive to proactive, from one that begins after the patient receives care to one that starts with the patient’s first interaction with the provider organization.

Forward-thinking providers are unlocking the value in their revenue cycles by becoming more patient-centric at all patient touch points. They are empowering patients through self-service communication tools such as patient account portals, scheduling apps and registration kiosks; using analytics to improve processes and patient communications; keeping patients informed of, and prepared for, their financial obligations; and making the billing process more consumer friendly. For example:

- ▶ In Nebraska, Omaha’s Bergan Mercy Medical Center offers “My Cost,” a customized, online tool. Patients can obtain out-of-pocket cost information

- ▶ Without major health care redesign or intervention, by 2022, health care costs in the US could make up as much as 19.9% of GDP – up from 17.2% in 2012 (source: CMS, 2014).
- ▶ According to an annual survey of governance structure and practices in the nation’s nonprofit hospitals and health systems, 52% of respondents have added value-based payment goals to their strategic and financial plans (source: Governance Institute, 2013 biennial survey).
- ▶ The US health care system wastes 30 cents of every dollar spent (source: IOM, 2012).
- ▶ The number of physicians accepting new Medicare patients increased by 3% between 2007 and 2012 and is higher than the number of physicians accepting new private insurance patients (source: HHS Office of the Assistant Secretary for Planning and Evaluation).
- ▶ Family premiums increased 4% in 2013, the same as in 2012, and individual premiums increased 5% versus 3% in 2012 (source: Kaiser Family Foundation, “2013 Employer Health Benefits Survey”).
- ▶ High-deductible plans can reduce health care costs by 5% to 14% (source: Robert Wood Johnson Foundation, 2012 report).
- ▶ A recent study finds that although 20% of health plans say value-based payment models support more than half of their business today, 60% of respondents anticipate they will support more than half their business within five years (source: Availity, “Health Plan Readiness to Operationalize New Payment Models,” May 2013).
- ▶ A recent survey finds that only 14% of adults understand basic insurance (source: Carnegie Mellon survey, July 2013).
- ▶ Despite increasing health care costs, less than 15% of internal medicine residency programs feature curricula aimed at teaching residents to be more cost-conscious (source: *Journal of the American Medical Association (JAMA)*, research letter, December 27, 2013).
- ▶ 5% of all inpatients will develop a hospital-associated infection – at an average cost of tens of thousands of dollars (source: Agency for Healthcare Research and Quality (AHRQ), 2014).
- ▶ The \$2.4 billion hospital revenue cycle management industry for software and services is expected to see double-digit increases in 2014 (source: Black Book Rankings LLC, 2013).
- ▶ Patients satisfied with hospital billing processes are five times more likely to recommend the hospital to a friend (source: Connance, December 14, 2011).
- ▶ A cost analysis of more than 10.2 million patient discharges for various conditions revealed that, at 24.2% of costs, supplies and devices were the leading contributors to the increase in average cost per discharge – surpassing intensive care unit charges, imaging and other advanced technological services (source: Jared Lane Maeda, PhD, et al., “What Hospital Inpatient Services Contributed the Most to the 2001 to 2006 Growth in the Cost Per Case?” *Health Services Research*, August 29, 2012).

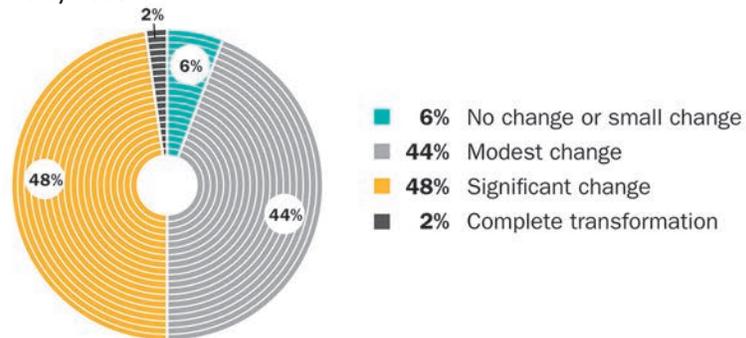
Value vignette

An employer view on value: exploring leading practices

The Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, now in its 19th year, tracks strategies and practices employers are using in the quest for health care value. The 2014 report, *The New Health Care Imperative: Driving Performance, Connecting to Value*, profiles the activities of high-performing companies, as well as current trends in the health care benefit programs of US employers with at least 1,000 employees. The survey was completed by 595 employers between November 2013 and January 2014. Respondents collectively employ 11.3 million full-time employees, have 7.8 million employees enrolled in their health care programs and represent all major industry sectors.

The survey found that employers are committed to providing subsidized health care benefits to active employees – even in an environment of continued health care cost increases, uncertainty about some provisions of health care reform and a slow-to-recover economy. Yet 94% of respondents expect employer-sponsored health care benefits to undergo modest or major changes over five years' time (see chart).

Nearly all employers anticipate significant or modest changes in health benefit programs by 2018



Survey responses indicate that employers are taking steps to derive the most value from their health benefit programs. In the view of the report's authors, employers who want their health plans to stay viable over the long term will need to take a holistic approach that includes five key steps:

- 1. Optimize benefit delivery channels.** Improve self-managed programs and explore alternatives such as private exchanges or hybrid arrangements.
- 2. Restructure benefits.** Consider offering new plan options, redesigning benefits, recalibrating contribution strategy and tier structures, and linking health savings account strategies
- 3. Enhance network and value-based contracting.** Reduce unit costs, and improve efficiency, quality outcomes, and risk-transfer arrangements to providers.
- 4. Focus on population health management.** Improve chronic-condition management, reduce risk factors and improve care gaps.
- 5. Engage employees and improve their accountability.** Use quality and transparency tools, point-of-care cost-sharing designs, account-based strategies and incentive approaches.

with your approach to retiree health benefits.

Source: Towers Watson, www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2014/03/towers-watson-nbgh-employer-survey-on-purchasing-value-in-health-care

for specific medical tests or procedures, customized to their insurance plan designs.

- ▶ In Ohio, Riverside Methodist Hospital in Columbus has made financial counseling a priority in its revenue cycle, including all patient accounts in one seamless discussion of patient responsibility and financial aid resources, as opposed to discussions with every visit. Hospital executives report Riverside has increased point-of-service collections by an average of \$50,000 per month.
- ▶ In Oklahoma, Saint Francis Hospital, the flagship facility for Tulsa's Saint Francis Health System, has taken steps to limit how often it asks for patient information and to integrate registration systems throughout the organization so that – regardless of setting – patient information can be collected in a unified way.

In a value-based world, creating a positive care experience is integral not only to building lasting patient relationships but also to maintaining a healthy cash flow. Putting the patient at the center of the revenue cycle brings an unparalleled opportunity to generate loyalty today – and provide for viability tomorrow.

No turning back: sailing to tomorrow

US health care is at a pivotal point in its journey. The realities of rapidly surging health care costs, flattening Medicare reimbursement and the rising tide of demand for services from the newly insured are forcibly coming together, leaving the industry with no easy route to make

Value vignette

Capacity management: reducing bottlenecks for a better patient experience

A recent study from software provider Central Logic – featuring input from such health care leaders as UPMC, Dartmouth-Hitchcock and Memorial Sloan-Kettering – offers six tips for how hospitals can better manage capacity to reduce length of stay and improve the patient-care experience:

1. **Focus on accurate patient placement.** Confirm that patients are in the right bed, at the right level of care, at the right time.
2. **Conduct daily, multidisciplinary rounds and bed meetings.** Make sure care teams work cohesively, appropriate tests are ordered, procedures are completed promptly, discharge plans are followed and capacity is optimized.
3. **Discharge patients as soon as possible, at any time of the day.** Focus on helping patients reach discharge as quickly as is clinically feasible.
4. **Smooth patient census.** Look at peak census patterns by time of day and day of week. Consider scheduling elective surgeries on weekends to relieve congestion, free up resources and reduce length of stay.
5. **Communicate consistently with staff and patients.** Streamline communication through case managers to facilitate communication across silos. Help patients manage expectations for length of stay.
6. **Measure and distribute the correct metrics.** Evaluate such indicators as 30-day readmission rates, average daily admits, observation volumes, case mix index and length of stay by diagnostic group against the impact on your organization's overall capacity management. Discuss metrics to ensure hospital administrators understand data implications for optimizing capacity.

Source: Central Logic, www.centrallogic.com/check-gate-resource?file=/public/uploads/global/2013/10/CapacityManagementSixThoughts.Final.pdf

headway toward the new horizon. Most agree the best course forward is to continue to pursue value-based approaches – while looking carefully within to better manage operating costs. The conditions are often uncertain. Yet for those whose sails are well set, the voyage to value can be a perfect opportunity for creating a stronger, more efficient and more resilient organization.

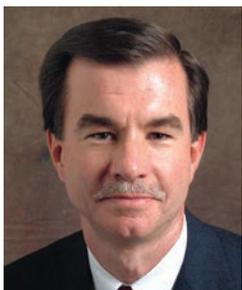
Our chapter concludes in a conversation with Harold Miller, who leads the Center for Healthcare Quality and Payment Reform. He offers his viewpoint on which payment models are the most effective in delivering long-term value.

Feature

Accountable payment models: paying to support higher-quality, lower-cost health care

A conversation with Harold D. Miller, President and CEO, the Center for Healthcare Quality and Payment Reform (CHQPR) (www.chqpr.com)

Harold Miller is a nationally recognized expert on health care payment and delivery systems and has worked with the federal government and several states and regions in designing and implementing system reforms. Along with his role in leading CHQPR, he also serves as adjunct professor of public policy and management at Carnegie Mellon University. We talked with him about how new payment models can improve the quality of care for patients, lower costs for employers and improve the financial viability of health care providers.



You have said that the biggest need in health care today is to change the way doctors and hospitals are paid, and the second-biggest need is to change the benefit designs for patients. Why are these the greatest concerns? And how should we address them?

Both the public and private sectors need to find a way to control health care spending – but to do it without harming patients. The biggest barrier to higher-quality, lower-cost care is that we don't pay physicians and hospitals for many services that would help patients stay well, and the fee-for-service payment system penalizes providers financially for achieving better outcomes and avoiding unnecessary tests and procedures.

Patient benefit designs also tend to do just the opposite of what is needed to support higher-quality, lower-cost care. High cost-sharing and high deductibles discourage people from getting services that will help them stay healthy, such as seeing a primary care physician early when they have a health problem and taking their medications regularly. On the other hand, if patients need an expensive procedure, such as a knee replacement or a cardiac stent, they will likely pay the same amount whether they go to a high-cost provider or a low-cost provider, because the cost is typically well above their deductible or out-of-pocket limit. So if they believe that higher cost means higher quality (even though evidence shows it doesn't), they will have a natural incentive to use the higher-cost provider.

We need to start paying doctors and hospitals for keeping patients healthy and to reward them for delivering high-quality, affordable care. And we need to change benefit designs so that patients also have the ability and incentives to use lower-cost, higher-quality services and providers.

You advocate for accountable payment models. What are these?

An accountable payment model has two main characteristics: flexibility and accountability. It gives providers the flexibility to decide what the patient needs rather than limiting the patient to narrowly defined procedures that a health plan is willing to pay for. But in return, the providers assume accountability for delivering high-quality care at an equal or lower cost than under traditional fee-for-service payment.

Examples of accountable payment models include:

- ▶ Bundled payments: making a single payment to two or more providers who are now paid separately, such as physicians and hospitals
- ▶ Warranted payments: paying providers more for high-quality care, with no extra payment for correcting preventable errors and complications
- ▶ Condition-based payments: paying providers based on the patient's condition, rather than based on how many procedures were used to treat the condition, so that providers have the flexibility to use fewer or lower-cost tests and procedures if they will achieve the same outcomes

Central to making these accountable models work are physicians. I've found that physicians in all specialties have ideas for how to change care in ways that would be better for patients and save money for purchasers, but they need to be paid in ways that support that. A challenge is that it's difficult to get physicians more involved because they're busy taking care of patients. We need to support their leadership in redesigning payment and delivery systems and make sure they don't lose money by devoting time to this effort.

.....
"An accountable payment model has two main characteristics: flexibility and accountability."
.....

Are there any payment models in existence today that illustrate what you describe?

I've seen several examples of how accountable payment models can significantly improve quality and reduce costs. For example, physicians and hospitals that are being paid for surgeries and procedures using bundles and warranties have been able to redesign care in ways that dramatically reduce infections, complications and readmissions. The patients get better care, the payers spend less money for the care, and the physicians and hospitals do better financially – a win-win-win.

There are other examples around the country where multiple small physician practices are working together through an independent practice association (IPA) to manage overall costs for a group of patients. One multi-specialty IPA manages global payment contracts from several payers and has even created its own Medicare Advantage preferred provider organization (PPO) plan. The IPA pays its primary care physicians 250% of what Medicare pays because investing in strong primary care has meant that patients need fewer hospitalizations, enabling the group to reduce total spending. Moreover, even though patients in the PPO plan are not restricted to using the physicians in the IPA, most choose to do so because the different payment structure for those physicians has enabled them to provide better, more coordinated care.

A lot of what is driving consolidation of hospitals and physicians is the continuing focus on price discounts and "shared savings" models. You have said that those structures are a barrier to innovative care delivery. Why?

What should matter to payers is spending, not price alone. If you demand large price discounts under fee-for-service payment, a hospital may be forced to try to increase the number of services it delivers in order to cover its costs. Conversely, if we're successful in reducing avoidable hospitalizations, it may actually cost more per patient to take care of the patients who do still need to be hospitalized, but overall spending will still be lower.

Discounts and shared savings don't change the underlying payment system, and that's what's really broken. For example, we want our hospitals to always be ready for us: to have the emergency room open if we need emergency care; to have a cath lab that gives us a short door-to-balloon time if we have a heart attack; to be prepared if our community experiences a disaster. But we don't pay the hospitals for this readiness – we pay only when the hospital treats someone. So if we demand that hospitals reduce the prices of individual services they deliver, they'll be forced to look for ways to deliver more and more services to make up for those discounts and to cover that standby capacity.

"Shared savings" sounds like a collaborative approach to payment, but it's really not because it doesn't change the underlying fee-for-service structure. If a hospital or physician practice performs fewer procedures, it will lose 100% of the revenue for those procedures, but its costs won't go down proportionally. Telling providers that a year from now they may or may not get back a small portion of that money isn't an attractive financial proposition, particularly for a provider that is already operating on thin margins.

How about accountable care organizations – are they a step in the right direction?

The concept of the ACO – providers working together to manage the overall cost and quality of care – is a good one, but the problem is that most ACOs are being paid fee-for-service plus shared savings, which doesn't really change anything. Physicians and hospitals in these models need to be paid differently so they can actually redesign the way they're delivering care. "Coordination" is only part of the answer. In a true ACO, every physician in every specialty would be looking for ways to redesign care for higher quality and lower cost. That's what I call "building ACOs from the bottom up" – changing how front-line providers are delivering care instead of adding yet another layer of management on top of the same approach to delivery and payment.

In the marketplace today, we're seeing a lot more providers and payers combining. How do you see that working or not working in the future?

There are huge advantages if payers and providers can work more closely together, and many providers have found that having their own health plan is a natural way to achieve that. It's more problematic, though, when a large payer acquires one provider or when a provider creates a health plan that tries to sell insurance covering other providers. In those cases, the organization is trying to be two things at once: a general health plan and a general provider. If they're trying to sell two different products – health care and health insurance – to two different sets of customers, which is the most important?

The real goal should be to try to create a closer connection between providers and employers. A growing number of employers are looking to do direct contracting with

provider organizations, and vice versa. Any time you can take out the middleman, you have a more efficient structure.

.....
“The real goal should be to try to create a closer connection between providers and purchasers.”
.....

How far along are we on the timeline of moving from volume- to value-based care?

I don't think we're very far, unfortunately. Providers can't redesign care for higher quality and lower costs without a payment model that supports that, but Medicare and private health plans haven't made the payment changes needed to support them. Too many payers are claiming that pay-for-performance and shared savings programs are “payment reforms” when they're not. We could go a lot farther a lot faster if we enabled providers to implement different payment models more rapidly than is being done today. If the most innovative providers can't make any progress, we won't have the diffusion of innovation we need to really change the system. With the right kind of support, I think we could see a significant fraction of providers using new models within five years.

What other obstacles are standing in the way of payment reform, and how can they be hurdled?

First, we need a fundamental change in how we view new payment and delivery models. Many see them as a win-lose. But they're potentially a win-win-win for all involved. The win for patients is better care; for purchasers, it's reduced spending or a slower trend in spending; and for providers, it's a way for them to be more financially viable when they succeed in delivering quality care.

At the Center for Healthcare Quality and Payment Reform, we've identified 10 barriers to implementing health care payment reforms, along with potential solutions (see chart on the next page). An overriding theme weaving through the list of barriers is a general lack of trust. In many cases, physicians don't trust hospitals, hospitals don't trust physicians and neither physicians nor hospitals trust payers. And the true purchasers, the employers, rarely if ever talk to the true providers, the physicians and hospitals. When employers actually talk with providers, however, they typically find that their interests are more aligned than they thought. One employer coalition that has started talking directly with physicians told me, “We've found that the care we want to buy is what the physicians want to sell.” That kind of conversation can lead to the win-win-win we're all looking for.

Because of the lack of trust, it helps to have a neutral convener. A growing number of communities are fortunate enough to have a multi-stakeholder regional health improvement collaborative that can bring purchasers and providers together, facilitate their discussions and also provide the trusted data needed to create win-win-win changes in payment and benefit designs. People who don't have one in their community should form one, and those who do have one should support and use it.

How can executives and board members in provider and payer organizations best support accountable payment models at their organizations?

Providers need to develop a vision of their future that's aligned with where the country needs to go. In the years ahead, a smaller hospital as opposed to a larger one may be the mark of success if fewer patients coming to your hospital means you're doing a better job of improving the health of your community's residents.

If hospitals and physicians improve their ability to keep people healthy, affordably, they can be an essential catalyst in the economic development of their communities. A healthier workforce and lower health insurance premiums will draw more employers to a community; more jobs and higher-quality, more affordable health care will draw more residents. As a result, hospitals will grow, but in a different way – not because they're hospitalizing a higher proportion of the community's residents, but because the population of the community is growing.

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“Unlike other industries, success in health care means selling less products and services, not more.”
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It will be difficult to get health insurers to implement new payment models unless they think it's good for their business, too. Payers will need to spend money to negotiate new contracts with providers and implement new payment systems, yet most of the savings will go back to their self-insured employer customers. There won't be a direct return on investment for the insurer unless employers begin to demand the use of accountable payment models, so that health plans that truly commit to and invest in these models will retain and gain customers.

Bottom line: unlike other industries, success in health care means selling less products and services, not more. It's a different mindset, requiring an entirely different payment system for future sustainability.

10 barriers to implementing health care payment reforms – and how to overcome them

| Barrier | Solution |
|---|---|
| 1. Continued use of FFS payment in payment reforms | <ul style="list-style-type: none"> ▶ Use episode-of-care payments, condition-based payments, and risk-adjusted global payments to eliminate undesirable incentives under fee-for-service and to give providers the flexibility and accountability for reducing costs and improving quality |
| 2. Expectation that providers will be accountable for costs they cannot control | <ul style="list-style-type: none"> ▶ Use risk adjustment and risk limits to keep insurance risk with payers but transfer performance risk to providers ▶ Use risk exclusions to give providers accountability only for the types of costs they can control ▶ Make provisions for contract adjustments to deal with unforeseen events |
| 3. Compensation of physicians based on volume, not value | <ul style="list-style-type: none"> ▶ Change physician compensation systems to match incentives under payment reform ▶ Modify federal and state fraud and abuse (F&A) laws to permit gain-sharing between hospitals and physicians |
| 4. Lack of data to set payment amounts | <ul style="list-style-type: none"> ▶ Give providers access to timely analyses of utilization and cost data through community multi-payer claims databases |
| 5. Lack of patient engagement | <ul style="list-style-type: none"> ▶ Ask patients to designate their primary care physicians rather than using statistical attribution rules based on FFS claims to assign them retrospectively ▶ Use value-based benefit designs to enable and encourage patients to improve health, adhere to treatment plans and choose high-value providers and services |
| 6. Inadequate measures of quality of care | <ul style="list-style-type: none"> ▶ Develop quality measures for all of the conditions and procedures that drive significant amounts of cost ▶ Use outcomes measures instead of process measures to give providers flexibility in redesigning care and supporting effective patient choice ▶ Use regional health improvement collaboratives (RHICs) to collect patient-reported information on outcomes |
| 7. Lack of alignment among payers | <ul style="list-style-type: none"> ▶ Ask physicians and other providers to define lower-cost, higher-quality ways to deliver care and the payment changes needed to support them ▶ Encourage employers to support regional payment reforms and to choose health plans that will implement them in a coordinated way ▶ Offer Medicare payment reforms to a broad range of providers on an ongoing basis ▶ Use state government and/or RHICs to facilitate agreement among payers |
| 8. Negative impacts on hospitals | <ul style="list-style-type: none"> ▶ Reduce fixed costs and improve efficiencies in hospitals ▶ Change payment levels to hospitals to reflect higher costs per admission that may accompany lower admission rates ▶ Increase transparency about hospital costs to ensure that prices for hospital care are adequate, but not excessive |
| 9. Policies favoring large provider organizations | <ul style="list-style-type: none"> ▶ Remove anti-trust barriers to small physician practices joining together to manage new payment models ▶ Combat anti-competitive practices by large providers ▶ Avoid unnecessary standards for structure and processes in payment systems and accreditation systems that increase costs and favor large organizations |
| 10. Lack of neutral convening and coordination mechanisms | <ul style="list-style-type: none"> ▶ Support the creation and operation of multi-stakeholder RHICs in all regions |

Source: Center for Healthcare Quality and Payment Reform, "Ten barriers to implementing healthcare payment reforms and how to overcome them," first edition, December 2012.



Considerations for your board and executive leaders

For providers

- ▶ How are you managing the transition from fee-for-service to value-based payment systems? Are you prepared to take on more responsibility for containing costs while demonstrating continuous improvements in patient outcomes? Do these plans include educating physicians and staff on the implications of value-based payment?
- ▶ Are you seeking out payers who are open to value-based contracts? What service lines best position your organization for a value-based bundled payment arrangement?
- ▶ If you are considering forming a provider-sponsored plan, have you evaluated risk, regulatory concerns and market position?
- ▶ Have you identified opportunities for reducing waste, determining which clinical areas can benefit from increased standardization and evidence-based practices?
- ▶ Are you building value-creating partnerships with your physicians? Are you engaging physicians in developing a true accounting of all costs and the value of each step involved in a procedure? Is physician compensation tied to value, efficiency and quality?

- ▶ Have you assessed the effectiveness of your admission, discharge and transfer protocols?
- ▶ What measures have you taken to enhance your organization's ability to reduce hospital-acquired conditions and readmissions and improve other key performance measures?
- ▶ Have your financial metrics and management reporting tools changed to adapt to new models of care, with broader metrics that include all aspects of the care continuum?

For payers

- ▶ Are you working with providers to develop new models of care that put incentives in the right place – and ensure the care delivery changes providers would like to see are incorporated into revised financial structures? Are incentives large enough to drive changes in provider behavior?
- ▶ Does your value-based payment model consider your current and future technology base, including automation and scalability?
- ▶ Have you developed scalable payment models that can be implemented seamlessly, along with toolkits providers can use to help them succeed under these models?

- ▶ How are you pursuing opportunities to pool your data and combine it with data from Medicare and Medicaid, to facilitate analyses of health cost drivers and enable a more granular assessment of provider performance?
- ▶ Are you developing tools and support that enable providers to deliver more cost-effective care and track their performance – for example, are member-specific care alerts and care guidelines integrated into physician workflows?
- ▶ Are you embracing opportunities to develop a more collaborative relationship with providers by creating the infrastructure for coordinated care models that have more sophisticated informatics and decision support systems to assist providers in improving care and reducing costs?
- ▶ Are you positioning yourself as a trusted source for patients' clinical and lifestyle information needs, providing better tools to help your members manage their health?

“The art of the sailor is to leave nothing to chance.”
Annie Van De Wiele, *20th-century Belgian author and voyager*



Value in delivery

Changing tack

Voyage to value

Providers and payers have a clear directive: to maximize health care value for patients as they journey through the health care system. For providers, that means planning and delivering the best possible care, partnering across the care continuum through seamless teams and making sure effective transitions take place. For payers, it means collaborating with providers in new ways, and it means empowering patients with coverage options that focus on high-performing providers and with incentives for better managing chronic illness and for maintaining health and wellness.

Just as sailing upwind requires a change in tack – back and forth across the wind – health care organizations must be nimble in their voyage to high-value care, ready to adjust their positions and approaches to adapt to rapidly changing conditions.



Today's move toward value-based care represents another step in the evolution from isolated to integrated delivery. Providers and payers are encouraged to work together at unprecedented levels of collaboration. The new horizon of care focuses on communicating fully with patients, anticipating their needs and treating them before costly complications occur. The journey forward also demands developing new programs and services designed to keep people healthy and help those with chronic conditions better manage their own care. In this chapter, we provide an overview of industry initiatives to improve care coordination, optimize quality and safety, and enhance the value of the patient experience.

Value in care management: learning from emerging models

Historically, for US health care consumers, the care experience has been a fragmented one. As patients move from clinician to clinician, they have struggled with navigating complex waters. They may be adrift in a sea of information, with little guidance in making sense of it all. This lack of coordination has added unnecessary risks, as test results may not be communicated accurately, prescriptions from multiple physicians may conflict, and follow-up after hospital discharge may be insufficient. Uncoordinated care has also added costs to the system – through duplicate or unnecessary testing and services, overused intensive procedures and preventable hospital readmissions.

Emerging models of care integration are demonstrating how health care can be delivered more seamlessly, accurately and effectively, particularly for people

with chronic illnesses and complex needs. Built on a foundation of strong clinical and organizational support, these models are designed to provide continuous, well-coordinated care across health care services and from acute to long-term settings. As discussed in Chapter 1, value-based payment models provide incentives for coordinating care and delivering value – and encourage patients and their support networks to be the center of care planning and delivery.

Evidence-based care and standardized practice guidelines

Providing high-value care hinges on having the best information on what treatment works best for which patient, and under what circumstances. Evidence-based protocols can help providers diagnose and treat various conditions – enabling care to be standardized yet tailored to unique patient needs. Integrated within an electronic health record, these protocols

automatically provide clinicians with the best evidence about a particular condition as well as a pathway for decision-making.

A scan of the health care horizon finds many initiatives focused on evidence-based care. For example:

- ▶ At Boston Children's Hospital, the hospital's cardiovascular department developed standardized clinical assessment and management plans (SCAMPs) in 2009. SCAMPs are described as practical and flexible tools for "narrowing practice variability" while still enabling providers to use their clinical judgment and adapt treatment pathways to individual patient needs. Since the program's creation, more than 12,000 patients have been enrolled in 49 SCAMPs in pediatric and adult medicine, and 19 institutions are currently collecting SCAMPs data.
- ▶ Kaiser Permanente's Healthy Bones Program identifies and proactively treats patients at risk for osteoporosis and hip fractures, using standardized practice guidelines for managing osteoporosis. Patients are treated in accordance with the latest clinical evidence, provided with osteoporosis education and supported through at-home care programs. According to Kaiser, the program has reduced hip fracture rates over five years by an average of almost 50%.
- ▶ Virginia Mason Medical Center in Seattle, WA, incorporated evidence-based decision rules into provider workflows at the point of ordering an advanced imaging test to reduce variability. If the provider cannot cite an appropriate evidence-based decision rule, the test cannot be ordered. The medical center reports this initiative has resulted in

reduced delays for necessary imaging, as well as no unnecessary tests and substantial decreases in imaging use.

The team approach

Just as teamwork is crucial in sailing – requiring all crew members to skillfully perform their assigned tasks – a high-performing team in health care is essential to achieving a more patient-centered, coordinated and effective health care delivery system (see Exhibit 2-1 on page 34). The concept has been advanced through the ACA and such initiatives as the Patient-Centered Primary Care Collaborative and the Interprofessional Education Collaborative, as well as exemplary programs in individual health systems such as:

▶ **Daily huddles:** In Ohio, the Cleveland Clinic’s care enhancement program for lung transplant patients calls for daily

huddles of caregivers, patients and their families. The goal is to keep all informed of each patient’s prognosis and recovery and enable development of a cohesive care plan. According to the Clinic, the program has reduced costs and lengths of stay, improved survival rates, and enhanced patient satisfaction with clinician communication by nearly 30%.

▶ **Multidisciplinary rounds:** In Texas, at the MD Anderson Cancer Center, integrated teams coordinate several specialties to develop a comprehensive cancer care plan. Disease-specific centers have multidisciplinary meetings to discuss new and complex cases and also conduct multidisciplinary rounds. Team members coordinate care through an electronic health record that the patient can also access.

“The clinician operating in isolation is now seen as undesirable in health care – a lone ranger, a cowboy, an individual who works long and hard to provide the care needed, but whose dependence on solitary resources and perspective may put the patient at risk.”

IOM
“Core Principles & Values of Effective Team-Based Health Care”
October 2012

▶ **Collaborative care units:** In Wisconsin, community health system ThedaCare leverages collaborative care units that organize care delivery around the patient’s experience. When a patient is admitted, an interdisciplinary care team coordinates with him or her to agree on

Value vignette

The VALUE framework: teaching value to future physicians

Teaching hospitals, academic medical centers and residency programs have a useful tool for training future physicians in delivering high-value care: the VALUE framework. The tool was developed by Mitesh Patel, MD, a physician and Robert Wood Johnson Foundation Clinical Scholar, along with colleagues at the Perelman School of Medicine at the University of Pennsylvania.

VALUE is an acronym for 1) validation and variability, 2) affordability and access, 3) long-term benefits and less side effects, 4) utility and usability and 5) effectiveness

and errors. According to the tool’s developers, this framework can be used with physicians in training to assess the benefits of medical interventions, from tests and medications to surgeries.

Patel points to findings that less than half of medical students feel they are appropriately trained in health care policy topics, such as medical economics. Residents can use VALUE, he notes, as they’re seeing patients to select those options that generate high value and reduce unnecessary costs.

“Training residents to practice medicine using concepts of value-based care is like learning a new language for both residents and their teachers. The VALUE framework can bridge this gap and become a useful tool for improving the care of our patients.”

Mitesh Patel, MD
Robert Wood Johnson Foundation
Clinical Scholar

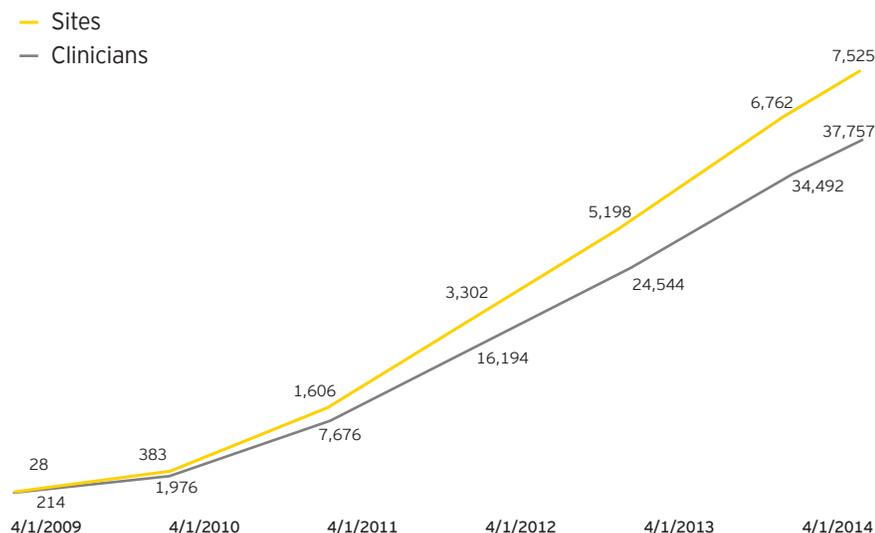
Source: University of Pennsylvania news release, http://www.uphs.upenn.edu/news/news_releases/2012/08/value/; Journal of General Internal Medicine, September 2012; www.amednews.com/article/20120919/profession/309199996/8/

Exhibit 2-1. Five principles of team-based health care

| Principle | The team |
|--------------------------------------|---|
| 1. Shared goals | Sets shared goals that reflect patient and family priorities and can be clearly articulated, understood and supported by all team members |
| 2. Clear roles | Has in place clear expectations for each team member that can optimize team efficiency and facilitate division of labor – so that the team can accomplish more than the sum of its parts |
| 3. Mutual trust | Engenders trust, creating strong norms of reciprocity and greater opportunities for shared achievement |
| 4. Effective communication | Prioritizes and continuously refines its communication skills, with consistent channels for candid and complete communication that are used by all team members across all settings |
| 5. Measurable processes and outcomes | Agrees on and implements reliable and timely feedback on how the team functions and achieves its goals, and uses this feedback to track and improve performance immediately and over time |

Source: Adapted from Pamela Mitchell et al., “Core Principles & Values of Effective Team-Based Health Care” (IOM discussion paper), October 2, 2012.

Exhibit 2-2. NCQA PCMH growth, 2009-14



Source: NCQA, 2013.

a care plan. ThedaCare reports that the program has reduced hospital lengths of stay, errors in patient care and inpatient care costs by 25%, while improving provider compliance with care protocol and achieving a patient satisfaction rate of 5 out of 5, 95% of the time.

As discussed in Chapter 3, robust health information technology (HIT) is essential to a team-based approach – enabling the care team to share and act on patient information among disparate care providers. Technology also supports team-based care through advanced analytics to identify and manage risk, real-time clinical analytics at the point of care and online and mobile applications that engage patients between office visits.

From medical homes to medical neighborhoods

The patient-centered medical home (PCMH) model continues to show promise as an anchor for patient care. The National Committee for Quality Assurance (NCQA) has recognized more than 37,000 clinicians at more than 7,500 sites throughout the country in its PCMH program (see Exhibit 2-2). Today, the focus on the medical home model has expanded to include “medical neighborhoods” – defined by the Patient-Centered Primary Care Collaborative (PCPCC) as a “clinical community partnership.”

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“[A successful medical neighborhood will] focus on meeting the needs of the individual patient, but also incorporate aspects of population health and overall community health needs.”

AHRQ
 “Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms”
 June 2011

.....

According to PCPCC, medical neighborhoods include the medical and social supports needed to enhance health, with the PCMH serving as the patient’s primary hub and coordinator of health care delivery. Beyond the medical home, neighbors in the medical neighborhood range from hospitals and specialty clinics to health plans and ancillary service providers that are part of the continuum of care. All work together to enable PCMHs to reach their full potential in improving patient outcomes and managing population health.

Patient-centricity: enhancing the customer experience

To transition from FFS to value-based reimbursement models, health care organizations are becoming more patient-centric – at the individual and population levels. Through providing ongoing education, proactive prevention measures and a consistently positive customer experience, providers and payers can help patients become better advocates for their own health.

.....
 “We need to flip from focusing on the medical condition to focusing on the patient.”

Maureen Bisognano
 President and CEO
 Institute for Healthcare Improvement

Many aspects of health reform effectively mandate patient centricity. The Hospital Consumer Assessment of Healthcare Providers and Systems measures the quality of caregiver-patient interactions, and payment is based in part on patients’ perceptions of their hospital care. The success of the Hospital Readmissions Reduction Program (see Chapter 1, page 18) and ACOs also hinges on keeping

patients connected to providers. Patient-centric initiatives are varied and numerous. For example:

- ▶ **Bedside communications:** In Michigan, Spectrum Health has installed an interactive care console with the goal of enhancing communication at the patient bedside. The console integrates medical information with customizable features

through which patients can learn more about their medical conditions. It also serves as a tool to help patients adhere to recommended treatment plans.

- ▶ **Chief experience officer:** In Ohio, the Cleveland Clinic has created the position of chief experience officer to determine what changes would improve the patient’s physical and

Value vignette

The Joslin Diabetes Center: creating a value-driven model

The Joslin Diabetes Center in Boston, MA – affiliated with Harvard Medical School since its founding in 1898 – is the world’s largest diabetes research and clinical care organization. It is focused on providing efficient, coordinated care for 24,000 patients with diabetes.

A value-driven model for helping contain and manage chronic disease, Joslin follows defined principles to create a streamlined treatment system. A full range of diabetes services are provided in a single location, with convenient scheduling and easy access to related medical services. Adult and pediatric patients can be seen by a team of medical experts – an endocrinologist, ophthalmologist, podiatrist and diabetes educator – all in the same day. Electronic medical records keep track of quality results.

Joslin’s team care has resulted in dramatically improved outcomes and lowered costs. For example:

- ▶ Early intervention has decreased late-stage blindness from 60% to about 1%

- ▶ Patients cared for at Joslin incur on average \$1,465 less in total health care costs each year

.....
 “[Joslin] represents an evolution ... from care delivered reactively at high cost to care delivered proactively and preventatively, which reduces longer-term costly complications.”

Ranch C. Kimball
 Former CEO
 Joslin Diabetes Center

Through its “Joslin Inside” program, Joslin works with US and worldwide affiliate organizations to provide care, education and tools for patients to manage their own diseases. Another program, “Joslin Everywhere,” leverages mobile apps and decision-support algorithms to provide patients with a virtual care experience. Joslin is also teaming with American Well™ in a global telehealth initiative that brings diabetes care to patients at home.

Sources: Harvard Business School, www.hbs.edu/centennial/businesssummit/healthcare/value-based-health-care-delivery.html; Diabetes Mine, www.diabetesmine.com/2013/04/behind-the-scenes-with-the-ceo-of-joslin-diabetes-center.html

By the numbers

- ▶ Between 2013 and 2025, the population over 65 years will grow by close to 45%; the number of patients with chronic diseases will increase between 21% and 27%; and demand for adult primary care services will increase by 14% (source: *Health Affairs*, November 2013).
- ▶ More than 15% of patients are likely to leave their current physician and practice, according to a recent survey (source: Press Ganey, "Protecting Market Share in the Era of Reform: Understanding Patient Loyalty in the Medical Practice Segment," December 10, 2013).
- ▶ The average American is 25 pounds overweight and does not exercise (source: Centers for Disease Control and Prevention, 2014).
- ▶ In improving population health management, lifestyle and wellness coaching is the most popular resource to invest in, a recent survey finds. More than 71% of survey respondents indicated their hospital invested in this resource (source: Premier, 2013 Fall *Economic Outlook* report).
- ▶ The average American visits the doctor three times a year but spends 52 hours a year searching for health information on the internet (source: Makovsky Health and Kelton, third annual national consumer survey, 2013).
- ▶ About 1 in 25 hospital patients acquired an infection during his or her stay in 2011 (source: S. Magill et al., "Multistate Point-Prevalence Survey of Health Care – Associated Infections," *New England Journal of Medicine*, March 27, 2014).
- ▶ Nearly 4 in 10 hospitalists responding to a survey from Johns Hopkins University School of Medicine said they struggle with unsafe workloads at least once a week. Almost a quarter believed their workload "likely contributed" to patient complications and even deaths. Most of them defined a safe workload as up to 15 patients per shift (source: Henry J. Michtalik et al., "Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists," *JAMA Intern Med.*, 173(5), 2013, pp. 375-377).
- ▶ According to the American College of Healthcare Executives (ACHE), turnover among hospital CEOs rose to 20% in 2013 – the highest it has been since ACHE began compiling data in 1981 and 3% higher than in 2012 (source: ACHE, 2014).
- ▶ Two-thirds of hospital CEOs hired in 2014 will come from a non-health care background, according to a poll of more than 1,400 human resources professionals at health care organizations (source: Black Book Rankings poll, December 18, 2013).

emotional experience. One of the first actions the officer recommended was redesigning patient gowns to make them more "dignified."

- ▶ **Care experience working groups:** In Pennsylvania, UPMC has developed a six-step methodology and practice to deliver ideal care experiences and improve clinical outcomes while decreasing waste and costs. Working groups and project teams strive to identify – and close – the gaps between current and ideal care experiences. The program has been adopted by numerous health care organizations outside of UPMC, nationally and internationally.

"The most important predictor of patient loyalty is a patient's confidence in their provider. Practices that foster trust between providers and patients not only can attract new patients, but will also optimize the impact of [patient satisfaction scores] and value-based payments."

Thomas H. Lee, MD
Chief Medical Officer
Press Ganey

Advances in home care

As technology enhances the ability to treat illness at home, as well as to remotely monitor and coach patients on health, home care is coming of age. According to home care management industry statistics, 12 million patients are receiving home health care services, with more than 428 million patient visits each year. About 70% of those using these services

are age 65 and older, most being treated for heart disease, diabetes and cerebral vascular diseases.

Leading health care providers reflect a range of home care approaches. For example:

- ▶ The Hospital at Home[®] model, developed by researchers at the Johns Hopkins Schools of Medicine and Public Health in Baltimore, MD, provides home care as a full substitute for acute hospital care. Patients who meet specific medical eligibility criteria can receive hospital-level care – including diagnostic tests and treatment therapies from physicians and nurses – at home. Clinicians and pharmacists visit daily to coordinate the medical care plan and work with family caregivers, while telehealth nurses provide additional support remotely. The program has been adopted by numerous health systems, home care providers and managed care programs as a tool to cost-effectively treat acutely ill older adults.
- ▶ At Partners HealthCare in Massachusetts, the Connected Cardiac Care Program, a self-management and telemonitoring program, helps patients with heart failure manage their health at home. Through advanced care coordination, patient education and technology, patients can report their weight, blood pressure, heart rate and symptoms daily to telemonitoring nurses – reducing the need for trips to the hospital. In its 10 years in operation, the program has yielded an estimated \$10 million in savings and a 51% reduction in hospital readmissions for patients with heart failure.

Value vignette

Mobile apps: adding value to wellness programs by engaging consumers

As the industry shifts from volume- to value-based reimbursement models, payers have a greater financial stake in keeping members healthy. More health plans are turning to mobile apps to engage patients in their own care and offer incentives for adopting and maintaining healthy habits. Many are using digital health trackers and fitness apps to create positive customer experiences and influence healthy behavior choices. For example:

- ▶ Aetna's *What's Your Healthy?* campaign features a fully integrated consumer website and mobile platform, CarePass, through which consumers can track health and wellness apps conveniently from one online hub. CarePass connects apps on its platform, enabling users to manage their fitness and set health and wellness goals.
- ▶ CareFirst Blue Cross Blue Shield's *Ready, Step, Go!* app lets users count steps, distance traveled and calories burned for each workout.
- ▶ Cigna and MyFitnessPal, a free personal health and fitness resource, have joined forces to combine Cigna's health coaching programs with MyFitnessPal's nutrition, physical activity and weight management resource. Customers can connect their MyFitnessPal accounts with their coach to share their diet and

exercise activity. Coaches can view a participating user's progress and offer advice and support.

- ▶ Humana *fit* for Android uses the built-in GPS of mobile devices to track fitness activities.
- ▶ Kaiser Permanente has created several mobile apps to help its members better manage their diet and exercise programs, including *Mix It Up*, an online nutrition program; *Thrive Across America*, a physical activity challenge; *Everybody Walk!*, a personalized walking program; and *KP Preventive Care*, an app offering personalized health reminders.
- ▶ UnitedHealthcare's *NOT ME* diabetes prevention program helps customers at risk for developing type 2 diabetes to eat healthier, exercise and lose weight. *OptimizeMe*, another UnitedHealthcare app, lets users track health and fitness goals and share them on social networks.

.....

“Any time you engage a consumer, you’re not only going to help that consumer live a healthier life, you’re going to help the payer lower their costs as well.”

Nick Martin
 Vice President of Innovation
 UnitedHealthcare
 Speaking to FierceHealthIT

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Sources: FierceHealthIT, www.fiercemobilehealthcare.com/slideshows/payers-invest-mhealth-7-mobile-health-and-wellness-apps; www.fiercehealthit.com/special-reports/unitedhealthcare-reward; HuffPost Healthy Living, www.huffingtonpost.com/shaan-gandhi/smartphones-health_b_4450403.html

- ▶ At Virginia Commonwealth University Medical Center in Richmond, the House Calls program has reduced hospital costs for patients with multiple chronic conditions by 60%. Described as a “doctor’s office on wheels,” it serves those who can’t easily come to the medical center for scheduled appointments.

Patient safety: taking action

Preventing harm is fundamental to delivering high-value care, and the industry continues to move forward in improving patient safety. Through system-level initiatives, such as procedures to guide the delivery of care, checklists and care protocols, and tools built into the electronic

health record (EHR) to help reduce errors, health care organizations are striving to create an environment that guards against human mistakes and supports a culture of consistently reliable care.

“An institution could have the best surgeons in the world, but if the aftercare is lacking and the patient develops an infection as a result, then the hospital has failed to protect its patient.”

Leah Binder
President and CEO
The Leapfrog Group

A May 2014 report from HHS indicates these efforts are beginning to show results: a 9% decrease in harms experienced by patients in hospitals in 2012 compared with the 2010 baseline and an 8% decrease in Medicare fee-for-service 30-day readmissions. The report estimates that national reductions in adverse drug events, falls, infections and other forms of harm have prevented nearly 15,000 deaths in hospitals as well as 560,000 patient harms – and saved \$4.1 billion in costs in 2011 and 2012. HHS credits these improvements to “strong public-private partnerships, active engagement by patients and families, and a wide range of aligned federal programs and initiatives – including new tools provided by the Affordable Care Act – working in concert towards shared aims.”

Recent improvements in patient safety are cited also in the Leapfrog Group’s spring 2014 update. The report notes nearly one in three hospitals improved its safety scores by 10% since 2012, most through safer practices and processes. Of the 2,522 scored hospitals, 804 received an A in safety, 668 a B, 878 a C, 150 a D and 22 an F. States with the highest percentage of A hospitals were Maine (74%), Massachusetts (70%), South Dakota (67%), Illinois (57%) and Hawaii (50%). The Leapfrog Group notes, however, that alongside improvement in many hospital scores, other hospitals – some with national name recognition – continue to have a poor safety record.

The approaching implementation of a key ACA provision is also ramping up safety initiatives. The law requires that, starting in 2015, hospitals with more than 50 beds

Value vignette

Four guidelines from the Lucian Leape Institute: helping patients feel valued

A new report from the National Patient Safety Foundation’s Lucian Leape Institute offers four recommendations for improving patient engagement:

1. **Core values:** Make engagement a core goal and value for your organization. Create standards of dignity and respect for all. Implement policies that facilitate patient engagement, such as providing open access to clinical records and establishing open visitation policies.
2. **Patient and family participation:** Involve patients and their families in designing and improving care. Invite them to serve on safety, quality and personnel review committees.
3. **Staff training:** Train all staff in patient and family engagement. Enable clinicians to learn from patients and families about the experience of illness, as well as the communication skills needed in patient/family partnerships, shared decision-making, and disclosure and apology.
4. **Community collaboration:** Raise public awareness by collaborating with community and patient advocacy groups. Inspire a strategic alignment across the communities of health care consumers and advocates, policy makers, researchers and health care leaders and clinicians to commit to increasing patient engagement and reducing harm.

Source: Lucian Leape Institute, “Safety Is Personal: Partnering with Patients and Families for the Safest Care,” 2014.

Value vignette

Mobile health clinics: delivering value in serving high-risk populations

Each year, mobile vans and clinics provide health services to an estimated 7.5 million people, targeting those who typically do not have a physician or insurance, or are otherwise outside the conventional health care system. According to the Mobile Health Clinics Association, 2,000 mobile health clinics are currently operating in the US. For example:

- ▶ In California, Napa's St. Joseph Health invests \$5 million each year in mobile health clinics, about 11% of which is offset by reimbursements.
- ▶ In southeastern Massachusetts and East Bay, RI, Southcoast Health System's mobile health system serves

seniors, teens and families who do not have access to medical care.

- ▶ In Virginia, Bon Secours Health Systems has had mobile clinics since 1984. The initiative was recently expanded with a fifth mobile clinic – and plans for a sixth focused on nutrition in areas lacking access to healthy foods.
- ▶ The Family Van program based at Harvard Medical School has demonstrated a return on investment of \$36 for every \$1 spent.
- ▶ Breathmobile, a group of mobile asthma clinics, provides free care to underserved children in different cities across the nation.

Most mobile units are run by hospitals, medical centers, public health departments, community health centers, private foundations and faith-based organizations. Many nonprofits have funds set aside for mobile vans as part of their community benefit requirements.

Proponents note that mobile units can reduce ED visits and keep chronic conditions from advancing to the degree where patients need higher-cost care. Trust for America's Health, a health advocacy organization, has shown a return of \$5.60 for every \$1 spent on prevention.

Source: Healthcare Finance News, www.healthcarefinancenews.com/news/mobile-health-vans-value-proposition, H&HN Magazine, May 2014

that want to contract with a health plan in the ACA's insurance exchanges participate in a patient safety organization (PSO). They will also be required to establish a patient safety evaluation system, defined as "the collection, management, or analysis of information for reporting to or by a patient safety organization." In addition to complying with the law, participating in a PSO can increase internal reporting and knowledge about adverse events and enable providers to better collaborate in preventing medical errors.

From silos to synergies: rounding the cusp

The voyage to value-based care is an effort that calls for all hands on deck. Health care providers and payers must continue to eliminate silos, create synergies and align strategies, structures and practices for delivering value to patients through the full cycle of care. The ultimate destination is a patient-centric system – one of relentless collaboration to improve health outcomes, keep people healthy and enhance the care experience.

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"We are on the cusp of the golden age of healthcare delivery."

George C. Halvorson
Former Chairman and CEO
Kaiser Permanente
.....

Value vignette

Value centers: focusing on solutions

“Think tanks” for health care value serve as resource hubs for advancing value-driven health care solutions. Profiled below are five leading centers.

Colorado Center for Improving Value in Health Care (CIVHC)

Denver, CO

Created in 2008 by Executive Order of the Governor, CIVHC is a nonprofit organization designed to advance statewide initiatives for improving Colorado's health care quality and containing costs. It is funded by some of the state's leading health foundations. With a 28-member board of directors and a broad base of support from more than 60 organizations statewide, CIVHC convenes diverse constituencies of consumers, providers, payers, businesses, policy makers and government agencies to work together in improving value across the health care system. The organization also administers an all-payer database.

Mayo Clinic Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery (CSHCD)

Rochester, MN

Established in 2011, the CSHCD is focused on the science of care delivery. Combining data analysis, health care

engineering principles and health care delivery research, the center tests theories, models and methods to determine if they can improve patient care, outcomes and cost. The center includes five major programs: Value Analysis, Health Care Delivery Research, Health Care Systems Engineering, Population Health Science and Surgical Outcomes. Each program plays a role in the center's quest to improve patient care while working to contain costs.

University of California, San Francisco (UCSF) Center for Healthcare Value (CHV)

Launched in early 2013, the UCSF CHV is designed to advance rational, science-driven and clinician-tested health care solutions that improve health care value. Its work includes initiatives in delivery systems, research and policy, and training. For example, through its Caring Wisely campaign, CHV is working with delivery system leaders to inspire and support front-line proposals that lower health care costs. Another initiative, the Action Research Program, partners a multidisciplinary team of implementation scientists and medical students with a clinical practice to help design and test new system strategies for care delivery.

The UPMC Center for High-Value Health Care (CHVHC)

Pittsburgh, PA

A nonprofit organization owned by UPMC, CHVHC translates the work of UPMC into evidence-based practice and policy change for improving health care quality and efficiency. Many CHVHC activities are supported through grants and contracts and conducted in partnership with community organizations and government agencies. Representative projects range from expanding the patient-centered medical home model to addressing the unmet medical needs of adults with mental illness.

Wisconsin's ThedaCare Center for Healthcare Value (TCHV)

Appleton, WI

TCHV is focused on improving value for patients by collaborating with patients and leaders in the provider, employer, payer and government communities. TCHV reports that, combined, its 61 member hospitals have eliminated millions of dollars of waste and thousands of defects in medical processes within their organizations. These lean provider health care organizations often become “centers of value” sought out by employers seeking high-quality outcomes and competitive prices.

Source: Program websites.

Considerations for your board and executive leaders

For providers

- ▶ How is your organization integrating care to provide value? What technologies and analytics are you applying to support integrated care? How are you pursuing strategies to align physicians and manage care beyond your walls?
- ▶ What procedures are in place to continuously monitor patient flow, occupancy and staffing levels for each major service line?
- ▶ How are you treating your patients like valued customers? Are you offering patients decision aids that clearly outline the risks and benefits of medical interventions – and help them make choices that are consistent with their preferences?
- ▶ How do you define the patient care team and ensure that each step in a patient's plan of care is delivered by the most appropriate team member? How are you assessing which care setting is most cost-effective and appropriate to the patient experience and outcome? What tools are being provided to your clinicians to aid in communicating complex medical information to patients and their families – and to engage patients as fully informed, active decision makers in planning and receiving care?
- ▶ What procedures are in place to ensure optimal care transitions within hospital units and between the hospital and community sites?

- ▶ Have you considered adding a chief experience officer to your executive leadership team?
- ▶ How are you collaborating with post-acute entities to make sure patients are compliant with treatment plans? What steps do you take to transfer discharge and follow-up instructions, along with treatment plans, to the appropriate post-acute community providers?
- ▶ Do you have evidence-based care protocols for all your common and highest-cost conditions and procedures? If all are not yet in place, what is your strategy for filling these gaps and keeping others current?

For payers

- ▶ What initiatives are in place to let your members know they are valued? Do you survey individual members as well as plan sponsors to determine how well the plan meets the personal needs of each insured individual and the sponsor organization's overall employee health goals?
- ▶ How are you providing physicians with information? Are you participating in development of evidence-based care protocols with health systems or physician groups in your market area, sharing your information to help them in identifying best practices for their population?

- ▶ How are you supporting members with information? Do you have a customer portal where patients can view their specific claims information and access generic health education and disease management information? Do you provide health coaching as an option, with coaches able to access a customer's specific relevant data (with the customer's consent) in order to make personalized recommendations?
- ▶ Are you advancing value in delivery by empowering members with coverage options that focus on high-performing providers?
- ▶ What incentives are you offering customers for managing chronic conditions and for maintaining health and wellness?
- ▶ Does your organization track developments in telemonitoring and eHealth initiatives and participate in demonstrations of these products to determine whether they are a cost-effective strategy for reducing readmissions or otherwise lowering the cost of care? When such initiatives are proven beneficial to the delivery of quality care and cost-effectiveness, how do you incorporate them as part of your plans' benefits and inform your customers of their availability?



“The winds and the waves are always on the side of the ablest navigators.”

Edward Gibbon, *18th-century British historian*

Value in information technology

Supporting the journey

Voyage to value

In the voyage to value, HIT – and the data it yields – serves as ballast, holding the ship steady in its journey forward. HIT supports a full range of value-based goals, from improving quality and outcomes to assisting in clinical decision-making, developing evidence, tracking costs, enhancing coordination and facilitating patient engagement. New systems and capabilities have proliferated, making it possible to collect outcomes data, analyze and convert it into useful information and share the information broadly with industry stakeholders.

To maximize the value of HIT, health care information technology (IT) staff are moving far beyond installing, supporting and repairing computer hardware and software. They are aggregating and reporting health data, delivering information needed by various clinical areas of their organizations and educating clinicians in how to make the most meaningful use of the data available to them. The ultimate goals are to buoy improvements in care delivery and to optimize patient engagement.



Health care organizations must continue to invest significant capital – human resources, time and money – in information systems design, implementation and training. These investments in EHRs and other health information technologies are essential to comply with government mandates. As their implementation becomes more widespread, and staff more skilled in their use, many health care organizations are realizing significant value from their IT investments. The data being captured today can yield salient insights into achieving better care management, more effective and efficient practices and improved outcomes. In this chapter, we provide an overview of key HIT initiatives and their role in value creation.

ICD-10 and EHR meaningful use: pushing back the deadlines

With the latest delay in the deadline for changing over to International Classification of Diseases, 10th Edition (ICD-10), health care chief information officers and IT staff now face the imperative to complete and continue readiness for this major transition. At the same time, they need to balance this effort with demands for time and resources to meet upcoming deadlines for achieving EHR Stage 2 meaningful use (MU).

The transition to value-based health care strains IT capacity even further because of the need for billing, management and point-of-care patient information access to support ACOs and other collaborative care initiatives. Provided below is an update on the status of these two major initiatives, discussed in further detail in the roundtable discussion at the end of the chapter.

ICD-10

Despite pleas for further delays from several trade associations representing various segments of the health care

provider industry, CMS stood firm on the October 1, 2014, deadline for ICD-10 implementation – only to see Congress take an opposing stance and impose a one-year delay as part of the sustainable growth rate (physician payment fix) legislation in early 2014. CMS estimates that this one-year delay could cost as much as \$6.6 billion, about 30% of what has already been invested by providers, payers and vendors.

In March 2014, the American Academy of Family Physicians released results of a survey reporting that most major national commercial health insurers were ready for the transition to ICD-10 claims processing. All surveyed payers have set up “ICD-10 preparedness pages” on their websites dedicated to assisting providers with the transition. Most reported that they were currently testing systems coordination with their larger clients – hospital chains and large physician practices – and had plans to move toward readiness testing for small and individual physician practices before October 1. The delay will help

those smaller provider organizations achieve readiness in preparing for the transition, now scheduled for no sooner than October 1, 2015. But for those organizations already well prepared to transition, the delay will require new demands, such as providing additional or refresher training and managing the requirements of two different coding systems, to make sure clinicians and IT staff comply with current ICD-9 system requirements while still preparing and training for the eventual switch.

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“The delay is going to be disruptive and costly for healthcare delivery innovation, payment reform, public health, and healthcare spending, and uncertainty on the implementation date only adds to the disruption and cost.”

Coalition for ICD-10
Letter to CMS Administrator Marilyn Tavenner
April 11, 2014
.....

While most health care providers already have the IT infrastructure and systems in place for the ICD-10 conversion, testing the interaction of these systems between providers and payers is crucial before implementation. In February, CMS announced that it would conduct “end-to-end” testing for some selected providers, followed by an announcement in March that this testing would be scheduled for the end of July. CMS requested more than 500 provider testing volunteers, but only 32 will actually be chosen to participate. With the delay in ICD-10 implementation, it is not clear now when this testing will take place. Many payer organizations had also planned to conduct significant system testing in the spring and summer of 2014, leaving time to work through any problems in time for the prior October 1, 2014, transition date. With the delay, payer system testing schedules may be revised.

For health care providers, a necessary investment for efficiently transitioning to ICD-10 is providing training for clinicians and information management staff, as well as post-implementation processes to test the effective use of ICD-10. Effectiveness

testing will identify specific re-training and optimizing needs to help organizations gain the most value from the conversion while minimizing cash flow delays. Since much of this training has already started, the delay in the transition deadline requires providers

to assess how best to use the additional year to achieve a successful transition.

There is no mandate to wait until October 2015 to put into practice the training that has occurred or is scheduled near term. Those providers most likely to succeed in

Value vignette

Beacon Community health IT pilot project: shining the light

Over three years, from 2010 to 2013, the HHS Office of the National Coordinator for Health Information Technology (ONCHIT) provided \$250 million of funding to 17 selected Beacon Communities nationwide. The communities selected had already made progress using HIT as a foundation for local improvement and innovation. Funding was to be used to further leverage the value of their HIT and health information exchanges (HIEs) in better coordinating patient care.

At the February 2014 Health Information Management Systems Society (HIMSS) conference, leaders from the Beacon Communities and ONCHIT presented results of the pilot project, along with ways these programs could be implemented in other communities. The initiatives improved cost, quality and population health, with measurable results over the three-year period, and tested innovative approaches to performance measurement, technology integration and care delivery. The pilot project:

- ▶ Involved more than 8,500 health care providers and 8 million patient lives
- ▶ Covered a variety of federal and state value-based health care payment initiatives, including:
 - ▶ State Innovation Model activities in Minnesota, Maine and Washington

- ▶ Comprehensive Primary Care initiatives in Colorado, Ohio and Oklahoma
- ▶ Pioneer ACOs in Maine, California and New York
- ▶ Medicare Shared Savings Programs in Indiana, Louisiana and Pennsylvania
- ▶ Produced six “Beacon Nation Learning Guides” covering such topics as “Capturing High Quality Electronic Health Records Data to Support Performance Improvements” and “Driving Clinical Transformation in a Practice Setting with Health Information Technology,” all of which can be downloaded at no cost from www.healthit.gov

Highlighted below are representative results achieved by various Beacon Communities:

- ▶ **Pediatric asthma improvement with the Cincinnati Children's Beacon team.** Using a combination of clinical interventions and alerts, the time between utilizations increased from 173 days to 311 days for Medicaid high-risk patients.
- ▶ **Care transition initiative for emergency services with the San Diego Beacon team.** Various initiatives – connecting ambulances to EDs, providing patient event notification to providers and

payers, and developing a Beacon Community health information exchange (HIE) that made patient information available to providers across systems at the point of care, whether ED, hospital or clinic – together resulted in a more than fourfold drop in calls. Over a two-year period, for a pre-identified group of 1,171 frequent emergency medical service users, calls per month to 911 dropped from 3,077 to 690.

- ▶ **Re-admissions reduced for patients with chronic heart failure and chronic obstructive pulmonary disease – and patient and clinician satisfaction improved – at Keystone Beacon Communities (five counties in Pennsylvania).** A web-based HIE was developed by 24 organizations with 38 unique delivery settings, including hospitals, long-term care (LTC) facilities, physician practices, home health agencies and a pharmacy. The system has been used to publish health information, share notifications and direct messages related to care transitions, and develop a patient portal. This HIE is now a nationally available web-based service.

More information about the Beacon Community Program can be found at www.beaconcommunityprogram.com/

Source: www.healthit.gov/policy-researchers-implementers/beacon-community-program

a smooth transition, with minimal cash flow delays, will be those that start practicing ICD-10 documentation and coding skills sooner rather than later. Physicians can certainly document in ICD-10 terms, and coders can dual-code sets of charts under both ICD-9 and ICD-10 requirements, to practice what was covered in training and to minimize the need for extensive retraining next year. With clinicians and coders practicing ICD-10 standards, this strategy will allow time to assess the effectiveness of training to date, as well as to identify specific weaknesses that require retraining or refreshing between now and October 2015. Practicing ICD-10 coding and documentation over the next year will help address major problems before the transition date.

Health payers and providers can also use the additional time for end-to-end testing to confirm that systems are ready to file and accept claims under the ICD-10 standards and that the exchange of data through claims clearinghouses will go smoothly. Efforts made now to test all

affected IT systems will help to minimize the disruption in cash flow that can be expected when ICD-10 conversion goes live.

EHR meaningful use

HIT teams were given a bit of breathing room with CMS' proposed rule, announced May 20, 2014, to extend Stage 2 MU through 2016, with Stage 3 pushed back to 2017. Also provided is some flexibility in meeting Stage 1 or Stage 2 requirements in 2014. As a result, the start of Stage 3 will be delayed until at least federal fiscal year 2017 for hospitals and calendar year 2017 for physicians and other eligible professionals. CMS and the Office of the National Coordinator for Health Information Technology (ONCHIT) decided to push back the Stage 2 timeframe to allow more time for Stage 3 preparation. During the extended time, ONCHIT will focus on helping health care providers meet Stage 2 requirements for patient engagement, interoperability and health information exchange. CMS and ONCHIT will also use this time to collect and analyze Stage 2 data in order to make more informed policy decisions for Stage 3.

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"The phased approach to program participation helps providers move from creating information in Stage 1, to exchanging health information in Stage 2, to focusing on improved outcomes in Stage 3. This approach has allowed us to support an aggressive yet smart transition for providers."

Robert Tagallicod, Director, Office of E-Health Standards and Services, CMS

Jacob Reider, Acting National Coordinator for Health Information Technology, ONC

Blog post, December 13, 2013

http://www.cms.gov/eHealth/ListServ_Stage3Implementation.html

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The proposed rule would provide additional flexibility by allowing eligible professionals and hospitals to use the 2011 edition of certified EHR technology (CEHRT), or a combination of the 2011 and 2014 editions of CEHRT, for the 2014 EHR reporting. Providers would be able to attest to meaningful use under the 2013 reporting

Value vignette

Connected providers: creating new lines in the "Old Line State"

Now in its fifth year, Chesapeake Regional Information System for our Patients (CRISP) functions as Maryland's state-designated HIE. Hospitals and authorized health care professionals access CRISP more than 12,000 times a month for real-time sharing of patient information. Maryland's efforts to establish an HIE began before the federal government's efforts to stimulate adoption of EHRs and HIEs. As Maryland Governor Martin O'Malley explained, "Even before the American Recovery and Reinvestment Act authorized the Medicare and Medicaid

Electronic Health Record incentive program, we took the lead and funded our Maryland HIE efforts with \$10 million of state-level programs. The federal law has continued to backstop our efforts." To date, 37 of the 46 acute care hospitals in Maryland are using EHRs and all 46 can share with other providers in real time.

CRISP has recently adopted an alerting system aimed at reducing readmissions by directing the most vulnerable patients to the most appropriate follow-up care. The system plans to increase the number

of users as well as clinicians' ability to access and use the data. CRISP has also deployed a prescription drug monitoring program to integrate prescription drug use information in real time. As the access point to Maryland's Prescription Drug Monitoring Program for health care providers, CRISP can help providers track potential drug abuse habits and connect patients with treatment that could lower potential future costs and enhance the likelihood of recovery.

Source: www.crisphealth.org

year definition and use the clinical quality measures from 2013. Also, providers scheduled to begin attesting to Stage 2 in 2014 could use the 2014 edition of CEHRT to meet the 2014 Stage 1 objectives if they attest that they ran into vendor problems.

The proposed rule also formalizes the agencies' plans to extend Stage 2 through 2016 and push back the start of Stage 3 until 2017, as previously announced last December.

The delay primarily impacts those hospitals that had achieved Stage 1 MU for two or three years by the start of the Stage 2 phase on October 1, 2013, and physicians who met Stage 1 for two or three years by January 1, 2014, the start of their Stage 2 window. Those providers required to step up to Stage 2 in 2014 will not be affected by the delay, as they already faced the start of Stage 3 in fiscal or calendar year 2017. All providers must demonstrate that they have met Stage 2 MU within their applicable year, either federal or fiscal.

In February, CMS also delayed for one month the reporting deadline for physicians to attest to meaningful use for the 2013 reporting year, with a new deadline of March 31, 2014. Hospitals had been required to submit their attestation data for fiscal year 2013 by November 30, 2013, but CMS allowed a "one-time opportunity" to submit retroactively if they were unable to meet the deadline because they "experienced difficulty attesting," as long as they contacted CMS for assistance by March 15, 2014. The 2013 reporting deadlines are significant because meeting them not only allows providers to receive Medicare incentive payments for 2013 but will also result in avoiding the 2015 penalty adjustment to payments.

More details about Stage 3 requirements, along with more details on the revised attestation timeline, are expected to be

released in fall 2014. Upcoming important dates for the EHR incentive programs are:

- ▶ **September 30, 2014:** end of 2014 fiscal year and end of the 2014 reporting period for eligible hospitals
- ▶ **November 30, 2014:** attestation deadline for Medicare-eligible hospitals for the 2014 program year
- ▶ **December 31, 2014:** end of 2014 calendar year and end of the 2014 reporting period for eligible professionals

Data analytics: connecting the community

As health care providers invest significant funds into building electronic health records, they are realizing returns on investment through more informed health decisions and better patient outcomes and satisfaction. The value of HIT investments is optimized when physicians, other clinicians and community providers partnering in medical homes and bundled care demos, or simply trying to best manage high-risk patients, can access data in real time, in a useable format. The health care industry is also looking to provide realistic insights into population health, patient management and best practices, all of which can be facilitated through optimal use of available data. The Value vignettes in this chapter provide several examples of specific initiatives that have been proven to achieve real value from HIT.

But connecting to and sharing data with other providers in the community is not a simple exercise. Despite the industry's movement to a common messaging standard – Health Level Seven International – and the standard requirement that EHRs exchange a common type of patient summary document, information sharing is far from uniform. The messaging standard is more a framework than a specific, detailed set of rules. And different IT vendors apply the standard differently. In another example,

one set of clinician groups may use certain medical terms differently than the hospital or other physician groups. Although this is really a matter of semantics, these differences can lead to errors and problems to be addressed before data can be effectively shared. Another complicating factor is that many post-acute providers still have limited information system capability and limited ability to send or receive data electronically.

In order to collect data efficiently and accurately for analyzing patterns in care delivery, the system needs to go beyond basic data interchange, which simply sends and receives "snapshots" of information as of a specific point in time. The value to be gained through analysis of data to identify practice patterns and provide decision support tools can be achieved only through an interface that builds a well-organized data warehouse and operates more like a private HIE.

A recent survey conducted by the eHealth Initiative and College of Healthcare Information Management Executives found that while 80% of health care chief information officers believe data analytics are important to achieving their organization's strategic goals, 84% felt using big data presents a challenge. Only 17% reported that they had staff trained to collect and analyze data.

Achieving the value of HIT is a time-consuming and costly process, requiring input, understanding and agreement from the hospital, physician practices and other community providers involved. Several steps should be considered in this process (see Exhibit 3-1 on page 48).

Telehealth: optimizing IT value in health care delivery

With the industry's move toward a value-based model, care coordination is a major driver – one that can be well supported by

Exhibit 3-1. Steps in achieving HIT value

1. Identify all available sources of data, whether or not part of the hospital's EHR, including items such as pharmacy records, billing systems, physician schedules and appointment logs, and patient health information from all providers involved.
2. Assess the accuracy of the available data from these sources.
3. Develop a plan to integrate clinical data from a patient's hospital records with clinical data from outpatient and clinic visits, claims data, physician encounters and services of other community providers.
4. Determine if the project will be done in-house or whether outside vendors will be used.
5. If an in-house data analytics deployment team will be used, involve representatives from hospitals, physician practices representing all major specialties, and other community providers to create a system-wide team. Offer sufficient career opportunities to keep team members committed to the analytics effort.
6. Get commitments from leaders of all participating organizations to make data-based decisions rather than relying on past personal experiences.
7. Identify goals and uses of data for specific end users so they will know what is expected of them, and can contribute to the design format and content to optimize the use of the data provided. Customize each analytical project for the specific department or service involved – for example, a readmission risk factor scorecard for discharge planners or a population-health tracking tool for primary care physicians to assess and track those patients with a specific chronic disease to prevent nonemergency hospital admissions.

Source: EY analysis, 2014

HIT. Ideally, each patient should receive the right care, in the right setting, at the right time from a health care provider who understands the patient's needs. HIT can facilitate data sharing to make sure each patient's history, needs, limitations and resources are considered by all providers when making care decisions. Telehealth provides many benefits in supporting this effort, including:

- ▶ Ensuring the most appropriate caregivers are involved, regardless of a patient's or physician's physical location
- ▶ Providing a new way to share specialty expertise over a broad geographic area – including getting specialists to places they couldn't physically get to in the crucial timeframe, assisting in covering

shortages in health care personnel and providing patients more convenient options for follow-up care, possibly resulting in better compliance with post-discharge instructions

- ▶ Monitoring and tracking specific symptoms of recently discharged patients at risk for readmission or those with chronic conditions
- ▶ Potentially, in a widespread facility campus, eliminating the need to move across the campus by enabling physicians to participate in an examination or emergency consult simply by using their laptops for a much quicker response time

Although telehealth is growing, with more than half of all US hospitals using some form of it, according to the American

Telemedicine Association, many regulatory and legal hurdles need to be managed. Measures to facilitate telehealth have been gaining bipartisan support in Congress. In February 2014, several former US senators launched the Alliance for Connected Care to advocate for federal and state regulatory changes to support telehealth, especially extending these programs to rural providers.

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 "Telehealth services are rapidly becoming a very important part of healthcare delivery under the new paradigm, but we unfortunately don't have a regulatory environment or policy environment that accommodates the new technology."

.....
 Former Senator Tom Daschle
 Co-founder, Alliance for Connected Care

Along with the investment in technology to support a telehealth initiative, telehealth faces other financial – and regulatory – challenges. Even though 20 states have parity laws requiring that some primary care telehealth services be reimbursed on par with face-to-face services, many payers do not yet cover remote consultations and other telehealth services. Currently, 43 states and the District of Columbia provide at least some Medicaid coverage for telehealth services. Medicare generally pays only for telehealth services provided in rural areas. As payers increasingly see the value of telehealth – in reducing ED visits and readmissions, increasing the quality of care, especially in remote areas, and providing measurable cost savings – insurance coverage for telehealth services is expected to rise.

Other regulatory challenges include licensure and credentialing requirements. The Federation of State Medical Boards is working on an interstate compact and plans to hold a vote at its 2014 annual

By the numbers

meeting on a proposed telehealth policy codifying standards and principles for state boards and legislatures to use in developing telehealth policies and regulations. The proposed compact clarifies that “the practice of medicine occurs where the patient is located at the time telehealth technologies are used.” This would result in physicians being required to be licensed in each state where their telehealth patients are located. Other less controversial items included in the compact are designed to make sure that patient privacy is protected, telehealth information is securely stored and there is no difference in the standards of care between a digital and face-to-face patient encounter.

For an in-depth look at telehealth initiatives, see EY’s *Health Care Industry Post*, “Shaping your telehealth strategy” (www.ey.com/US/en/Industries/United-States-sectors/Health-Care/EY-shaping-your-telehealth-strategy).

A view to the future: riding the momentum

As the industry moves toward value-driven health care, payer and provider organizations will find more ways to mine the intrinsic value of HIT. Many IT systems can readily collect vast amounts and types of data – procedures ordered, costs of care, volumes of services provided by diagnosis, post-discharge activity and much more. By analyzing, sharing and using this data, health care organizations can determine best practices, support care management decisions and continue to work toward achieving health care value’s “holy grail”: improved outcomes at lower costs.

We conclude this chapter with a roundtable discussion featuring leaders of EY’s HIT Advisory Services practice. Together, they offer further insights on the strategic role of HIT in creating and enabling system transformation.

- ▶ Using data analytics helped Kaiser Permanente’s Southern California hospitals achieve mortality rates 26% lower than other hospitals in the system (source: Kaiser’s chief medical information officer John Mattison presentation to VentureBeat Data Science Summit, December 2013).
- ▶ The global health care analytics market is projected to be worth \$21 billion by 2020 (source: MarketsandMarkets report, December 2013).
- ▶ In 2013, 170 data breach incidents affected about 6.4 million individuals, compared with 2012’s 200 incidents, which affected about 2.8 million individuals (source: HHS).
- ▶ Nearly 80% of family medicine and internal medicine practitioners surveyed in April 2013 use smartphones in their “day-to-day practice.” In the same survey, 61% reported using mobile tablets (source: Ipsos survey conducted for Wolters Kluwer Health, 2013).
- ▶ By 2013, 59% of hospitals had adopted at least a basic EHR system, an increase from 34% in 2012 (source: ONCHIT Data Brief, May 2014).
- ▶ In 2013, 78% of office-based physicians used an EHR system, an increase from 18% in 2001 (source: National Center for Health Statistics, January 2014).
- ▶ About 13% of all office-based physicians reported that they intended to participate in meaningful use incentives and also had EHR systems with the capabilities to support 14 of the Stage 2 Core Set objectives for meaningful use (source: National Center for Health Statistics, January 2014).
- ▶ The estimated costs for small physician practices to implement ICD-10 ranges from \$56,639 to \$226,105 (source: American Medical Association, January 2014).
- ▶ Through April 2014, more than 408,000 health care providers received more than \$23.7 billion in EHR incentive payments from Medicare or Medicaid (source: Medicare and Medicaid Incentive Programs HIT Policy Committee presentation, June 2014).
- ▶ A total of 51,000 health IT professionals will be needed to implement EHRs, support the conversion to ICD-10 and implement federal health care initiatives such as patient-centered medical homes (source: US Bureau of Labor Statistics, January 2014).
- ▶ Health information technician positions are expected to increase 22% from 2012 to 2022 (source: US Bureau of Labor Statistics, January 2014).

Value vignette

Healthway: developing strategies for innovative information exchange

A nonprofit public-private partnership, Healthway is “in the business of providing cost-effective HIE operational services.” The partnership supports the eHealth Exchange, a rapidly growing community of exchange partners who securely share health information. Currently, nearly 50 participants – including four federal agencies, six state health information networks, eight Beacon communities and more than 20 health information organizations and health systems – collaborate across the industry to develop implementation strategies enabling secure and interoperative, standards-based HIEs. The eHealth Exchange has a presence in all 50 states covering more than 800 hospitals, 6,000 medical groups and more than 1 million patient records.

While Healthway was formed in 2012, the eHealth Exchange began in February 2009 with just two participants,

the Social Security Administration and MedVirginia, exchanging transactions to expedite processing of benefits to the disabled. By the end of 2014, eHealth Exchange expects to have nearly 100 participants, connecting 1,600 hospitals, 10,000 medical groups and nearly 100 million patients.

In 2012, Healthway began a collaboration with the Care Connectivity Consortium (CCC) to enhance HIE capabilities and services. Founded by five early adopters of electronic medical records – Geisinger Healthcare System, Group Health Cooperative, Intermountain Healthcare, Kaiser Permanente and Mayo Clinic – CCC is designed to improve and advance the technology for comprehensive, secure, reliable and innovative electronic exchange of health information across the country. It has a presence in 18 states with 18 million members and more than 23,000 physicians.

The collaboration between CCC and Healthway is intended to achieve widespread connectivity, efficiently and effectively at the lowest cost, while addressing critical challenges to information exchange. Both organizations are pursuing innovations to improve HIE interoperability and efficacy. CCC has developed advanced patient-centered care technology that will be supported by Healthway's network services and shared with eHealth Exchange participants as part of the collaboration. This has made available to participants:

- ▶ Enhanced content management services
- ▶ A trait sensitivity study to optimize demographic traits for patient matching
- ▶ Patient identity management services

As CCC continues to develop information-sharing services, these services will be made available to all eHealth Exchange participants.

Source: www.healthwayinc.org; www.careconnectivity.org/wp-content/uploads/2014/02/CCC-Healthway-Overcoming-Challenges-in-HIE-HIMSS.2014-Web.pdf

Value vignette

HIMSS: quantifying the value of health IT

Unveiled in July 2013, the HIMSS Health IT Value Suite™ is a knowledge repository of value-focused, evidence-based data to guide providers, policy makers and payers in assessing the value of investments in health IT. The Suite offers examples to help stakeholders evaluate the success of their IT investments, emphasizing performance improvements by considering numerous clinical, business and financial factors. Because the value of health IT can be demonstrated in many

different ways, the Suite organizes a “common vocabulary to identify, classify and discuss the many known examples of health IT value.”

The Suite contains hundreds of provider case studies that can be researched to measure value and educate users on the findings. Based on these studies, HIMSS has identified five kinds of value that health IT creates to benefit patients, health care providers and communities (see table below).

Using the Suite, health care organizations can determine how health IT can help reduce:

- ▶ Redundancies in testing, labs and x-rays
- ▶ Hospital-acquired infections
- ▶ ED admissions
- ▶ Costs, while maintaining or improving the quality and safety of patient care

| STEPS | Subtypes | Documented examples in Health IT Value Suite |
|----------------------------------|---|--|
| Satisfaction | Patient, provider, staff | <ul style="list-style-type: none"> ▶ Improving patient satisfaction scores ▶ Improving internal communications with providers and staff |
| Treatment/clinical | Safety, quality of care, efficiency | <ul style="list-style-type: none"> ▶ Reducing medical errors ▶ Reducing readmissions ▶ Improving scheduling |
| Electronic information/data | Evidence-based medicine, data sharing and reporting | <ul style="list-style-type: none"> ▶ Increasing use of evidence-based guidelines ▶ Increasing population health reporting |
| Prevention and patient education | Prevention, patient education | <ul style="list-style-type: none"> ▶ Increasing immunizations ▶ Improving patient compliance |
| Savings | Financial/business, efficiency savings, operational savings | <ul style="list-style-type: none"> ▶ Reducing days in accounts receivable ▶ Reducing patient wait times ▶ Improving inventory control |

Source: www.himss.org; table adapted from “HIMSS Introduces Health IT Value Suite to Realize the Value of Health IT,” July 16, 2013, www.himss.org/News/NewsDetail.aspx?ItemNumber=21536

Feature

The move to meaningful use and ICD-10: finding the bearings

*A roundtable discussion
Craig Kappel, Partner
Health Care Advisory Services
Ernst & Young LLP*

*Rob Wallace, Executive Director
Health Care Advisory Services
Ernst & Young LLP*

Practice leaders Craig Kappel and Rob Wallace offer their perspectives on today's most pressing HIT challenges – and how organizations can realize the most value from their meaningful use and ICD-10 initiatives.



As we look at the role of health information technology in delivering value, how should organizations view value through the significant investments in meaningful use and ICD-10?

Rob Wallace: Meaningful use is a key effort by the federal government to deliver value by moving from a fee-for-service health care system to one that is outcomes-based. Each stage brings a different level of value. Stage 1 was all about capturing data and sharing it by implementing certified electronic health record systems. Stage 2 is focused on advanced clinical processes and patient engagement. Stage 3 is designed to measurably improve health outcomes.

Meaningful use also brings value in helping providers deliver safer care. No longer do they need to deal with handwriting that can't be deciphered or medical chart information that isn't well defined. Accepted protocols, built into software applications, make decisions easier. And hospitals and physicians – working from shared information – have incentives to improve their ability to serve patients.

Craig Kappel: The move to ICD-10 can yield significant value for health care organizations. It can be used to improve not only medical management and claims processing but other core business processes. As health care moves toward outcomes-based payment models, population health and comparative effectiveness, the more granular ICD-10 codes – along with more availability of digital clinical information that meaningful use is prompting – can be a catalyst for accelerating adoption of these evolving models.

In the midst of competing HIT priorities, how high is the sense of urgency for both these initiatives?

Rob Wallace: A proposed rule from CMS – announced May 20, 2014 – would extend Stage 2 through 2016 and begin Stage 3 in 2017, as well as allow flexibility for meeting 2014 Stage 1 and 2 requirements. This could provide some much-needed relief based on the readiness of many EHR vendors and providers. However, some key dates are imminent and priorities should reflect these timeframes. Unless successful with a hardship exception, eligible hospitals (EHs) must attest by July 1, 2014, and eligible professionals (EPs) by October 1, 2014, to avoid penalties in 2015.

Craig Kappel: Now that we've been delayed twice with ICD-10, the concern is that the industry will not take the October 1, 2015, compliance date seriously – and will approach readiness half-heartedly. If the 2015 deadline becomes a reality, although we can't know for certain that it will, this lack of full focus could be detrimental to providers and payers alike. It's interesting that the current wording of the new compliance date includes the phrase, "at the earliest." That could lead to lukewarm efforts to meet the October 1, 2015, date.

Part of the cause of the most recent delay is that small physician practices and sole proprietors were not ready for ICD-10. Now that the delay has been announced, we're seeing varied responses from small organizations. Some are now dismissing ICD-10 as a priority – a focus they may return to next year. Or they may lobby again to delay it.

Medicare meaningful use timeline

| First payment year | Stage and reporting period | | | | | | | | | | |
|--------------------|----------------------------|---------------|---------------|----------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | 2011 | 2012 | 2013 | 2014 | 2015* | 2016 | 2017** | 2018 | 2019 | 2020 | 2021 |
| 2011 | 1 90 days | 1 365 days | 1 365 days | 1 or 2 calendar qtr. | 2 365 days | 2 365 days | 3 90 days | 3 365 days | TBD | TBD | TBD |
| 2012 | | 1 90 days | 1 365 days | 1 or 2 calendar qtr. | 2 365 days | 2 365 days | 3 90 days | 3 365 days | TBD | TBD | TBD |
| 2013 | | | 1 90 days | 1 calendar qtr. | 2 365 days | 2 365 days | 3 90 days | 3 365 days | TBD | TBD | TBD |
| 2014 | | | | 1 90 days | 1 365 days | 2 90 days | 2 365 days | 3 90 days | 3 365 days | TBD | TBD |
| 2015 | | | | | 1 90 days | 1 365 days | 2 90 days | 2 365 days | 3 90 days | 3 365 days | TBD |
| 2016 | | | | | | 1 90 days | 1 365 days | 2 90 days | 2 365 days | 3 90 days | 3 365 days |
| 2017 | | | | | | | 1 90 days | 1 365 days | 2 90 days | 2 365 days | 3 90 days |

Notes: In 2014, regardless of stage, if performing subsequent attestation, the reporting period is a calendar quarter. If first attestation, the reporting period is a continuous 90 days. For EPs, attestation must be completed by October 1, 2014, to avoid penalties beginning January 1, 2015. EHs must attest by July 1, 2014, to avoid penalties beginning October 1, 2014.

* According to the proposed rule, the Stage 2 reporting period will be 365 days in 2015.

** Data collection for attestation periods and MU requirements are yet to be defined. Dates shown for 2017 and beyond are subject to change when Stage 2 and Stage 3 MU final rules are issued.

Although not seeming to be, another major challenge is that in the IT space, a plethora of systems are already ICD-10 compliant. If changes are required, the window between now and the October 2015 deadline isn't wide enough to make any other major revisions to IT systems. No IT function wants to be in the midst of a major implementation when the ICD-10 compliance date kicks in.

How are the best-performing organizations maintaining their ICD-10 readiness?

Craig Kappel: Instead of parking the project on the side, leading organizations are continuing a measured march toward ICD-10 readiness. They are looking at it less as a compliance exercise and more as a way to improve their operations – by getting physicians and coders trained, implementing computer-assisted coding

and creating stronger systems for documentation. Improving the quality of medical information will also likely improve their payments.

Payers have a different challenge. They can't "flip the switch" and start asking for bills to be rendered in ICD-10 format until the compliance date is locked and loaded. In general, they need to continue testing with as many providers as they can.

What metrics are providers and payers using to gauge how well their HIT investments are delivering value?

Craig Kappel: In the ICD-10 world, measures are different than day-to-day operational metrics of financial performance and productivity. ICD-10 measurements gauge whether physicians and coders are being trained on time, whether IT systems are being remediated and tested on time and whether the revenue cycle is being adjusted as needed. These macro-operational milestones need to be monitored along the way.

.....
“Smaller organizations that can’t adopt MU criteria may be open to aligning with larger organizations that are successfully meeting MU requirements.”
.....

Rob Wallace: Meaningful use has clear thresholds for measurement. Providers who started Stage 1 in 2011 or 2012 – and who are transitioning to Stage 2 in 2014 – need to assess the costs and benefits of the program and potential incentives and penalties. Meeting MU requirements becomes more difficult with Stage 1, 2014 measures and Stage 2. The new measures include patient engagement requirements. We’re just beginning to understand how to

give patients incentives for taking a greater role in their care. The first step is educating them on how they can access their information. Many organizations are using portals for this purpose and measuring patient use.

As more and more providers actively seek opportunities for consolidation, what part will meaningful use play?

Rob Wallace: Smaller organizations that can’t adopt MU criteria may be open to aligning with larger organizations that are successfully meeting MU requirements. If the newly consolidated entity doesn’t meet MU thresholds, buyers could be putting their progress at risk. For example, if the acquiring hospital is demonstrating MU and the target hospital isn’t, the buyer may be at risk of losing incentive payments or may face payment adjustments. Executive teams should involve their IT leadership early in the M&A process to mitigate any financial risks of MU misalignment and prepare properly for IT integration.

CMS’ meaningful use audits are expected to affect between 5% and 10% of providers. How can providers best prepare?

Rob Wallace: Two areas of documentation typically scrutinized are an electronic snapshot of EHR capabilities and use and a security risk analysis of the EHR

system during the reporting period. CMS is using an external firm for many of these MU audits. Although we’ve found that the information the external resource is looking for isn’t always as restrictive as CMS guidelines, as organizations prepare for an audit, our advice is to always follow the frequently asked questions guidance and other guidelines from CMS. No provider wants to be surprised in a subsequent audit that may be more rigorous.

Given the revised timeframes for both meaningful use and ICD-10, how should executives and board members proceed?

Rob Wallace: Know exactly where your organization is in MU implementation and have confidence in your monitoring and reporting mechanisms. What gaps need to be filled and what plans are in place to mitigate risks? It’s a tremendous risk to attest that you’ve met MU measures and then find out through an external audit or through your own discovery that you haven’t. Perform your own internal audit before attesting.

Craig Kappel: Organizations need to move forward with as many of the activities as they can to stay on course for ICD-10. But they need to approach ICD-10 as an opportunity to improve their operations and strengthen their ability to demonstrate quality in their organization. If we fast-

forward a year from now and the deadline is postponed again, then if I were a board member, I would be highly distraught if my organization had spent countless hours and millions of dollars on a compliance exercise that has brought no benefit. But I would be delighted if our investment resulted in improved operations and strengthened our ability to measure quality.

.....
"Organizations need to approach ICD-10 as an opportunity to improve their operations and strengthen their ability to demonstrate quality."
.....

How can the board and executives best support IT strategies and initiatives at their organizations?

Craig Kappel: For any health care organization, IT is an important enabler. If I were a board member I would be less interested in someone reporting to me that an application has been successfully implemented or will be successfully implemented. I'd be more interested in knowing that the entire organization – the business as well as IT – has jointly enabled this new technology for the overall benefit of the organization.

Each organization is different. In some, IT is a world unto itself and doesn't always involve the business as much as it should. All too often, we see organizations implementing 50% to 60% of the capabilities of any given application, and the rest are never really used. Focusing on leveraging all capabilities these technologies offer is key.

Rob Wallace: The sheer volume of information health care organizations have to work with can be daunting. They need to sift through all of it, decide what matters most and set priorities. And they can't forget about the fundamentals of HIPAA security and to consider the overall risk of any data breaches – balancing the imperative to keep sensitive information secure while giving clinicians access to track and share the data needed for more effective care delivery.



Considerations for your board and executive leaders

For providers

- ▶ Has your organization assessed the many significant issues facing your IT staff over the next two years, setting priorities for competing demands?
- ▶ Have you assessed ICD-10 implementation plans and adjusted them to address the delay in conversion? Have you arranged to test systems with payers and claims processors?
- ▶ Are opportunities in place for patient charts to be coded under ICD-9 and ICD-10 conventions so that staff maintain skills learned in training, and areas of weakness can be identified and addressed before the conversion date?
- ▶ Have clinicians been encouraged to document to ICD-10 standards, with staff or consultants available to assess their efforts and provide one-on-one consultation, making sure that patient documentation will be adequate to support ICD-10 coding before the conversion date?
- ▶ Do you have processes in place to confirm you meet Stage 2 MU reporting requirements? Have you assessed the value of any remaining incentive payments you may receive as well as potential payment penalties if Stage 2 MU is not achieved – and determined that this value exceeds the cost of compliance with Stage 2 MU? For example, the requirement for active use of a patient portal may be exceedingly expensive, if not impossible to achieve, for some medical practices dealing primarily with elderly patients.
- ▶ Are IT representatives participating on implementation teams for all new payment models, such as ACOs and medical homes?

- ▶ Have you implemented data analytics? Do you have staff trained in collecting and analyzing data or do you plan to rely on consultants to set up data collection, analysis and monitoring processes? Are end users involved in developing data reporting and data analytic projects?
- ▶ Do you need to hire a new breed of IT staff skilled in decision support, clinical areas and strategic planning to move forward with unearthing the value in the data your HIT systems capture?
- ▶ Are your patient privacy and data security guidelines and standards reviewed and updated regularly to confirm that new data-sharing arrangements, remote access and telehealth initiatives are addressed, and that staff involved in these arrangements are well trained in patient privacy and data security requirements?
- ▶ Does the team assessing the feasibility and viability of telehealth services for your organization include representatives of all stakeholders involved? Have they identified safe, high-quality services when deciding which telehealth services to support? Are they tasked with determining the coverage available for telehealth services by the most likely payer organizations?

For payers

- ▶ Have you assessed your ICD-10 implementation plans and adjusted them to address the delay in conversion? Have you arranged to test your claims acceptance and processing systems with participating providers in adequate time to address and correct any issues before the conversion date?

- ▶ Are you effectively using the claims, outcomes and cost data processed to identify opportunities for starting new payment initiatives with specific providers, or for use in contract negotiations and coverage decisions? Do you have staff trained in collecting and analyzing data or do you plan to rely on consultants to set up data collection, analysis and monitoring processes?
- ▶ Are participating providers consulted in your data analytics efforts when considering causes behind variations in costs and outcomes and in developing opportunities for new payment initiatives?
- ▶ Do you seek out and support opportunities for providers in your market to implement telehealth initiatives where the expected result is cost savings or improved outcomes?
- ▶ Do you share with plan sponsors information about the telehealth coverage your plans provide as a marketing tool, particularly those telehealth programs that can save patients travel time and time needed to be away from work for consultations with specialists?
- ▶ Do you confirm that all medical services your plans cover are appropriately reimbursed – whether provided face to face or remotely?
- ▶ Are your health information privacy and data security guidelines reviewed and updated regularly to confirm that new data-sharing and remote access arrangements with providers are properly addressed, and that staff are well trained in privacy and data security requirements?



“Never go into strange places on a falling tide
without a pilot.”

Thomas Gibson Bowles, *19th- and 20th-century British journalist*

Value in compliance

Heeding the warnings

Voyage to value

As health care organizations sail on their voyage to value, growing demands – for greater transparency, increased collaboration and seamless transitions in providing quality services across the care continuum – require heightened vigilance in complying with a myriad of rules and regulations, some familiar and some new. An effective compliance program, like a lighthouse in a storm, helps health care organizations steer clear of dangerous waters – curtailing risk, reducing penalties and proactively protecting them from running aground with the law.

The compliance programs of tomorrow, however, will need to do more than shield organizations from government investigations. They will need to move beyond the minimum standards set by laws and regulations to reflect the full value of the compliance investment – supporting efforts to lower costs, deliver better patient care and enhance employee engagement.



Understanding and meeting the expectations of industry stakeholders is paramount to demonstrating integrity and delivering value to all who are onboard the health care voyage. In the rolling seas of high risk, it could mean the difference between sinking and sailing. In this chapter, we provide a summary of recent enforcement activity in the battle against health care F&A and how organizations are responding by strengthening – and achieving value through – their compliance programs. Along with provider imperatives, issues unique to payers are highlighted, including new compliance requirements mandated by the ACA.

CMS oversight: setting direction

CMS is responsible for overseeing compliance with an enormous cache of regulations that govern the Medicare, Medicaid and Children’s Health Insurance programs. Also under its purview are regulations spawned by the ACA that govern the health insurance exchanges. In fact, CMS oversees more pages of regulations for the Medicare program alone than the Internal Revenue Code.

Over the past decade, new health care legislation expanded or added new responsibilities for CMS in compliance oversight:

- ▶ The Deficit Reduction Act of 2005 created a Medicaid Integrity Program to address fraud and abuses in Medicaid.
- ▶ The Tax Relief and Health Care Act of 2006 established a physician quality reporting program and quality

improvement initiatives, and enhanced CMS’ program integrity efforts through the Recovery Audit Contractor (RAC) program.

- ▶ The American Recovery and Reinvestment Act of 2009 provided incentives for investing in technological advances, prevention and wellness activities, and a concurrent burden on CMS to monitor compliance and reporting activities related to these incentives.
- ▶ The ACA holds CMS responsible for implementing its consumer protections and private health insurance provisions.

Most of these initiatives are directly attributable to determining whether the federal government – and the American population – receives appropriate value for its large investment in health care.

.....

“[Compliance is] the process of ... helping health care professionals understand and meet the expectations of those who grant us money, pay for our services, regulate our industry ...”

The Health Care Compliance Association

.....

2013 enforcement overview

Continuing a trend of the past several years, well over half of all government recoveries in 2013 resulted from health care fraud cases. Most of these settlements were from lawsuits brought under the *qui tam* provisions of the False Claims Act (FCA). The number of *qui tam* lawsuits has grown significantly, with more than 750 new cases filed in 2013 – about double the annual number five years ago.

FCA lawsuits are civil cases, but federal and state governments also pursue criminal cases under health care F&A laws. The Department of Justice (DOJ) generally pursues such cases, often involving the cross-agency Medicare Fraud Strike Force. The HHS Office of Inspector General (OIG) conducts criminal, civil and administrative investigations of fraud and misconduct against individuals and health care organizations, assessing penalties ranging from exclusion from participating in Medicare and Medicaid to civil monetary penalty settlements and administrative recoveries of overpayments. The OIG also oversees settlements of provider self-disclosure matters.

Exhibit 4.1 on page 61 provides a brief summary of the types of enforcement activities in 2013 by organization type.

Exhibit 4.1. 2013 enforcement activity summary

| | |
|---------------------------------|--|
| Hospitals | Most settlements in 2013 were related to FCA claims of improper billing for short stays and misclassification as inpatient/outpatient/observation. Cases involving the Stark Law and Anti-Kickback Statute (AKS) increased in 2013. Most stemmed from allegations of improper payments to physicians for consulting, rent or bonuses. |
| Long-term care (LTC) | With a growing number of <i>qui tam</i> lawsuits, LTC cases ranged from allegations of providing medically unnecessary services to hospice patients who did not meet the required prognosis of six months or less to live, to cases of inadequate nursing care or unnecessary therapy services. The Medicare Fraud Strike Force brought several actions involving home health providers for fraudulent claims. |
| Physician practices | In this segment, enforcement actions primarily related to upcoding for higher levels of physician services than were actually provided, as well as AKS violations in physician relationships with labs and other ancillary service providers, particularly those in which physicians held an investment interest. The Medicare Fraud Strike Force takedowns resulted in charges being filed against many individual physicians as well as group practices. |
| Pharmaceuticals | Unlike the previous year, no blockbuster multibillion-dollar settlements were made in 2013. Cases were primarily related to off-label marketing allegations and AKS violations for inducements to physicians to prescribe certain drugs through consulting arrangements, free continuing education courses and other forms of payment. |
| Medical device companies | Cases ranged from encouraging physicians and other providers to submit claims with incorrect diagnosis and procedure codes, lack of medical necessity for devices, and AKS allegations of rebates or free medical equipment in exchange for prescribing certain medical devices. Increased scrutiny by CMS resulted in many denials of medical device providers' initial applications to participate in Medicare and Medicaid. |
| Health plans | Only one notable settlement was reached with a health plan in 2013. It was related to allegations that the plan artificially inflated its patient risk adjustment scores to receive higher payments. |

Source: Compiled from DOJ statements, www.justice.gov

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 "We will also produce savings for taxpayers by continuing to crack down on waste, fraud and abuse. Every dollar we invest in the Health Care Fraud and Abuse Control initiative, for example, returns \$8.10 in money we recover, which last year was a record-breaking \$4.3 billion."

Kathleen Sebelius
 HHS Secretary
 Oral Testimony before the Committee on Ways & Means, United States House of Representatives
 March 12, 2014

Reviewing the types of cases settled in 2013, as well as the enforcement activities of the DOJ, OIG and CMS over time, can guide health care organizations as they steer through regulatory waters. To stay on course, then, in developing an effective compliance program, organizations should devote part of their efforts to consistently monitoring regulations.

FCA
 CMS and other federal officials have often referred to the FCA as the most effective tool in fighting against fraud because of its provisions to reward those who go public with information about allegedly abusive

practices. The FCA allows the government to recoup up to three times the actual damages, plus up to \$11,000 per violation. Federal enforcement of the FCA has been expanding from overbilling or inappropriate billing to cover such concerns as off-label drug marketing and cases involving violations of good manufacturing practices and other broad applications. We can expect federal enforcement activities to continue to encompass new and wide-ranging applications of the FCA.

The Stark Law

Growing activity in the Stark Law and AKS violations also can be expected to continue, along with increasing focus on the Stark Law's application to Medicaid claims. Historically, enforcement of Stark was centered on claims submitted to Medicare, due to specific wording in the law that prohibits federal payments for self-referrals. With Medicaid payments made by the states, there is no direct federal payment to prohibit. Amendments to Stark expanded its reach to Medicaid by prohibiting federal matching fund payments to the states for Medicaid claims that would have been prohibited by Stark if made for Medicare claims.

A proposed rule to implement this provision stated that each state would have to establish its own sanctions for such violations. A final rule implementing this provision has not been issued, and CMS has not provided any further guidance on how the Stark Law applies to Medicaid claims. However, in two significant 2013 cases, the US District Court in both the Middle and Southern Districts of Florida upheld the government's argument that under the FCA, certain referral practices prohibited under Stark can be applied to both Medicare and Medicaid claims. The government is expected to rely on these rulings, greatly expanding the sizes of potential settlements in Stark Law cases by imposing penalties on Medicare and Medicaid claims.

Physician activities

With CMS' focus on physicians as the "gatekeepers" of the health care system, and based on increasing numbers of enforcement activities directed at individual physicians and physician group practices, we can anticipate increasing scrutiny of physician activities,

relationships and actions. In particular, continuing investigations into payments by pharmaceutical and medical device companies to physicians as paid speakers, consultants and advisory board members can be expected. CMS has stepped up activities to increase physicians' awareness of their responsibilities in combatting health care fraud and abuse as part of their role in providing quality medical care. For an update, see the Value vignette on page 63.

Along with CMS, other federal agencies are engaging physicians in identifying instances of health care fraud or noncompliance with applicable statutes. Part of the compliance education effort involves providing examples of compliance problems and advising physicians how they can report such concerns. For example, the US Food and Drug Administration is seeking help from physicians in its Bad Ad program, asking doctors to report misleading advertisements for drugs, biologicals or medical equipment as well as advertisements for off-label use of drugs. Off-label marketing cases will continue to be an area of high interest in enforcement activities.

Health insurance exchanges

As the federal and state insurance exchanges begin their second national open enrollment period, CMS is expected to increase its oversight and enforcement activities related to adequacy of networks, minimum loss ratios and other provisions intended to hold payers responsible for complying with the ACA's insurance plan requirements. Also, all payments made through, or in connection with, the exchanges are subject to the FCA. This significantly expands enforcement opportunities over a much broader universe than Medicare and Medicaid claims.

Health care payers can expect greater enforcement activity than they have experienced in the past.

CMS fraud detection initiatives

CMS uses a wide variety of initiatives to help detect and prevent fraudulent programs – from low tech, such as the Senior Medicare Patrol, to high tech, such as predictive modeling in the agency's Fraud Prevention System.

For the Senior Medicare Patrol, the Administration is expanding its activities to educate Medicare beneficiaries on how to prevent, detect and report Medicare fraud, waste and abuse. Government officials have stepped up educational initiatives and raised financial incentives for beneficiaries to enlist their help in battling fraudulent claims. In 2013, more than 49,000 complaints from Medicare beneficiaries were reported and referred for further evaluation.

CMS reported that its Fraud Prevention System helped to stop, prevent or identify about \$115 million in fraudulent payments in its first year of operation. The system uses predictive modeling and data analytics to review Medicare fee-for-service claims for indicators of fraud. Highlighted claims are bumped for review and scrutiny. In addition to enforcement measures, CMS can also use its authority to suspend payments to providers and suppliers suspected of fraudulent activities, moving from the effort of collecting overpayments to preventing inappropriate payments.

Over the past several years, the OIG has increasingly focused its investigations on the responsibilities of corporate executives. Under the "Responsible Corporate Officer," or Park doctrine, a responsible corporate officer's liability "does not depend on their

Value vignette

Physician education: enlisting the gatekeepers

CMS has launched a major compliance education initiative for physicians, who are described as the health care system's "principal gatekeepers." According to the agency, formal education on program integrity will help increase awareness and compliance. As a result, physicians will be less likely to submit inappropriate claims or to become victims of fraud schemes themselves.

Although physician compliance with Medicare and Medicaid legislation and regulation has always been subject to review and oversight by the HHS OIG and other agencies, the ACA upped the stakes by requiring all physicians, as well as all health care providers who treat Medicare or Medicaid patients, to establish an effective compliance program as a condition of enrollment.

To help physician practices in creating an effective compliance program, as well as increase their overall awareness of compliance matters, the OIG issued *Compliance Program Guidance for*

Individual and Small Group Physician Practices (available at: <http://oig.hhs.gov/authorities/docs/physician.pdf>).

The OIG has also compiled a wealth of compliance education materials on its website "Compliance 101" (<http://oig.hhs.gov/compliance/101/>). This site was designed to help health care providers and suppliers understand F&A laws and the consequences of violating them, as well as offer ways to cultivate a culture of compliance. It includes a variety of webcasts, videos, documents and other training materials, available at no cost.

To further educate physicians on compliance and other Medicare concerns, CMS established the Medicare Learning Network (MLN). A one-stop site, it includes official CMS information, education and resources for Medicare fee-for-service providers. Information is also available from other federal agencies to promote physician awareness of fraudulent, or otherwise illegal, activities. The MLN provides a variety of informational and educational products,

including web-based training courses, many of which offer continuing medical education credits.

One of the many educational documents included on the MLN is "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" (available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf). This document aims to help physicians in complying with federal laws by outlining "red flags" in relationships with payers, fellow physicians and vendors. Summaries are provided of applicable laws with related enforcement measures and penalties, along with recommendations for how physicians can respond to potential red flags. The document also includes links to other sources for further information, including where to go for help and what to do if a physician identifies a problem in a current business relationship.

Sources: Websites cited.

approval or knowledge of wrongdoing, but hinges instead on whether they had the responsibility and authority to prevent or correct the violation and failed to do so." This doctrine permits the OIG to exclude individual officers or owners of companies investigated for F&A violations from participating in Medicare and Medicaid. Few individuals have been excluded under this doctrine to date, but the OIG continues to emphasize that it intends to use

exclusion to hold executives and owners accountable for their companies' conduct.

The OIG has also indicated its intent to actively enforce "corporate integrity agreements," seeking exclusion from Medicare or Medicaid for any breaches. In March 2014, the OIG issued a notice of exclusion for numerous breaches of a national health care organization's corporate integrity agreement.

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"OIG is committed to driving positive change through work that is relevant, innovative, customer-focused, and high impact. During this reporting period, we continued to advance our core mission of protecting HHS programs and the people they serve."
.....

Daniel Levinson
HHS Inspector General
Semiannual Report to Congress, Fall 2013
.....

By the numbers

- ▶ In the first two years that the ACA's screening and review requirements were in effect, CMS revoked the Medicare participation agreements of 14,633 providers and suppliers compared with only 6,307 revocations in the two previous years (source: CMS, 2013).
- ▶ In the first half of 2013, Medicare RACs collected \$1.37 billion in overpayments and returned \$65.4 million in underpayments (source: CMS, 2013).
- ▶ Each day, CMS' Fraud Prevention System monitors 4.5 million claims (Medicare Part A, B and durable medical equipment) using a variety of analytic models (source: Center for Program Integrity, CMS, 2012).
- ▶ A nationwide takedown by the Medicare Fraud Strike Force in six cities resulted in charges against 90 individuals – including 27 doctors, nurses and other medical professionals – for their alleged participation in Medicare fraud schemes involving about \$260 million in false billings (source: DOJ, May 2014).
- ▶ A New Jersey medical center paid \$435,640 to settle allegations that it violated the FCA by making improper rent payments to a cardiology practice that referred large numbers of patients to the medical center (source: US Attorney, District of New Jersey, April 2014).
- ▶ In 2013, Health Care Fraud Prevention and Action Team efforts resulted in filing charges against 274 individuals or organizations, 251 criminal actions and \$333 million in investigative receivables (source: OIG, Semiannual Report to Congress, 2013).
- ▶ In the federal fiscal year ended September 30, 2013, the federal government recovered nearly \$3.8 billion in settlements and judgments from civil cases involving fraud; \$2.9 billion of this recovery resulted from *qui tam* lawsuits. The whistleblowers in these cases recovered \$388 million (source: DOJ, December 2013).
- ▶ In 2013, only one FCA settlement was made against a health insurance plan. It concerned allegations that the plan artificially inflated its patient risk adjustment scores to receive higher payments (source: DOJ, 2013).
- ▶ The government's decision to intervene (join with the whistleblower) in a *qui tam* lawsuit greatly increases the potential value of settlements and recoveries. In cases in which the government intervened in 2013, more than \$2.87 billion was recovered, but only \$109 million was recovered in cases in which the government did not intervene (source: DOJ, December 2013).

Summary of benefits and coverage: complying with a new mandate

The ACA requires that a summary of benefits and coverage (SBC) be provided to employees eligible for employer-sponsored health insurance with written health plan enrollment materials when coverage is renewed, by the first day coverage is in force (if any changes have been made since enrollment) or upon request. Group health plans, individual health plans and self-insured plans are all required to comply with this mandate. Intended to help insured individuals make an informed choice, the SBC must summarize health coverage options in a standard format to enable comparisons across plan options.

Effective January 1, 2014, SBCs are required to indicate whether the plan meets the minimum essential coverage as required by the ACA's individual mandate. They need to indicate also whether the plan meets the minimum value requirement – that the plan pay at least 60% of allowed charges for covered services. The SBC must also include a notice of coverage options.

Because of the nature of health insurance operations, the Department of Labor (DOL), HHS and the Treasury Department were all involved in developing and implementing regulations for SBCs. These departments are also working together on implementing and overseeing this mandate. As explained in "FAQs About Affordable Care Act Implementation Part VIII," posted on the DOL website (www.dol.gov/ebsa/faqs/faq-aca8.html), the departments' approach to ACA implementation is "[to work] together with employers, issuers, states, providers and other stakeholders to help them come into compliance with the new law and [to

Value vignette

Value-based purchasing: addressing compliance issues

Medicare's Hospital Value-Based Purchasing Program, authorized by the ACA (see Chapter 1, page 13), now links hospital payments to outcomes, process of care and patient satisfaction. As a result, the accuracy of clinical and patient satisfaction data has become a significant compliance risk – compelling compliance officers to monitor the accuracy of this data. Failure to keep accurate and complete HVBP data can result in underpayments or overpayments.

In HVBP's first year, Medicare redistributed almost \$1 billion to hospitals based on their reported outcomes, process and patient satisfaction measures. While the maximum payment gain or loss

to a hospital was limited to 1% of regular Medicare payments (with that percentage growing over the first five years of HVBP), 1,557 hospitals received increases while 1,427 saw payment reductions.

With payment partially based on performance data, failure to report accurate and complete data can be considered submitting a false claim or making a false statement. For example, failure to document that a medication was administered or a procedure performed, or failure to include a patient in the documentation counts, can impact payment and be considered fraudulent. HVBP compliance reviews must determine that all patients who

should be included are, in fact, taken into account. HVBP compliance audits should also consider who can access and edit the data, and review any questionable data access. The patient satisfaction survey process should also be part of the compliance review process to determine that answers were not coerced in any way.

Adding the review of HVBP processes of care and patient satisfaction survey reporting to the compliance team's responsibilities may at first be like sailing in uncharted waters, but – with the widespread impact of the False Claims Act – it is a necessary precaution.

Source: "Medicare Discloses Hospitals' Bonuses, Penalties Based on Quality," Kaiser Health News, <http://www.kaiserhealthnews.org/stories/2012/december/21/medicare-hospitals-value-based-purchasing.aspx>; Nina Youngstrom, "Medicare Value-Based Purchasing Opens a Large New Can of Compliance Worms," Report on Medicare Compliance, Volume 20, Issue 11, March 28, 2011.

work] with families and individuals to help them understand the new law and benefit from it, as intended."

The departments have agreed not to impose penalties on health plans and issuers that are "working diligently and in good faith" to provide the required SBC content consistent with the final rule's requirements and to work with health plans and employers over time to achieve maximum uniformity in SBCs. An initial, two-year, safe harbor and enforcement relief period has ended, with employers expected to provide employees with SBCs consistent in format and length with the template provided by the DOL. However, the departments will work with the plans/insurers to help them come

into compliance and will allow some modification for conditions that do not fit within SBC requirements.

Compliance program best practices: following the leaders

With the additional onus on health care organizations to have in place an effective compliance program, due to provisions of the ACA, every organization needs to periodically assess its compliance practices and procedures. Compliance programs cannot be effective as stand-alone silos of review; they need to be woven throughout an organization's systems and operations. The emphasis of federal sentencing guidelines on having a culture of compliance lends further

support to the need for organizations to embed compliance processes throughout their operations.

By implementing and maintaining an effective compliance program, health care organizations benefit from an improved ability to detect and remediate potential compliance violations and to demonstrate their ongoing process of self-assessment and commitment to ethical and compliance practices. This will enhance the organization's perception by its stakeholders and foster a positive public image. Having a viable compliance process in place will also help to mitigate damages from any violations that may occur. Self-reporting problems can result



in considerably lesser penalties and help to avoid long-running, resource-demanding investigations and settlement negotiations.

An effective compliance program must flow from the top down, with the board and executives firmly committed to a culture of compliance and accountability. Compliance officers need to have authority to oversee a robust program but need to

work as partners within the organization, not strictly policing but educating, strategizing and encouraging compliance efforts. The compliance officer, working with each department or division, should identify areas of compliance risk unique to the operations and functions of that department or division. When risks have been identified, compliance staff needs

to work with operational staff to develop effective policies, identify necessary training and establish ongoing monitoring programs specific to the risks identified. Compliance officers also need to create a structure for employees to anonymously report any noted violations or instances of noncompliance.

Value vignette

Employee surveys: benchmarking the effectiveness of compliance programs

In its compliance guidance documents, the HHS OIG calls for benchmarking and showing evidence of compliance program effectiveness. One recommended method of benchmarking is surveying employees. Surveys can demonstrate how well employees understand their organization's compliance program and their obligations to it.

Two types of employee surveys can be used to gauge program effectiveness:

- ▶ A culture survey, measuring employees' perceptions, attitudes and beliefs about their organization's compliance environment. These questions are typically asked in the form of a statement, with the respondent selecting from choices such as completely agree, agree somewhat, neutral, disagree somewhat and completely disagree. Starting with a baseline survey taken early in program development and re-surveying periodically after it is implemented – with employees trained and working within the compliance program guidelines – can demonstrate an organization's progress in establishing a culture of compliance.

- ▶ A knowledge survey, measuring employees' understanding of the compliance program's structure, operations and the role of the compliance officer. Typically, these surveys are structured as questions or statements with yes/no/don't know answers. Such surveys can demonstrate how effective the compliance program is in reaching all employees. They can also be supplemented with selected open-ended questions to provide more in-depth assessment of employees' knowledge of specific program aspects.

For a survey to be effective, the questions should:

- ▶ Be short and simple
- ▶ Be specific and unambiguous
- ▶ Use familiar terms
- ▶ Avoid hypothetical questions
- ▶ Be written in the present tense
- ▶ Avoid cultural bias

Surveys should be a reasonable length to hold employees' interest and avoid careless responses. To avoid bias in responses, employee identity needs

to be protected – and respondents assured of their anonymity.

The OIG's Compliance Program Guidance for Hospitals notes that "the compliance officer or reviewers should consider techniques such as ... using questionnaires developed to solicit impressions of a broad cross-section of the hospital's employees and staff." The US Sentencing Guidelines state that businesses must promote an organizational culture that "encourages ethical conduct and a commitment to compliance with the law." Both guidelines stress the importance of understanding and documenting an organization's culture of compliance.

Surveys can provide insight into how effective an organization's compliance program has been in changing and improving compliance throughout the organization. They can also illuminate the program's strengths and weaknesses, as well as provide a way to let employees know that their opinions are valued and that their input is being used to make positive changes.

Source: Richard P. Kusserow, "Measuring and Benchmarking Compliance Program Effectiveness," *Journal of Health Care Compliance*, Vol. 15, No. 2, March – April 2013.

Value vignette

Compliance and long-term care: tracking the ACA mandate

The ACA requires owners, operators and administrators of LTC facilities to operate, by March 23, 2013, an effective compliance and ethics program that prevents and detects criminal, civil and administrative violations and promotes quality of care. Since CMS has not yet issued implementing regulations, compliance will not be enforced until the rule is in place. This rule will eventually be enforced through LTC surveys and the certification process. The ACA identified eight elements of an effective compliance and ethics program:

- ▶ Develop compliance standards and procedures that reduce the prospect of criminal, civil and administrative violations
- ▶ Assign executives within the organization responsibility for monitoring and overseeing compliance
- ▶ Avoid assigning or delegating responsibility to individuals likely to commit criminal, civil or administrative violations
- ▶ Communicate compliance standards to all employees and agents through publications and training programs
- ▶ Implement measures to achieve compliance, such as monitoring and auditing procedures to detect noncompliance and a reporting system where employees can report violations
- ▶ Consistently enforce compliance standards, including effective disciplinary measures in cases of noncompliance
- ▶ Take reasonable steps to respond to violations and institute mechanisms to correct and prevent recurrences of noncompliance
- ▶ Periodically assess the compliance program to determine if modifications are needed to reflect changes within the organization

Source: Amy Runge, "How the Affordable Care Act Impacts Compliance and Ethics Programs of Long-Term Care Facilities," Washington Healthcare News, 2013, www.wahcnews.com/newsletters/wa-arunge-0613.pdf

An effective compliance program will also maintain appropriate documentation of its compliance processes and procedures, results of reviews, evidence of training and education, and any manuals or guidelines developed. The compliance officer should report to the board to help members fulfill their obligation for overseeing the organization's compliance efforts. Once CMS issues regulations implementing the ACA's compliance provisions, each organization should carefully assess the policies and operating and reporting practices of its compliance plan to confirm it will meet CMS' definition of an effective compliance program.

Beyond compliance: adding value

As health care organizations voyage forward, effective compliance programs can do more than create safeguards. They can add value by establishing processes and procedures directed toward delivering better patient care, lowering costs and improving employee engagement – following the same protocols for program monitoring, tracking, oversight and reassessment. A logical starting point could involve monitoring compliance with tracking and reporting outcomes, operational care practices and patient satisfaction for value-based purchasing initiatives, moving toward encompassing

system-wide efforts to improve the quality of care. Together, these efforts can lead to a culture of compliance not only in regulatory matters but also in an organization's overall commitment to value in health care delivery.

.....
"By going after the practices that shake our trust in the marketplace and risk harm to us when we need medical care, we seek to make our health care system work better."

Stuart F. Delery
US Assistant Attorney General
Keynote address, CBI Pharmaceutical
Compliance Congress
January 29, 2014
.....

Considerations for your board and executive leaders

For all health care organizations

- ▶ Does your board foster a culture of compliance, looking beyond regulatory compliance to incorporate compliance as a way of enhancing the value of the services you provide?
- ▶ Does your board hold everyone in your organization accountable for conforming to compliance policies and procedures?
- ▶ Does the executive responsible for your compliance plan report directly to the CEO or board? Is this executive required to report periodically to the board on compliance efforts, results of compliance reviews, results of employee surveys on compliance efforts and resolution of any reported potential violations?
- ▶ Do you have procedures in place that encourage employees to safely and anonymously report potential F&A concerns or events of noncompliance, along with a clear process to follow up on any reported issues?
- ▶ Do you use employee surveys to assess the effectiveness of your compliance program and your progress in fostering a culture of compliance?
- ▶ Do you have a designated individual or team that monitors developments in enforcement activities by state and federal agencies, assessing the implications if such investigations were extended to your organization?
- ▶ Does this individual or team also monitor federal and state legislative and regulatory activity so that your organization can proactively address compliance with new laws or regulations that apply to your operations? Does this individual or team follow pending

legislation so that your organization can proactively plan for changes that may affect future operations?

For providers

- ▶ Does your organization have an effective compliance program that meets the eight requirements for a provider's compliance plan as defined in the ACA?
- ▶ Has your compliance program been customized to suit the needs and operations of your organization?
- ▶ Do you review the annual OIG Work Plan to understand the issues the OIG plans to focus on each year, assessing the implications for your organization as well as your organization's ability to comply with all applicable regulatory guidelines?
- ▶ Do you actively monitor the federal Medicare and state Medicaid exclusion lists to confirm that your organization does not contract with, hire or otherwise work with anyone excluded from participating in the Medicare or Medicaid programs?
- ▶ Do you coordinate compliance and quality assurance functions to meet requirements of HVBP programs while avoiding any inadvertent violations of F&A regulations?
- ▶ Do you conduct a self-assessment of your billing, coding and documentation efforts each year and evaluate the results to determine where modifications are needed to your compliance plan or employee education efforts?
- ▶ Do you have a clear process in place to thoroughly and promptly assess any potential improprieties and, where applicable, self-report any violations to appropriate government agencies?

For payers

- ▶ Does your compliance team review the terms of contracts each year to determine that your organization is in compliance with existing contracts, particularly in such areas as utilization management, data tracking and reporting, customer education and timely claims processing?
- ▶ Are you prepared for increased oversight and review activities by CMS for plans sold on the federal or state insurance exchanges?
- ▶ Have you analyzed the claims data your organization maintains to identify patterns of potentially fraudulent activity? Do you track your competitors' initiatives to identify best practices or to curb fraudulent activity and assess whether those practices would be effective for your organization?
- ▶ Do you educate your members to show them how they can be involved in preventing health care fraud and abuse and to arm them with the ability to identify potentially abusive practices? Do you provide a hotline or other mechanism for members to report unusual or potentially fraudulent claims or practices?
- ▶ Do you work with employers or other plan sponsors for the group health insurance plans you provide to create summaries of benefits and coverage that comply with ACA requirements and the DOL template?

“The real voyage of discovery consists not in seeking new landscapes, but in having new eyes.”

Marcel Proust, *20th-century French author*



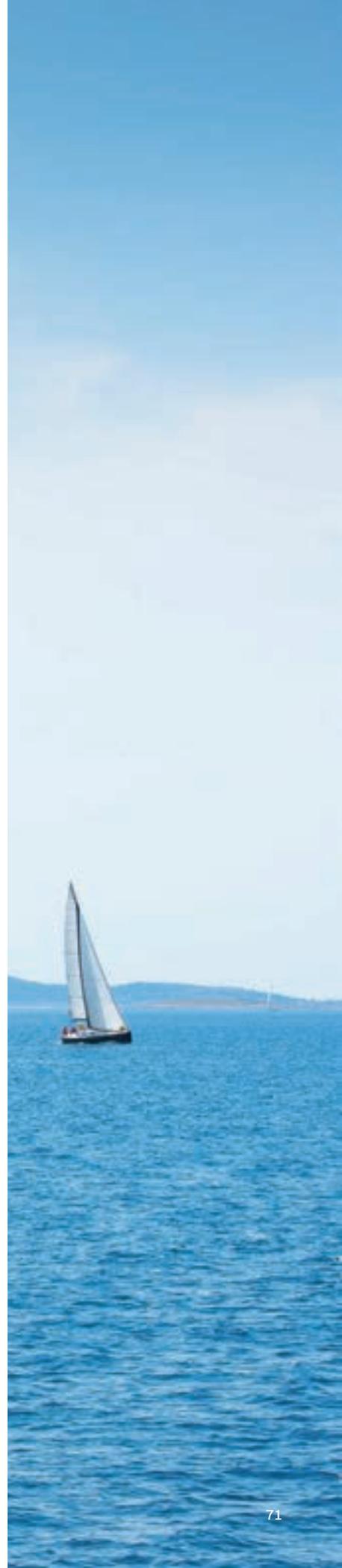
Value in transactions

Gaining the wind

Voyage to value

Mergers and acquisitions (M&As), affiliations and even divestitures offer organizations the opportunity to create significant financial, operational and strategic value. Providers and payers are finding value in transforming their business models to expand scope and diversify their market and revenue sources. Nontraditional players are entering the health care waters to gain share in new or existing markets. The success of today's transactions is no longer measured by size but by the ability to create value.

Health care organizations need to maneuver carefully, however, through the potentially turbulent winds of M&As and other affiliations, aiming for high-value transactions while avoiding risks inherent in any deal – for example, the wrong choice of partner, a flawed transaction structure, inadequate due diligence or a lack of compatible cultures. On the other hand, staying on the shore of a promising transaction brings risk also. As the tide to value rolls out, those who fail to capitalize on opportunities to transform their business models may be left behind.



Health care reform demands that providers meet performance and quality goals and payers implement methodologies to tie payments to high-quality outcomes. As a result, many are seeking partners on their voyage to value – to extend networks, provide a wider range of services and products, and share financial and operational practice data in determining the most cost-effective and high-value options for care delivery. In this chapter, we provide an overview of the year’s developments in transaction activities. Also explored is the synergistic value of provider-provider, provider-payer and payer-payer M&As and other kinds of affiliations and combinations.

M&A activity overview: rolling with the changing tides

Over the past decade, health care organizations have seen a variety of opportunities to collaborate, at times informally, but increasingly as part of a structured agreement – be it a merger, acquisition, partnership or other non-traditional affiliation. While M&As continue to be a viable option for extending market area, other affiliation strategies can help achieve an organization’s long-term goals by adding services not currently in an organization’s portfolio, or providing an opportunity to reduce operating costs.

In the past two years, trends in health care M&A transactions have ebbed and flowed. Overall, health care M&A activity in 2013 decreased from 2012, which had the greatest number of transactions since 2007. However, even with fewer deals, some sectors saw an increase in the dollar value of transactions closed.

The fourth quarter of 2013 did show an uptick in the number of deals compared with the first half of the year. Continuing into the first quarter of 2014, both the health care services and health care technology sectors overall have seen a slight drop in the number of transactions compared with the fourth quarter of 2013, but a slight increase over the first quarter of 2013. While we will continue to see some large deals announced, generally, current deals trend toward smaller and more strategic transactions, as health care organizations look for opportunities to fill gaps in service coverage or specialties, or to cover all segments of a redefined market area. While finding the right strategic fit may result in fewer deals and the possibility of higher prices, strategic deals promise greater potential for adapting current business models to meet the demands of health care reform, providing greater value for acquiring organizations.

“The health care market is moving beyond the uncertainty that surrounded implementation of the Affordable Care Act. Acquirers now are investing in improving patient outcomes, whether it’s buying a long-term care facility or a data analytics company that will help to streamline operations and contain costs.”

Lisa E. Phillips
Editor
Health Care M&A News
February 3, 2014, press release

Services sector overview

Compared with other health care sectors, the hospital sector reflects a different trend in M&A activity. Although hospital transactions had been steadily increasing since 2009, a slight drop in 2013 appears to be continuing into 2014. Transaction activity in the first quarter of 2014, with 12 deals completed, shows a significant decrease compared with the first quarter of 2013, when 21 transactions were completed. Yet despite hospital transactions’ drop in number in 2013, their value spiked more than eightfold – from \$1.9 billion in 2012 to \$18.6 billion in 2013. The big increase is due primarily to two multibillion-dollar deals: the acquisition by Community Health Systems of Health Management Associates and Tenet Healthcare Corp.’s acquisition of Vanguard Health Systems.

As hospital organizations assess the impact of the ACA and the movement toward value-based purchasing, the decrease in the number of hospital transactions suggests that other provider segments are currently

Exhibit 5-1. Deal volume by health care sector, quarterly comparison

| Sector | Q1:14 | Q4:13 | Change | Q1:13 | Change |
|--|------------|------------|-------------|------------|------------|
| | Deals | Deals | | Deals | |
| Services | | | | | |
| Behavioral health care | 3 | 2 | 50% | 7 | -57% |
| Home health and hospice | 6 | 10 | -40% | 9 | -33% |
| Hospitals | 12 | 17 | -29% | 21 | -43% |
| Labs, MRI and dialysis | 11 | 9 | 22% | 9 | 22% |
| Long-term care | 60 | 65 | -8% | 44 | 36% |
| Managed care | 5 | 4 | 25% | 2 | 150% |
| Physician medical groups | 10 | 20 | -50% | 13 | -23% |
| Rehabilitation | 2 | 6 | -67% | 2 | 0% |
| Other health providers and clinical research organizations | 27 | 15 | 80% | 24 | 13% |
| Services subtotal | 136 | 148 | -8% | 131 | 4% |
| Technology | | | | | |
| Biotechnology | 26 | 30 | -13% | 12 | 117% |
| e-health | 19 | 24 | -21% | 16 | 19% |
| Medical devices | 25 | 30 | -17% | 25 | 0% |
| Pharmaceuticals | 33 | 46 | -28% | 28 | 18% |
| Technology subtotal | 103 | 130 | -21% | 81 | 27% |
| Grand total | 239 | 278 | -14% | 212 | 13% |

Source: Levin Associates, The Health Care M&A Report, April 2014.

more valuable targets than hospital consolidations. Acquiring complementary organizations may also be quicker and easier than consolidating hospitals, as there may be fewer management and governance issues to resolve. Increases in transactions of LTC providers and ancillary services providers support this observation. However, acquisitions of

smaller rural hospitals are expected to continue as those hospitals struggle to raise the capital necessary to meet health care reform's demands for a more robust IT infrastructure.

Physician group practice deals show trends similar to those of hospitals. In the first quarter of 2014, transactions decreased

compared with the first quarter and the fourth quarter of 2013. A look at who is acquiring physician group practices shows another interesting trend. While hospital organizations continue to show strong interest in acquiring physician group practices, in 2013, only 14% of physician group acquisitions were completed by

hospital organizations compared with 51% in 2011. Publicly traded physician practice management companies represented 54% of physician group acquisitions; several managed care companies and an LTC provider also acquired physician group

practices in 2013. As the uncertainties of the ACA are sorted out and health care providers continue to assess how best to manage population health, strategic transactions can be expected to increase in the market's voyage to value.

Technology and life sciences sector overview

The health care technology segments show almost exactly the same trend: in the first quarter of 2014, the number of transactions fell compared with the

Value vignette

Health IT companies: leveraging emerging technologies for value

Health care providers and payers are moving swiftly to capture the value of the information they maintain in their HIT – developing strategies for optimizing the impact of participating in pay-for-value models and achieving operational efficiencies. They are also continually seeking opportunities to engage patients through data access, information portals and mobile health care applications. In the quest to realize HIT value, health care organizations are increasingly relying on HIT companies to provide software, data structure and data analysis and are adopting new technology offerings at unprecedented rates. As a result, HIT companies providing these services and products are increasingly targets for acquisition.

Of particular interest for acquisition are those companies that facilitate health information sharing and the interoperability of systems between providers, as well as those that develop new software and technology applications. Many of these technology companies are private, smaller businesses that focus on a niche specialty or emerging technology. The acquiring companies look to supplement their current software

offerings with additional capabilities, reach new target markets through specialized product suites, capture new technologies, broaden their distribution channels and achieve their own operational efficiencies.

A sample of HIT acquisitions over the past year illustrates the high demand by buyers looking to add a new niche to their existing service lines, or investors looking for profits and growth in a high-demand market.

Adding a niche

Roper Industries, a diversified company providing engineered products and solutions for global niche markets, acquired several HIT companies in the past two years, broadening its current offering by targeting companies operating in specific niche markets. In the largest strategic HIT transaction of 2013, Roper acquired Managed Health Care Associates, Inc., a company providing services, software and technology to pharmacies and LTC providers and sponsoring a network that connects post-acute and alternate-site health care providers with ACOs nationwide. Roper also had the largest strategic HIT acquisition in 2012 with its purchase of

Sunquest Information Systems, a market leader in laboratory IT services.

Aiming for investment value

In 2013, private equity buyers were responsible for 51% of acquisitions of HIT companies based on acquisition value, or 25% based on number of transactions. Private-equity interest in HIT continues to be strong in 2014. In the first quarter of 2014, private equity firms completed 163 health care IT deals. Technology companies that focus on the practice of health care accounted for about 53% of these transactions. Consumer-focused HIT companies represent about 46%, and telehealth, scheduling and rating companies make up the balance.

The largest private equity HIT deal of the first quarter of 2014 was the acquisition by Kohlberg Kravis Roberts of a majority interest in Sedgwick Claims Management Services for \$2.4 billion. Sedgwick provides technology-enabled claims and productivity management solutions. The largest HIT initial public offering in the first quarter of 2014, raising \$1.3 billion, was IMS Health Holdings, a health care data analytics company.

Sources: Roper Industries, Managed Health Care Associates, Sunquest Information Systems, Sedgwick Claims Management Services and Mercom Capital Group; BerkeryNoyes Investment Bankers, "An overview of M&A in the Healthcare/Pharma Information and Technology Industry," 2014; "Strong Start for Healthcare IT Sector with \$858 Million in VC Funding in Q1 Executive Summary," Modern Healthcare.

By the numbers

prior quarter but increased from the year-ago quarter (except that medical device organizations held constant over the previous year). Although the pharmaceuticals segment saw an increase in the number of transactions, there were, unlike previous years, no multibillion-dollar deals announced in 2013. Generic drug makers and specialty drug companies showed significant activity.

As population health management grows and efforts intensify to revamp health delivery and reduce health care spending, e-health and medical device companies – with their potential to readily meet these demands – are particularly attractive targets. In the first quarter of 2014, private equity companies invested about \$858 million in e-health companies. A sell-off can be anticipated as these companies grow and mature over the next several years and private equity companies move on to their next horizon.

And it appears the growth in health care technology and pharmaceutical deals this year is just getting started. The last week of April 2014 saw a major spurt with three large pharmaceutical deals and one major medical device transaction announced.

A big deal – in health care real estate investment trust transactions

Another significant acquisition, announced in early June 2014, is Ventas' plan to acquire American Realty Capital Healthcare Trust in a \$2.6 billion transaction. Ventas is currently one of the country's larger health care real estate investment trusts (REITs), as measured by market capitalization. If this acquisition, planned to close in the fourth quarter of 2014, is completed, Ventas will become the nation's largest health care REIT. Both Ventas and American Realty Capital Healthcare Trust invest in medical office buildings and senior housing.

- ▶ In the past two years, the health care industry's most active M&A segment was health care IT, with 280 transactions (source: BerkeryNoyes Investment Bankers, April 2014).
- ▶ Fitch Ratings predicts hospitals in the 25 states that did not expand Medicaid in 2014 will "face greater financial challenges and rating pressure" compared with hospitals in states with Medicaid expansions. Overall, hospitals in the 25 non-expansion states are expected to lose out on over \$200 billion in additional revenue over the next decade, which may spur interest in finding a strategic merger partner to derive operating efficiencies or as a source of capital. (source: Fitch Ratings, October 2013).
- ▶ Acquisitions of physician medical groups dropped from a high of 108 in 2011 to 65 in 2013. In 2011, 51% of the transactions saw hospitals or an integrated health system as the acquiring organization. In contrast, in 2013, only 14% of the acquisitions were by hospitals or integrated health systems. The remainder were acquired by managed care companies (payers) or publicly traded practice management corporations (source: *Health Care M&A News*, April 2014).
- ▶ In September 2013, a health system in Chicago committed \$230.5 million, plus annual payments of \$118.5 million through 2016, to acquire a 900-physician practice, in one of the largest sums ever paid for a medical practice acquisition (source: *Modern Healthcare*, February 2014).
- ▶ As many as 1,000 health care facilities are expected to undergo an M&A between 2013 and 2020 (source: Booz & Company, March 2013).
- ▶ 88% of health care provider executives plan to pursue an M&A within the next 12 months (source: GE Capital survey, January 2014).
- ▶ Hospital markets in 71% of the country's metropolitan statistical areas are already considered "highly concentrated" under Federal Trade Commission (FTC)/DOJ guidelines (source: American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2013 Edition).
- ▶ 86% of insurance executives expect to see an increase in the volume of M&As over the next one to three years (source: Towers Watson survey, March 2014).
- ▶ Just one insurer accounted for more than 50% of the market in 15 states and just two health insurance organizations accounted for more than 50% of the health insurance market in 45 of the 50 states (source: American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2013 edition).
- ▶ A recent study – covering mergers in the 10-year period from 1998 to 2008 – revealed that only 41% of acquired hospitals outperformed their market peers and most M&A deals failed to live up to expectations (source: S.B. Saxena, A. Sharma and A. Wong, "Succeeding in Hospital & Health Systems M&A: Why So Many Deals Have Failed and How to Succeed in the Future," Booz & Company, 2013).



Antitrust laws and M&As: sounding the foghorn

In January 2014, a federal judge ruled in favor of the FTC in deciding that a health system in Idaho violated antitrust laws when it acquired the state's largest independent physician practice. The judge ruled that the acquisition must be unwound – a difficult and expensive task to accomplish.

Although the judge acknowledged that the acquiring system sought to improve patient outcomes through the acquisition, he also ruled that it would result in an “unfair and illegal marketplace advantage” by dominating primary care and would increase the risk of price increases.

This decision will likely influence future acquisitions of physician groups by hospital organizations. Each potential acquisition should anticipate raising antitrust concerns if it will result in high market shares, even if limited to a localized area. According to this ruling, organizations seeking to achieve integrated care in their communities do not have to purchase a group practice to achieve this goal; they should consider alternatives such as integrated networks or co-management arrangements that stop short of an acquisition.

“Keeping health care costs low and quality high by ensuring vigorous competition between providers is, and will continue to be, a top commission priority.”

Edith Ramirez
Chair, FTC

In April 2014, the FTC continued its winning streak with a victory in a federal appeals court case. An Ohio health system's acquisition of a hospital was determined

to be “extremely likely to illegally increase prices.” The acquiring organization argued that the acquisition was the only way to keep the financially struggling

Value vignette

Transaction alternatives: merging efforts, not assets

Sometimes an alternative to a full merger of two organizations' assets may accomplish the merging entities' goals while eliminating the need for antitrust approval that an asset merger would require. A recent example of an alternative solution is the creation of Together Health Network (Together), a new company jointly founded by two large, competing health systems, Ascension Health and CHE Trinity Health.

Together was formed in response to the need for value-based payments and population health management for managed care contracting in Michigan. It is a closely aligned, clinically integrated network, uniting 27 hospitals, more than 12 physician organizations and 5,000 physicians across Michigan. In all, 75% of the state's residents will be 20 minutes or less from at least one of the network facilities.

Moving forward, Together plans to:

- ▶ Offer health insurance products to health insurers and also directly to employers by fall 2014
- ▶ Sell a variety of managed care plans on private health exchanges and also on the federally run HIX in Michigan

Source: “Ascension Health, CHE Trinity form integrated network in Michigan,” Modern Healthcare, May 7, 2014.

- ▶ Offer managed care contracts with shared-savings arrangements, pay-for-performance payments and global budgets with bundled payments tied to specific procedures and narrow provider networks
- ▶ Provide patient care through its network by January 2015

“We believe this one-of-a-kind collaboration between two of the state's largest healthcare organizations will set a new standard for providing value-based healthcare in Michigan.”

Patricia Maryland, PhD
President of Health Care Operations and
Chief Operating Officer
Ascension Health
Press release, May 9, 2014

Together will be physician-run, with plans to hire a physician CEO. The managing board will include nine physicians, four Trinity and Ascension executives and two members representing the community. In the initial start-up period, staff from both health systems will support the new company.

acquiree from closing; the FTC argued it had enough cash to pay its obligations. The court upheld an earlier FTC ruling that the acquired hospital must be divested. This case is expected to be appealed to the US Supreme Court. The decision will likely prompt hospitals to consider alternative strategies, such as reducing services or other cost-cutting moves, if a potential merger may raise antitrust concerns.

In a recent interview with *Modern Healthcare*, Markus Meier, Assistant Director for Health Care Enforcement in the FTC's Bureau of Competition, was asked about the FTC's apparent efforts to discourage M&As despite the ACA's goals to create networks that coordinate care. He responded by explaining, "We're worried about organizations that are not much more than a price-fixing cartel, or organizations that are fairly integrated but are so large that they dominate their marketplace and have the ability to exercise significant market power. Both of these types of behavior have a very high likelihood of harming consumers, raising prices and not improving quality at all." When asked if he thought it was fair that the FTC was stepping up enforcement efforts in this era of reform, he replied, "I sometimes have to remind physicians and hospitals that the antitrust laws aren't there to protect their interests as producers of health care services, they're intended to protect consumers, including patients, health plans and self-insured employers. By promoting competition, we hope that leads to lower prices, better quality, more choices and innovation."

Do payers need to sail together? Achieving economies of scale

Health care payers are likely to consider whether scale and efficiencies that can be achieved through mergers are needed to thrive under the ACA. The law requires health insurers' claims and allowable costs for quality improvement activities to account for a specified percentage of premiums charged (the minimum medical loss ratio). Payers that fail to meet the required ratio must issue rebates to their members. Also, the increased transparency and ability to compare costs of various plans facilitated by the health insurance exchanges (HIXs) is expected to increase payer competition. These factors increase the incentive to generate efficiencies in operations, cut costs and keep revenue on track. Given these pressures, payers may find mergers a viable option for achieving their goals.

Through a merger or acquisition, payers can expand their markets, achieve operational efficiencies and spread their risk over a larger pool of customers. Potential acquisition candidates can range from strategic targets such as another payer operating in a different market or providing niche insurance products to a vertical target, such as a physician practice or other health care provider. Finding the right strategic fit is critical (see Exhibit 5-2).

Divestitures: cutting the sails free

Often when looking to cut costs or improve quality, health care organizations consider divesting certain services from their portfolios. Sometimes, arrangements are

Exhibit 5-2. Payer questions in searching for the right M&A fit

To find the best strategic fit and select an effective target for acquisition, payers should consider several factors. Does the acquisition target:

- ▶ Have a product line that complements yours?
- ▶ Offer your organization access to new markets or new technology?
- ▶ Have the current medical expertise, systems or programs to better manage the health of your population?
- ▶ Provide expertise that could help to reduce your current administrative costs – for example, a claims processing firm or call center?
- ▶ Have an insured population that will help to reduce your current acuity risk?
- ▶ Have an acceptable medical loss ratio? And will you be able to reduce medical costs through combining your operations to ensure minimum medical loss ratios will be achieved?
- ▶ Provide an opportunity to increase vertical integration, delivering medical services or products necessary to meet your customers' health care needs – such as a physician practice or pharmacy company – with the potential to increase revenues or lower costs?

Source: EY analysis, 2014

made to transfer or sell service lines to competitors better situated to provide them cost effectively. Other times, specific service lines are simply shut down and no longer offered.

The state of Louisiana has taken divestiture of costly services to a new level. After several years of extensive budget cuts to the Louisiana State University (LSU) Health Care Services Division (formerly known as Louisiana's Charity Hospitals), the cost of maintaining the Division's 10 hospitals was still considered too expensive for the state budget. In a move to cut state costs, in 2013 the governor of Louisiana proposed closing or divesting most of these hospitals and their affiliated clinics. The hospitals divested would be converted from public to private entities and leased to private operators. Several hospitals would be closed and their operations transferred to existing private health care organizations. The university's board of supervisors approved the plans and the Louisiana State Civil Commission has approved eight of the privatization plans with one deal pending. The state intends to retain only one LSU hospital as a public entity.

Lease payments from the newly privatized hospitals are expected to generate about \$100 million per year for the state. Further budget "savings" are expected through layoffs of all hospital and clinic employees. About 90% of these former state employees were rehired by the private entities running the hospitals, although with significantly reduced benefit packages. All privatizations are planned to be complete by the end of 2014.

In May, CMS took the wind out of the privatization plan, rejecting the financing plans for the first six hospitals privatized. CMS determined that the "advance lease payments" the private operators paid up front as part of their no-bid contracts do not meet federal guidelines for how Medicaid funds can be spent. CMS indicated that the structure of the contracts "amounted to Louisiana trying

to get extra federal Medicaid dollars to repay private managers" for the advance lease payments. The state is planning to appeal the ruling and work on changing the financial structure of the privatization deals to gain CMS approval. Should the appeal and restructuring attempts fail, estimates of amounts the state would have to repay the federal government range from \$200 million to \$500 million.

Value vignette

Achieving high value: building a formal alliance without a merger

In 2012, the Central Georgia Health System and Tift Regional Health System created a formal partnership intended to develop a regional care, integrated services network. The goal of the partnership was to work as equal partners to "enhance the level of medical service delivery in the region and position both systems for the challenges of health care reform."

With the growing need to manage population health, these organizations decided to broaden their geographic reach. In late summer 2013, they joined with 21 other hospitals in south and central Georgia to create a not-for-profit limited liability corporation, Stratus Healthcare. Along with combining resources to reduce costs, the collaborative alliance is designed to exchange best practices, develop coordinated information systems and manage population health.

Source: Stratus Healthcare.

Today, a total of 29 hospitals, 14 health systems, about 2,000 physicians and more than 18,700 employees make up Stratus Healthcare. Through this formalized alliance, members can "take advantage of a shared service model, yet remain independent," according to the company. Stratus' work is conducted by work groups formed with representatives of each partner hospital.

Stratus work groups have already been analyzing primary care, emergency medicine, hospitalist and specialty care networks to assess the development of consistent clinical guidelines, coordinate transfer arrangements, launch telemedicine programs and share outcomes data. Future work groups will consider computer technology platforms and data warehouse capabilities to enable the seamless exchange of electronic health information, collective purchasing, shared business resources and an integrated clinical network.

Value vignette

EY's Capital Agenda: evaluating strategies

To gain the wind in their voyage to value, health care organizations should continually evaluate their capital strategies, review their capital investment methods and focus on their capital assets. EY's Capital Agenda includes four dimensions of evaluation to facilitate this process:

- ▶ **Preserve:** assess the potential impact of evolving market conditions on your operational performance and capital base
- ▶ **Optimize:** drive cash and working capital, and manage your portfolio of core and noncore assets to accelerate return

- ▶ **Raise:** consider future capital requirements and determine how funding sources can be diversified to increase options
- ▶ **Invest:** strengthen investment appraisal and execution methods to manage risk while realizing opportunities

How organizations manage their capital today will define their competitive positions tomorrow. The Capital Agenda serves as a resource for evaluating opportunities, making strategic decisions and creating efficient transactions.



Source: EY, Provider Post, Health care's Capital Agenda. For more guidance, request a copy from your local EY executive.

Toward a new horizon: achieving high-value transactions

Health care provider and payer organizations have set sail on a rigorous journey – one fraught with financial and operational challenges. Many are finding it a critical imperative to seek partners, assessing the potential of various forms of affiliation. But to fare successfully in the shifting winds, any such arrangement must yield high value.

Achieving value is much more than a larger organization swallowing a troubled entity; it is a strategic deal deliberately designed to align incentives and share successes. In assessing opportunities to collaborate, EY's Capital Agenda can serve as a guide (see Value vignette). Those that seek out best-fit partners to build a stronger organization have the greatest chance of sailing through the changes reform and the market demand – and reaching the destination of true value delivered.

Considerations for your board and executive leaders

For all organizations

- ▶ Whether you are pursuing an M&A target or are considering offering your organization as an acquisition candidate, do you have a strategic plan in place? Does it include a SWOT analysis? How are you documenting that you are following your plan?
- ▶ Before pursuing a transaction, as either the acquiring or selling company, does your organization take into account who will be responsible for transaction-related tasks, such as gathering and organizing data for due diligence, communicating with other parties, and analyzing and synthesizing acquisition-related documents? If an internal team will be used, who will be responsible for their day-to-day activities? Have you considered hiring an interim executive or team to assist in this process?
- ▶ When considering a potential M&A candidate, do you carefully assess whether aligning with the candidate will advance your long-term strategies and help your organization better serve your stakeholders?
- ▶ Early in the process, do you determine whether the candidate meets criteria for cultural alignment with your organization?
- ▶ Have you considered whether an alternative to a merger or acquisition would better meet your needs and goals?

- ▶ Do you start drafting a post-merger transition/action plan early in the process, during due diligence, as well as identifying transition team members and responsibilities?
- ▶ Does your transition plan include responsibility for monitoring quality and performance throughout the process to make sure day-to-day operations stay on schedule, are consistent and do not suffer as a result of efforts to integrate the newly acquired organization?
- ▶ Do you have a process in place to provide any required notifications to federal and state agencies and to assess the probability of FTC challenges to your planned merger or acquisition?

For providers

- ▶ When considering an M&A candidate, do you understand what value this organization will bring to your organization? Will the candidate provide lasting value to help your organization in managing risks related to pay-for-performance contracts or fill a strategic gap that meets a clearly defined need?
- ▶ Do your due diligence process and integration plans include detailed review and inventory of all HIT systems, both clinical/operational and financial, to identify redundant systems and software and to determine the adequacy of systems planned to be used by the newly merged entity? Are decisions

about which systems will be retained and plans for necessary conversions made early in the process to best achieve a smooth transition?

For payers

- ▶ When evaluating an M&A candidate, does your team carefully assess their participation in state and federal HIXs, the plans offered, the demographics of enrollees and the networks with which they have contracted? Will the networks be broad enough to stand up to CMS' scrutiny intended to make sure networks are not so narrow as to discourage or prohibit enrollees from obtaining needed care?
- ▶ Do you consider acquisitions of companies that can enhance your organization's capabilities in e-health, risk management, data analytics and population health management of healthy individuals as well as specific categories of chronic care populations?
- ▶ Do you assess the impact an M&A candidate will have on your member engagement and satisfaction?

“Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.”

Albert Einstein, 20th-century German physicist



Value in measurement

Sounding the depth

Voyage to value

The concept that cost and quality determine value in health care has remained a constant. Yet historically, value has been difficult to measure. Unlike in many other industries, the end user of health care's product, the patient, has often been displaced from purchasing decisions while the value equation has typically focused on cost or quality, but rarely the two together.

With today's industry sea change – including the ACA's expansion and refinement of measurement and reporting requirements – new methods are emerging to measure value in its many dimensions. These measures are core to “sounding the depth” of cost and quality challenges and enabling system transformation: care reorganized, processes continuously improved and new routes taken to enhance value for all industry stakeholders.



Measuring value in health care has been an earnest yet often elusive pursuit. Typically, measures have centered on the provider rather than the patient. They have often fallen short of gauging the things that matter most to health care consumers, such as clear and respectful communication, early and timely treatment and stronger, quicker recoveries. In this chapter, we highlight organizations that are making waves in value measurement, along with methods being tried across the waterfront to calculate health care value.

Measurement leaders: meeting the challenge

A variety of organizations have taken on the mission of developing metrics for value. Profiled below are the contributions of several leaders in value measurement.

American Hospital Association (AHA)

AHA has offered 19 metrics to help health care providers measure their progress toward value-based care (see Exhibit 6-1 on page 85). These measures are focused on meeting four value-based strategies as the industry transitions from pay for volume to pay for value.

AHA has also published a “road map” to help health care leaders assess and score their progress in achieving these strategies (available at www.hpoe.org/resources/hpohretaha-guides/1360).

High Value Healthcare Collaborative (HVHC)

A consortium of 19 top US medical centers and the Dartmouth Institute for Health Policy and Clinical Practice, HVHC provides a forum for sharing data to reduce variance and improve value. The collaborative collects and exchanges

data on quality, outcomes and cost for expensive, high-variation conditions and treatments; identifies and evaluates best-practice health care models and innovative, value-based payment models; and shares with the public the knowledge and lessons learned. The group is currently focused on nine high-volume, high-cost and high-variation conditions: total knee replacement, diabetes, congestive heart failure, depression, spine surgery, labor and delivery, asthma, hip surgery and bariatric surgery.

HVHC’s first research, studying nearly 11,000 total knee replacements performed across five health systems, found considerable differences in procedures and outcomes. According to the group, findings are intended to spur value improvements, including more coordinated management of complex patient cases, more consistent operative teams for surgeons and a process for better managing patient expectations.

Integrated Healthcare Association (IHA)

For 13 years, IHA has served as the convening organization for California’s statewide pay-for-performance program.

Eight commercial health plans and about 200 physician organizations (POs) participate in the program, which covers an estimated 9 million Californians enrolled in commercial health maintenance organization (HMO) and point-of-service (POS) products. According to IHA, seven of the plans – Aetna, Anthem Blue Cross, Blue Shield of California, Cigna Healthcare of California, Health Net, UnitedHealthcare, and Western Health Advantage – have paid out more than \$450 million in incentives through 2012 based on the results, which have shown over time a steady improvement in quality metrics.

Recently, IHA has started to transition to value-based P4P. This shared-savings model holds POs accountable not only for the quality of care provided to their HMO and POS members, but also for the cost, cost trend and resources used for care provided. In 2013, one participating health plan – Blue Shield of California – fully implemented the new program design; several others are planning to adopt it in 2014. IHA notes that standardized measures of quality and cost will help in assessing health care value, supporting the development of value-based network tiers, informing consumer selection and serving as a key resource for HIXs.

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 “I have been struck ... by how important measurement is to improving the human condition. You can achieve amazing progress if you set a clear goal and find a measure that will drive progress toward that goal ...”

Bill Gates
 Co-Chair, Bill & Melinda Gates Foundation
 2013 Annual Letter

Exhibit 6-1. Measures of progress toward value-based care

Strategy 1. Align hospitals, physicians and other clinical providers across the continuum of care

1. Percentage of aligned and engaged physicians
2. Percentage of physician and other clinical provider contracts containing performance and efficiency incentives aligned with ACO-type incentives
3. Availability of non-acute services
4. Distribution of shared savings and performance bonuses or gains to aligned physicians and clinicians
5. Number of covered lives accountable for population health (e.g., ACOs or patient-centered medical homes)
6. Percentage of clinicians in leadership

Strategy 2. Use evidence-based practices to improve quality and patient safety

7. Effective measurement and management of care transitions
8. Management of utilization variation
9. Reduction of preventable admissions, readmissions, ED visits, complications and mortality
10. Active patient engagement in design and improvement

Strategy 3. Improve efficiency through productivity and financial management

11. Expense per episode of care
12. Shared savings, financial gains or risk-bearing arrangements from performance-based contracts

13. Targeted cost-reduction and risk-management goals

14. Management to Medicare payment levels

Strategy 4. Develop integrated information systems

15. Integrated data warehouse
16. Lag time between analysis and availability of results
17. Understanding of population disease patterns
18. Use of electronic health information across the continuum of care and community
19. Real-time information exchange

Source: AHA, Health Research & Educational Trust, and Hospitals in Pursuit of Excellence, Metrics for the Second Curve of Health Care, April 2013.

Value vignette

Why is health care value so hard to gauge? Assessing the need for new measures

From HHS to local business coalitions, many organizations are rigorously attempting to measure value. But efforts often flounder in addressing value from a patient outcome perspective. According to ThedaCare's Center for Healthcare Value, measures fall short when they are:

1. **Department- or process-centric.** Metrics arising from internal patient surveys or provider reviews often look at a single department or function, for example, the ED and patients' satisfaction with their experience there. Although these are worthy measures for teams working to improve a specific area of care, they do not reflect the full value continuum of the patient experience.
2. **Too broad.** Health care rankings such as Thomson-Reuters' 100 Top Hospitals or U.S. News Best Hospitals typically look at care throughout the organization or in large specialty areas. National rankings are too broad for patients in evaluating value for the specific treatments they need, where they need them.
3. **Subjective.** Health care grading websites such as HealthGrades have proliferated, reflecting the growing consumer quest for local health care information. Yet these services typically deliver subjective information provided by patients and their family members as opposed to objective data for decision-making.
4. **Focused on half the value equation.** Many public and private organizations have focused on improving health care quality, exploring ways to quantify and improve outcomes. These efforts, however, often exist in isolation of costs. Conversely, many initiatives document and report costs but do not measure the effectiveness of care. Claims data, for example, can yield a clear picture of costs, but has not been intricately linked to the quality of patient care for specific spending.

Source: ThedaCare's Center for Healthcare Value, Measuring Healthcare Value: Linking cost and quality of patient outcomes to drive organization and industry improvements, February 2012, www.createhealthcarevalue.com

International Consortium for Health Outcomes Measurement

ICHOM's mission is to define a global standard set of outcome measures that matter to patients for the most relevant medical conditions, and to drive adoption of these measures worldwide to unlock the full potential of value-based health care. ICHOM defines outcomes as "the results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives." The ICHOM website (www.ichom.org) offers a searchable metrics repository designed to increase the comprehensiveness of measures in use and to standardize existing measures across registries.

For more information on ICHOM's activities, see the conversation with Dr. Jens Deerberg-Wittram, pages 4-7.

National Quality Forum (NQF)

A standard-setting organization, NQF endorses measures that are considered the gold standard for health care measurement in the US. Expert committees made up of varied stakeholders, including patients, evaluate measures for NQF endorsement that are used by the federal government and private sector.

NQF has endorsed several resource-use measures designed to gauge health care value. These measures are defined as "comparable measures of actual dollars or standardized units of resource in the care of a specific population or event." Current resource-use measures span a variety of conditions, including asthma, cardiovascular conditions, chronic obstructive pulmonary disease, diabetes, hip and knee replacements and pneumonia. Measures also include a population-based per-member-per-month index and a total cost population-based per-member-per-month index.

Network for Regional Healthcare Improvement (NRHI)

A national membership association, NRHI works to support the efforts of the 30 regional health improvement collaboratives in the US (see page 26 of the conversation with Harold Miller). NRHI reports that the collaboratives help communities covering nearly 40% of the US population to improve their quality of health care services while controlling costs.

Intended to serve as neutral, trusted sources of actionable information about health care value and population health, the collaboratives publish reports for the public and health care providers on aspects of quality and cost of care. Measurements and reporting initiatives are developed and operated with the participation and supervision of the physicians and hospitals whose performance is being measured. According to NRHI, the involvement of participating providers increases their willingness to change care processes with the goal of performance improvement.

Pacific Business Group on Health

Founded in 1989, the nonprofit PBGH is one of the nation's leading nonprofit business coalitions focused on health care (see Value vignette, page 15). PBGH represents 60 large companies, such as Boeing, Target and Wells Fargo, as well as public agencies such as CalPERS. Together, these organizations provide health care coverage to 10 million Americans and their dependents in all 50 states.

PBGH has led efforts to have private employers and government reach consensus on quality care and value measures. For example, the group has advocated for measures beyond those that gauge clinical processes and structure to those that measure outcomes. It has called

for Congress to direct CMS to identify and adopt "useful, standardized measures that address consumer and purchaser concerns."

Methods for measurement: capturing the value equation

A variety of methods have been developed and implemented to measure the value delivered by providers and payers alike. Profiled below are several approaches.

Diabetes value metric

Work from the Wisconsin Collaborative for Healthcare Quality (WCHQ) breaks new waves in blending quality and cost into a single, actionable health care value measure specific to a health care condition. In late 2010, WCHQ formed a Resource Use Work Group to develop a value metric linking quality data and cost data for a specific condition – diabetes – and episode of care. The diabetes value metric used quality data provided from WCHQ provider organizations, along with diabetes standards cost data provided by the Wisconsin Health Information Organization (WHIO) consisting of claims-based data submitted by WHIO payer organizations.

According to WCHQ, the diabetes value metric demonstrates that a condition-specific value measure is possible, showing the way for developing and disseminating health care value measures more broadly. The metric will eventually be provided to the public for use in assessing the value that organizations provide to their diabetic patients.

Global cardiovascular risk (GCVR)

Under a grant from the Robert Wood Johnson Foundation, the National Committee for Quality Assurance (NCQA) is evaluating a new measurement tool that focuses on enhancing patient value by improving the health outcomes of patients

By the numbers

with heart disease and diabetes. The GCVR measure has been co-developed by the NCQA and health care modeling software company Archimedes, Inc. GCVR has been called a “next generation” quality improvement tool, measuring how well providers reduce the risk of future adverse outcomes – such as heart attacks, strokes and diabetic complications – in the populations they serve. The measure will draw on clinical information from electronic health records to provide the data needed to assess improvement in preventing adverse outcomes.

“[GCVR] has the potential to become the first customized, outcomes-based electronic health record measure used by Medicare and commercial payers. Its widespread adoption could have a profound impact on health care costs because it assesses how well providers engage in prevention and goal-setting for their high-risk patients.”

Margaret E. O’Kane
President
NCQA

Patient-reported outcomes measures (PROMs)

PROMs capture patient perceptions of the outcomes of their care. These measures reflect whether patients believe the services they received actually delivered value by improving their overall health and well-being.

With the growing focus on patient-centered care and value-based payment approaches, PROMs are expected to play a larger role for providers in assessing their performance and determining the

- ▶ In a 2014 survey of health care executives, nearly three-quarters (72%) of respondents believe the industry can make the shift from volume-based reimbursements to value-based care, while more than one quarter (28%) do not (source: HealthLeaders Media, *2014 Industry Survey, Forging Healthcare’s New Financial Foundation*, February 21, 2014).
- ▶ The value of care offered to hospital patients can vary by as much as 40% across the US (source: Data Advantage’s Hospital Value Index™ study, 2009).
- ▶ According to a recent report, 10 cities – Boston, Portland (OR), Philadelphia, St. Louis, Charlotte, New York, Washington, DC, Minneapolis, Chicago and Atlanta – have the best health care in the country, based on market and hospital performance for populations. The study notes that if lower-scoring markets improve their performance, they could save nearly 4 million years of potential lives lost – the equivalent of an extra year of life for the entire population of Los Angeles (source: iVantage Health Analytics, March 2014).
- ▶ By 2030, the number of primary total knee replacements is expected to increase by 673%, to 3.48 million procedures annually, and the number of primary total hip replacements will increase by 174%, to 572,000 procedures annually (source: S. Kurtz et al., “Projections of primary and revision hip and knee arthroplasty in the United States from 2005 to 2030,” *J Bone Joint Surg Am.*, 2007 Apr, 89(4):780-785).
- ▶ In 2013, 20% of covered workers were enrolled in high-deductible health plans – up from 13% in 2010 (source: Kaiser Family Foundation, 2013, Health Benefits survey).

comparative effectiveness of different treatments. By 2015, for example, providers participating in ACOs will need to demonstrate that the care they have delivered produced value for the patient, as reported by the patient. The HHS ONCHIT also plans to incorporate PROMs into meaningful use standards, which is expected to accelerate their use.

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“These are things that matter to patients: do I feel better? Can my mom go up the stairs after hip surgery?”

Mary Barton, MD
Vice President for Performance Measurement
NCQA

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Provider Peer Grouping (PPG) system

This initiative from the Minnesota Department of Health (MDH) is designed to offer a clearer picture of the value of services offered by the state's providers. According to MDH, Minnesota is the first state in the nation to develop a comprehensive system offering information about health care value – both cost and quality. With this data, payers and consumers can compare provider performance and choose high-quality, low-cost providers.

The PPG initiative is authorized by the state's 2008 reform law, which calls for developing an all-payer database and risk-adjustment methodology for measuring quality and prices for hospital and physician services. PPG draws on provider information across all payers, offering a standardized approach to value measurement and reporting. The initiative

includes a rapid response team of providers, purchasers and consumers who provide input on issues that arise in PPG implementation.

Quality-adjusted life year (QALY)

QALY is a measure of health improvement used worldwide in guiding decisions for health care resource allocation. This metric combines quality of life with quantity of life. Quality of life is measured on a scale of 0 to 1; one year in perfect health yields 1 QALY.

Although QALYs have been used by many countries – most notably, the UK – in cost-effectiveness analyses to guide coverage and reimbursement decisions, their use is a matter of long-standing debate in the US. Proponents maintain that QALYs provide a reliable gauge for measuring and comparing the health effects of different interventions across a diverse range of diseases and conditions. Opponents cite concerns that QALYs discriminate on the basis of age and disability, unfairly favoring younger and healthier populations that have more potential QALYs to gain.

In 1996, the US Panel on Cost-Effectiveness in Health and Medicine recommended that cost-effectiveness analyses use QALYs as a standard measure for identifying and assigning value to health outcomes. The ACA, however, contains language specifically forbidding the use of cost per QALY “as a threshold to establish what type of health care is cost effective or recommended.” Many industry observers note that strict adherence to a QALY approach is unlikely in the US, but a modified approach – coupled with other criteria – may help illuminate the value of health interventions.

Relative resource use (RRU)

For more than two decades, the NCQA has reported on care quality received by health plan members. Its new measure, RRU, is a pioneering effort to better understand the value of care delivered. RRU combines two indexes, one measuring quality and another measuring service utilization. It is based on the concept that patients who receive high-quality care for certain chronic conditions are more likely to be able to manage their health and thus avoid expensive services such as ED visits, surgery and hospitalization. NCQA reports RRU for five common chronic diseases: asthma, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and hypertension.

In calculating RRU components for diabetes, for example, the quality index assesses whether patients receive guideline-recommended care and adequate control of blood glucose, cholesterol and blood pressure. The utilization component is calculated by multiplying the number of times a patient receives a specific service by a standardized price, not a plan's negotiated provider rate. The utilization component is risk-adjusted for age, gender and health conditions. NCQA calculates averages for plans nationally and compares them to individual plans. Several major health plans, such as Aetna, Cigna Corp., Health Net and UnitedHealth Group, are participating in the RRU program.

Time-driven, activity-based costing (TDABC)

Developed by Harvard Business School professors Robert Kaplan and Michael Porter, TDABC is a costing method for assessing value. In health care, the cost of looking after a patient along the care

continuum is calculated by multiplying the time spent at each step by the cost per unit of time associated with the step. According to Kaplan and Porter, TDABC requires health care providers to 1) trace the path of a patient through the care experience; 2) identify the actual cost of each resource that the patient uses through the full cycle of care, from personnel to space and equipment; and 3) document how much time the patient spends with each resource.

The methodology has been used by such leading health care providers as Boston Children’s Hospital, the Cleveland Clinic, the Mayo Clinic, MD Anderson Cancer Center and UPMC. At UPMC’s Bone and Joint Center, for example, TDABC is being used to help assess the true cost of knee and hip replacements. Real-time metrics are gathered through “shadowing,” where an unbiased observer follows the patient and family as they journey through the care experience. UPMC is participating in an Institute for Healthcare Improvement effort with 31 other medical facilities to share cost and outcome data. Participants in this initiative, called the Joint Replacement Learning Community, will use the TDABC metric to measure costs, analyze and review data, and set improvement targets.

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“One goal of this effort is to enhance efficiencies and process improvement along with clinical outcomes in order to finally answer the ‘value equation’ of outcomes divided by true costs.”

Anthony M. DiGioia III, MD
 Medical Director
 Bone and Joint Center at Magee-Womens
 Hospital of UPMC
 Speaking to Pittsburgh Business Times

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Value vignette

Healthcare Transparency Index: finding better value for health care dollars

Eight health care services that are high cost as well as highly variable in price present the greatest opportunity to save on health care costs, according to Change Healthcare Corporation, a Brentwood, TN, company focused on consumer engagement and cost

transparency. The company’s Healthcare Transparency Index (HCTI) measures price variability for different procedures. Leading the list of opportunities for cost savings is CT scans, which vary in price from \$300 to more than \$2,600.

Services offering the greatest opportunity for health care savings

| Service | Price range | Price variability |
|--|------------------|-------------------|
| CT scans | \$300-\$2,681 | 794% |
| MRIs | \$485-\$2,708 | 458% |
| Colonoscopies and upper GI endoscopies | \$1,290-\$4,035 | 213% |
| Mammograms | \$118-\$402 | 242% |
| Ultrasounds | \$100-\$572 | 472% |
| C-section deliveries | \$6,128-\$23,526 | 284% |
| Office visits with lipid screening | \$179-\$506 | 182% |
| Office visits with diabetes screening | \$118-\$470 | 298% |

Change Healthcare’s HCTI tracks cost variability of common health care services across various prescription, medical, dental and vision services from quarter to quarter. Certain services, when analyzed at the most granular level, can vary by as much as tenfold, according to the report.

The company notes that health plan sponsors can leverage this information by applying the Transparency Index to their own populations. By reviewing

services that are high cost, highly variable in price and used often within the plan, plan sponsors can better target communications to employees to help them find better value for their health care dollars.

The HCTI report, updated quarterly, is based on more than 167 million claims arising from more than 5.5 million patients obtaining health insurance through Change Healthcare member organizations.

Source: www.changehealthcare.com

Value-driven outcomes (VDOs)

In 2012, the University of Utah Health Care (UUHC) launched VDOs as a tool to create cost and outcomes data at a granular level. Led by an executive team, the initiative is designed to illuminate what it costs to care for a patient for a given episode of care – with a focus on hospital, physician and professional costs across the inpatient and outpatient spectrum.

With costs on an x-axis and outcomes on a y-axis, users can see direct correlations between the cost of every choice made and how it affects the quality of care. By looking at information in the aggregate, UUHC leaders note they can ask larger questions about overall health care delivery – and find new ways to redesign care pathways. From these standardized care pathways, clinical-decision support tools can be designed that hardwire best practices into the EHRs. Protocol-based computer reminders can then help guide practitioners to make evidence-based decisions at the point of care. The VDO technology may eventually be shared with other institutions for measuring costs and outcomes throughout patient cycles of care. The tool received a 2013 Innovator Award from *Hospitals & Health Networks* magazine.

Value Quotient® (VQ)

University of California, Los Angeles (UCLA) Health System has created a Value Quotient to compare the value of services to patients

with health care costs. The measure has been piloted in helping patients manage chronic intestinal ailments, with plans to expand to other chronic diseases such as heart failure and diabetes.

The VQ incorporates the annual burden of the patient's disease, including such factors as disease activity, complications, medication side effects and hospitalizations; quality of life; and work productivity. Each year, an individual patient's VQ is analyzed by health system staff to determine factors that influence the score and to develop a plan for the year ahead. The health system is also creating apps for tablets and smartphones to help manage these chronic diseases.

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"Words can spearhead social transformation. Let's hope that's true for value in health care. Where other mantras – such as quality or managed care – have failed to galvanize the system's diverse stakeholders, value may have a chance."

David Blumenthal, MD
President, The Commonwealth Fund
Kristof Stremikis
Senior Researcher, The Commonwealth Fund
"Getting real about health care value"
Blog, September 17, 2013
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The measurement movement: collaborating for better outcomes

Creating the value-based health care system of tomorrow calls for new measures – metrics that all stakeholders view as fair, consistent and patient-focused; that unite cost and quality dimensions into standard measures; and that require robust methods of collecting information and reporting on the value of specific providers, health plans and technologies.

As the demand intensifies for value measures, the trends discussed in this chapter are sure to accelerate. Clearly, patients and employers want to make health decisions based on useful measures of the outcomes they care most about. Working together, providers, payers and policy makers can catch the wind in setting these industry standards and delivering on the value promise.

Considerations for your board and executive leaders

For providers

- ▶ What metrics are you using to gauge value in your organization's health care delivery? Have you identified measurable factors that contribute to variability in costs? Are you participating in any regional or national initiatives in developing value metrics?
- ▶ Are you participating in any initiatives aimed at developing outcomes metrics for patients that gauge improvements in quality of life?
- ▶ How are you engaging physicians in establishing value metrics for their services? Are you providing tools to help them understand how they practice and the costs of care they are providing? How will these value metrics incorporate a measure of patient well-being – determining which services contribute positively and which are unnecessary or even counterproductive?
- ▶ Are you collecting, analyzing and linking accurate quality and financial data to support your organization's decision-making through integrated clinical and management information systems?

- ▶ Are you collaborating with other health care organizations in your market to gather comparable cost and outcomes data to develop broad value measurements for a total episode of care or time period? Are you comparing and contrasting the value provided across the market to identify best practices and reassess your current practices?
- ▶ How are you using value measurements to make strategic decisions about new investments and business initiatives?
- ▶ Are you leveraging measurements to negotiate with payers in a more informed way, demonstrating what it costs your organization to provide high-value care?

For payers

- ▶ What metrics are you using to evaluate providers to identify those most capable of succeeding in a high-value contracting network?
- ▶ Are you supporting providers with care management tools, patient information and education resources, timely data analysis and reimbursement systems that encourage value delivery?

- ▶ How are you using outcomes and cost data to establish and measure the effectiveness of bundled reimbursement models?
- ▶ Are you monitoring the various initiatives in value measurement across the country and incorporating any such initiatives, at least on a demonstration basis, with selected providers in your markets?
- ▶ Are you measuring members' satisfaction with the care they received and regularly sharing these measures with providers? How are these scores used in negotiating contracts with providers? Are the results shared with health plan sponsors and/or directly with your insured members?



“It is not the ship so much as the skillful sailing that assures the prosperous voyage.”

George William Curtis, *19th-century American writer*

Postscript

Value in leadership

Taking the helm

The future of American health care is no longer a blur on the distant horizon. It is coming rapidly into focus. Today's convergence of market, economic and government pressures requires bold responses from health care executives and board members to secure their organizations' long-term viability.

In the journey toward a value-based health care system, leaders are asked to navigate through often volatile conditions. The ability to read the wind and the waters – foreseeing changes and responding with agility and resilience – is vital to effective leadership.

As you reflect on this edition of *New horizons*, consider how your leaders are piloting your organization's course to a prosperous future, including:

- ▶ Pursuing payment systems that reward high-value care while looking internally to curtail costs
- ▶ Maximizing care delivery and the patient experience
- ▶ Making strategic use of information technology
- ▶ Staying the course in compliance programs to avoid hazards and create value
- ▶ Considering transaction opportunities for their potential to yield financial, operational and strategic returns
- ▶ Using measures for gauging the outcomes that matter to patients
- ▶ Watching the legislative and regulatory forecast – and responding proactively

In today's sea change of reforms and transformations, executive leaders and board members are the most visible champions for value. Although they can't change the direction of the winds above or the currents beneath, those with staying power – and strong partnerships – will be able to continuously adjust their sails for a successful journey.

The endpoint of this edition of *New horizons* is a conversation with the president and CEO of the Robert Wood Johnson Foundation, Dr. Risa Lavizzo-Mourey. Under her leadership, the Foundation has launched a variety of value-based programs to address the nation's most pressing health care challenges. She offers her insights on taking the lead in the continuous voyage to value.

Feature

Leadership in transformative times: navigating the changing tides

A conversation with
*Risa Lavizzo-Mourey, MD, MBA,
President and CEO, the Robert Wood
Johnson Foundation (RWJF)
(www.rwjf.org)*

Since 2003, Dr. Lavizzo-Mourey has led the Robert Wood Johnson Foundation, the nation's largest philanthropy dedicated solely to health and health care. We talked with her about her perspective on pursuing value, creating a culture of health and developing the next generation of health care leaders.



In your varied roles as a practicing physician, a contributor to developing national health policy and an executive leader of the Robert Wood Johnson Foundation, you've had many opportunities to observe and advocate for value. What is your concept of value in the health care world?

The starting point for me is always what value means for patients – those we are seeking to serve in our health care system. In short, if you're a patient, it means getting the care you need so you can actually get better.

A patient I encountered early in my career as a physician taught me this. She had a number of challenges. But the one that brought her into the hospital was a swollen leg that had been infected many times. Each time she was admitted, she received the same things – good care, a change in her dressing, IV antibiotics and a warm place to sleep for the night. But after treatment, discharge and a few more days, she would be back again with the same problem.

"In my view, value is not only high-quality care for the price you pay; it is high-quality care that gets patients the outcomes they want."

Beyond her medical issues, she had other life challenges: chronic behavioral health problems, no stable living situation and no one from outside the hospital to help her with her care. We were paying a lot of money for care that was suboptimal, and ultimately, we were not delivering the outcomes that mattered to the patient.

If we are going to provide high-value care, we need to look beyond what happens in the health care setting and determine what we can change that will help people get to the functional status they want.

In my view, then, value is not only high-quality care for the price you pay; it is high-quality care that gets patients the outcomes they want.

What stands in the way of getting more value out of our health care system? How can these obstacles be overcome?

A person's ability to stay healthy is influenced largely by his or her environment. So we need to create the kinds of environments that are conducive to the kinds of individual behaviors and outcomes we want to see.

If you have cardiovascular disease and are advised to quit smoking, you have a much better chance of being able to be smoke-free if your environment supports your goal – for example, if the pharmacy where you have your prescriptions filled decides it's not going to sell cigarettes.

In designing a system that delivers high-quality outcomes, we need to make sure people understand the kinds of services they need and where these services are provided in the community. We need to rigorously pay for care that will lead to a decrease in the need for higher-cost care. And, we need to realize that often, particularly in the complex world we live in, providers, patients and payers don't have enough information about the prices being paid for services, the quality they're getting for those prices and how likely it is that these services will lead to positive outcomes. This lack of information is the biggest barrier to having a truly sustainable, high-quality health system.

You talk often of the need to create an American “culture of health.” Paint the picture for us of what that would look like.

A culture of health means having access to the care you need where and when you need it and preferably in a setting that is the most convenient for you. It means

**Improving health care value:
10 characteristics of an American
culture of health**

1. Good health flourishes across geographic, demographic and social sectors.
2. Being healthy and staying healthy is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices that lead to healthy lifestyles.
4. Business, government, individuals and organizations work together to foster healthy communities and lifestyles.
5. Everyone has access to affordable, quality health care.
6. No one is excluded.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. The health of the population guides public and private decision-making.
10. Americans understand that we are all in this together.

Source: Robert Wood Johnson Foundation, 2014.

creating an environment that promotes prevention and wellness to all members of the population.

If you're a child, you should be able to walk to school and be safe. You should know when you get to school what you learn there will help you grow up to be healthy. If you're an employee, you should be confident your employer will help you make healthy choices for you and your family.

For all, it means knowing your community has a stake in the kinds of infrastructure that support good health. That can be as simple as a store that provides fresh produce, a place where you can exercise safely and community services that help you address the stresses of life. It's the assurance that the issues that diminish health – from inadequate housing to unsafe streets – will be addressed by community leaders. In a culture of health, good health is a national value, one that keeps us focused on being healthy and staying healthy.

Many of the Foundation's initiatives have been exemplary in their pursuit of value. Tell us about some of your key programs and what we can learn from them.

We've worked in many areas that are thresholds for improving the culture of health and achieving value. The first is making sure that as many people as possible have insurance coverage so they can begin to address their health care needs. Our goal at RWJF is coverage for 95% of all Americans by 2020.

When a significant part of the population is not covered, we tend to see a lower health status for everyone. This is part of the reason that the ACA was enacted. The Foundation has been working on this issue for more than 40 years –

demonstrating to individuals and communities the consequences when people cannot get the health care they need when they need it. For most people, being sick is, gratefully, a relatively infrequent event. So, because they are rarely ill, they haven't focused on what could happen when they are sick. Educating the public about the importance of health care coverage is work that should never stop.

We have also learned that working at the community level is critical to improving value. At RWJF, our best learning laboratories have been in local environments. For example, we're supporting the Boston-based Health Leads program (www.healthleadsusa.org). Through this initiative, health care providers can “prescribe” food, heat and other basic resources their patients need to be healthy – as well as medications. Health Leads is making it easier for providers to address social factors affecting their patients' health and to connect low-income patients with resources and services in their communities.

Today, the program is in place at 20 adult, pediatric and prenatal clinics and in community health centers across the country. It is providing health care leaders and policy makers with a working example of how community programs can address the nonmedical factors that affect health and well-being.

What are the Foundation's top priorities today, and what might they be over the next 10 years in the voyage to value?

If we're really going to improve the value we get from health care, we need to do a better job in several areas – from reversing the epidemic of childhood obesity to creating a smoke-free culture nationwide.

We need to make sure patients are more engaged in the value they receive for their health care dollars. That means paying attention to prices and quality in a way we haven't before.

We need to invest in the health of the population and to continue to find ways for people to make health the easy or default choice.

And we need to prevent violence. We can't be a healthy nation if we continue to be a violent one. At RWJF, we have supported several initiatives to prevent domestic and community violence and are broadening our focus so that nonviolent behaviors can be inculcated in children at a very young age – and will become the behaviors that endure.

How can businesses help employees derive more value from their health care dollar – and drive accountability for providers and payers?

First, businesses can provide complete and transparent information – along with the analytics to help employees make the best choices in health care. We have been living in a world where the information people need to make decisions is treated in a proprietary way. The more we can share that information and develop the analytics to measure value, the closer we will be to reaching our goals.

Second, we know that comprehensive worksite wellness programs bring strong returns for employers, especially when they're extended to families. The numbers

are staggering: for every dollar invested in these programs, there is an average return of more than three dollars, through lower medical costs, reduced turnover rates and increased employee retention. We hope to see more and more employers investing in and promoting these programs.

Third, we must recognize that the kinds of coverage benefits that will be provided over the next few years will – by necessity – be evolving. Employers, since they cover such a significant part of the cost, will need to take a rigorous approach to analyzing the most high-value benefits they can provide and their impact. I would argue the impact they need to look at is not just services provided but the overall health of their populations. Providers and payers should be helping employers demonstrate the value of population health.

In this time of industry transition, what are the greatest challenges – and opportunities – in developing the next generation of health care leaders to “navigate the changing tides”?

It's critical that our leaders be able to reach across sectors and silos to create a value-based world – not only health care value but the value of broader systems. When we talk about the value proposition, we tend to refer almost exclusively to the value we get from the services health care systems provide. But we need to recognize that the health care dollar is inextricably tied to the money we invest in many other areas, such as public health, education and public infrastructure. Often we don't put a health

value on those investments. Health needs to be considered in all policies, not just health care policies.

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“It's critical that our leaders be able to reach across sectors and silos to create a value-based world – not only health care value but the value of broader systems.”
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An already complex health care system becomes even more so when you start asking how to make the system work with communities and businesses to promote the health of a population. Whether it's an individual organization or a city or region that has succeeded in achieving this goal, all have tended to have leaders from sectors and areas that we don't think of as being related to health – architects who know how to create healthy spaces, for instance, or transportation specialists who understand the importance of the infrastructure in contributing to population health.

This collaboration among disciplines is sometimes difficult to cultivate. But it's absolutely essential. Building networks of people who understand and are committed to health outcomes in their communities will help achieve high value and enable all people to live long and healthy lives.





“A change in the weather is sufficient to recreate the world and ourselves.”

Marcel Proust, *20th-century French novelist*

Value in government initiatives

Reading the forecast

Voyage to value

“Show me the value” are the abiding watchwords of health care policy makers. The way toward the industry’s future will continue to be guided by government policies to reduce cost, create greater efficiencies and maximize value for system stakeholders. While federal and state lawmakers of both parties may have different visions of how to achieve health care value, they share the belief that the US health care system must readily embark on the value journey.

As legislators negotiate health care laws – from new payment methods to treatment options, insurance parameters to reporting requirements – the overall course should veer toward opportunities that will enhance the value of care provided for money spent. Legislative and regulatory initiatives provide direction as health care organizations read the forecast on their voyage to value.



March 31, 2014, was a significant date for the US health care industry. The ACA initial enrollment period ended that day with more than 7 million Americans selecting health insurance plans through the federal or state health insurance exchanges (HIXs). On the same date, the US Congress passed the Protecting Access to Medicare Act of 2014 (PAMA), which implements a variety of provisions affecting virtually every health care organization. In this Appendix, we provide a high-level review of these and other developments and government activities. Highlights are intended to help you assess the current legislative environment and gain perspective on initiatives affecting your operations and strategies.

The ACA: launching new health care coverage

Although estimates of 7 million new health care enrollees were met by the original March 31, 2014, ACA deadline, in late March, CMS announced a special enrollment extension period through April 15, 2014. Qualifying for the special extension were those who tried to enroll by the deadline but could not complete their applications in time and those who had previously encountered website problems that prohibited them from enrolling earlier. In the last week of March, a surge of enrollees caused slow processing and activated a “virtual waiting room” when the number of people trying to sign up exceeded the exchange’s capacity. Those who chose to take advantage of this special enrollment extension period had to attest that they had trouble signing up before the original deadline. In total, about 8 million Americans selected health plans through

the federal and state exchanges by the end of the ACA’s first open enrollment, April 15, 2014.

Sustainable growth rate: adding another temporary fix

The PAMA provided a temporary patch to the sustainable growth rate (SGR) physician payment update formula, preventing the 24% Medicare payment cut scheduled to go into effect April 1. This bill represents the 17th deferment of payment cuts resulting from the SGR formula since its implementation in 1997. Physician groups had hoped that a permanent fix to the SGR formula would be enacted instead, and they continue to push for this.

While legislators of both parties attempted to implement a permanent fix, these efforts failed largely because of the inability to fund such a measure. The Congressional Budget Office (CBO) now estimates that a permanent repeal of the SGR will cost

\$138 billion to \$180 billion, depending on other payment policies included in the package and whether some temporary Medicare payment rules are made permanent. Although the issue will likely be revisited in 2015, no further action is expected in 2014.

.....
“Full repeal of the sustainable growth rate formula is the answer to strengthening the Medicare program, not another patch.”

Ardis Dee Hoven, MD
President
American Medical Association
.....

ICD-10 implementation: delaying the start again

The PAMA also includes a variety of other measures with significant impact on the US health care system – including, somewhat unexpectedly, mandating a delay in ICD-10 diagnostic and procedure codes for one more year.

While physician trade associations actively worked to prevent the 24% SGR cut in physician payments, preferably through a permanent fix, the addition of a delay in ICD-10 implementation to this legislation surprised many. Most major health insurance organizations have indicated that they were well-prepared for the switch to ICD-10 on October 1, 2014. And, shortly before the delay was enacted, CMS – as a final step in its readiness agenda – issued a request for health care provider organizations to apply to be part of ICD-10 “end-to-end” testing.

However, some physician trade associations had lobbied for a delay. They cited the lack of available/affordable systems and

the significant cost of implementation and training as factors preventing a reasonable conversion to ICD-10 by October 2014, especially for small physician groups or individual physician practices. Despite the availability of CMS' eHealth University, designed to help health care providers – particularly smaller groups – to implement the conversion successfully, many small physician groups were not expected to be ready by the October 1, 2014, conversion date.

With the date for conversion to this significantly more complex coding system now set for October 1, 2015, health care providers and payers will need to re-evaluate their training and testing plans to make sure the key points of conversion are top of mind when the actual switch to ICD-10 is finally implemented. Provider and payer organizations that have already invested in training sessions to prepare their clinicians and health information management staff for ICD-10 implementation now must assess whether those efforts will need to be repeated next year to bring staff up to speed. And HIT staff will need to reassess their priorities, changing the schedule for ICD-10 conversion activities and postponing planned moves to take on other initiatives. For more on ICD-10, see chapter 3 of this edition of *New horizons*.

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"Even if you slow down, don't stop ... use [the ICD-10 delay] to your advantage. Strengthen your clinical documentation programs."

Lynne Thomas Gordon
CEO
American Health Information
Management Association
Speaking to Modern Healthcare, April 5, 2014
.....

Other provisions: spanning a range of industry sectors

The PAMA further extends until 2023 the 2% reduction in Medicare payments imposed by the federal budget sequester, which was first extended in the federal funding deal agreed to in December 2013. This is two years longer than the original budget sequester imposed.

Also included in the PAMA are a number of other health care provisions. Some measures are geared to further implement pay for value or otherwise reform current payment methodologies. Key provisions, by industry sector, are highlighted below.

Hospitals

- ▶ Postponing until March 15, 2015, compliance with Medicare's controversial "Two-Midnight Rule" for determining inpatient versus observation patient status
- ▶ Suspending until March 15, 2015, RAC audits of allegedly medically unnecessary claims
- ▶ Preserving until 2017 disproportionate share payments for safety-net hospitals

Physicians

- ▶ Implementing a 0.5% Medicare update for physician services with claims dated during calendar 2014 and a 0% update to the 2015 Medicare physician fee schedule
- ▶ Reducing certain "misvalued" physician payment codes and creating a program designed to promote proper use of diagnostic tests and treatments, while discouraging overuse

Skilled nursing facilities (SNFs)

- ▶ Establishing a new value-based purchasing program for SNFs based on their performance on hospital

readmissions – readmission scores will be posted on the Nursing Home Compare website (www.medicare.gov/nursinghomecompare/) beginning in 2017, with the value-based purchasing program starting in 2018

- ▶ Reducing payments to SNFs by \$2 billion over 10 years

Clinical labs

- ▶ Reforming the current clinical laboratory fee schedule used to determine payment for Medicare diagnostic lab services through changes in the process of setting rates and in the identification codes used to enable better assessment of the efficacy of individual tests – this provision will forestall another round of across-the-board cuts in lab payment rates

Medical imaging

- ▶ Requiring providers to consult "physician-developed appropriateness provisions," such as clinical decision support tools, before ordering advanced medical imaging procedures for Medicare patients; backed by the American College of Radiology, this quality initiative is intended to reduce duplicate and unnecessary scans

Outpatient therapy

- ▶ Extending the outpatient therapy caps exceptions process through March 31, 2015, and extending the outpatient therapy caps (and exceptions process) to hospital outpatient therapy services; these caps have been extended a number of times since they were first implemented in 2006



Mental health

- ▶ Authorizing a multistate pilot program designed to raise standards for mental health services and improve integration of care
- ▶ Establishing a new grant program, with up to \$60 million available over four years, to improve outpatient treatment for individuals with serious mental illnesses

Payers

- ▶ Extending for an additional year (to 2017) Medicare Advantage Special Needs Plans, which provide services to beneficiaries who are institutionalized, have chronic conditions or are dually eligible for Medicare and Medicaid
- ▶ Eliminating the cap on deductibles for employer-sponsored health plans

The legislative/regulatory horizon: looking ahead

A variety of other health care-related initiatives can be expected in the months ahead, some as potential legislation by the US Congress or state legislatures and others as regulations issued and implemented by CMS and other agencies. Profiled below are upcoming considerations.

A new captain at the helm

After seeing the ACA through its first open enrollment and a vast number of implementing regulations, Kathleen Sebelius resigned as Secretary of Health and Human Services. President Obama nominated Sylvia Mathews Burwell, Director of the Office of Management and Budget, to be her replacement. Burwell's confirmation hearings presented another opportunity for Senate Republicans to raise concerns about the ACA, revisit problems with the initial enrollment process and critique

extensions and delays in ACA provisions. The Senate confirmed Burwell as Secretary on June 5, 2014.

Through the eyes of some observers the new Secretary will be jumping headfirst into churning waters. With the federal and state exchanges gearing up for the second enrollment period, she will also need to address funding and staff shortages at CMS and the need to replace several senior CMS staffers who have recently resigned.

HIX premium rates and plans for 2015

Now that commercial insurers participating in the HIXs have initial enrollment information, they must move quickly to set their rates for the next open enrollment period. While premiums are expected to increase, the extent of the increase is not yet known. Insurers are still in the process of evaluating the age, health status and plan selections of those newly insured, as well as those expected to enroll in 2015. Initial reports from insurers participating in the HIXs indicate that most expect to stay in the exchanges they participated in during 2014. Some are also considering participating in additional HIXs for 2015.

Premiums for HIX plans were lower than the CBO had originally predicted for 2014. Some insurers are believed to have offered lower rates in some of their plans to help persuade the uninsured to sign on. In some plans, narrower networks and tight plan limitations contributed to the lower-than-expected premiums. Some insurers may choose to keep 2015 rates low to build market share, while others may increase rates to improve profitability or to offset adverse selection, especially in the rate of younger, and presumably healthier, individuals.

While preliminary demographic analyses show younger people signed up at a lower rate than older people, some insurers indicate that more young people enrolled than they had expected when they submitted their bids for 2014. For 2015, the CBO projects that new enrollees will be younger and healthier than those who enrolled during 2014, which will help reduce the costs of insurance plans – perhaps somewhat mitigating the need for large premium rate increases.

In April 2014, the CBO issued an analysis on the cost of the ACA's insurance subsidies, predicting that over the next 10 years, the subsidies will total about \$1 trillion, compared with the \$1.2 trillion originally estimated. This revised estimate is partially due to new projections of the cost of health insurance plans sold through the HIXs. The CBO expects the average premium to rise about \$100 for 2015, and to then grow about 6% per year through 2024.

Another consideration in setting premium rates is the provider networks included in each health insurance plan. Insurers are expected to limit networks in negotiations with providers to help soften the increases in premium rates for 2015. In March, CMS issued proposed regulations under which CMS would no longer defer to the states to certify adequate provider networks. It would instead establish its own process to make sure networks include a sufficient number of hospitals and other health providers so that the insurer meets the reasonable access review standard. Plans would, in general, be expected to contract with at least 30% of the essential community providers in their market. Comments on this proposed rule were

accepted until April 14, 2014. CMS is reviewing them and will issue a final rule later this year.

Insurers are under pressure to consider these factors to determine soon which markets they intend to offer plans in, as well as 2015 premium rates. Some state HIXs require that plan information and premium rates be submitted as early as May 1, 2014, while the federal HIXs have a deadline of June 27.

CMS oversight

Now that the new health insurance plans offered on the HIXs are in effect, many participating insurers face oversight by CMS. Yet it is unclear just how much scrutiny CMS will apply. CMS is responsible for enforcing market reforms in states that are not enforcing them directly, or have not entered into a collaborative enforcement agreement with CMS.

CMS oversight for Medicare Advantage plans has been comprehensive in reviewing services covered, rates charged and customer service issues. Insurers that have not previously participated in Medicare Advantage may find the oversight from CMS more rigorous than they typically experience with state insurance commissioners. Final regulations defining essential health benefits have been issued, and throughout 2014, insurers will learn just how aggressively CMS will interpret its requirements to monitor these health insurance plans.

HIX changes

Several state-run HIXs have indicated plans to make changes after the initial enrollment period. For example, Oregon's

state-run exchange was unable to sign up any enrollees online, although it did enroll applicants over the phone and by mail. After consultant analyses showed that it would be far less expensive to move to the federal exchange and abandon the state's exchange rather than refurbishing it, CMS has informed Oregon officials that it does not believe Oregon can repair its exchange. Oregon will likely operate under the federal exchange for the 2015 enrollment period.

On the other hand, two states, Idaho and New Mexico, plan to move from the federal exchange to their own state exchanges for the 2015 enrollment period. Both had initially planned to offer a state-run exchange but decided they could not get their own exchanges established in time to meet the 2014 deadlines.

Employer mandate

In February 2014, the Administration issued long-awaited final regulations on the employer mandate and employer requirements for information reporting. With this issuance, the IRS can begin enforcing these provisions. The employer mandate and information reporting will generally take effect on January 1, 2015, although the Administration has provided an additional year, to 2016, for smaller employers, i.e., those with 50-99 full-time equivalent (FTE) employees, to comply with the ACA's mandate to provide health coverage to their FTEs. Businesses and insurers will have to begin collecting data on January 1, 2015, although the first reports will not be due to individuals (January 31) and the IRS (March 31) until 2016. The effective date of the employer mandate and the information reporting

requirements results from a one-year delay of the provisions that the Administration announced in July 2013.

The final employer mandate rules phase in the percentage of full-time workers who must be provided coverage in order to avoid penalties, from 70% in 2015 to 95% in 2016 and beyond. They also include other transition policies for the first year of the employer mandate.

The final regulations on information reporting generally incorporate the reporting method outlined in proposed rules issued in September 2013. They include limited options for streamlined reporting for large employers in specific circumstances.

Medicaid plan changes

Most states will assess their current Medicaid programs for opportunities to save money and best handle increased enrollments, particularly those states that enacted Medicaid expansions funded through ACA provisions. A number of states have begun considering changes in payment structures to value-based programs such as ACOs or medical homes, moving away from fee-for-service models.

Some of the 24 states that initially decided not to expand Medicaid are reconsidering their decisions. Pennsylvania has requested approval to use federal Medicaid expansion funds to subsidize private health insurance policies. One controversial provision of this plan requires able-bodied, working-age Medicaid applicants to complete certain work-search activities as a condition of receiving Medicaid-funded health insurance. Initial reaction from CMS is that a work-

search requirement will not be permitted. Indiana is considering a consumer-driven model in which beneficiaries would contribute some of their own money toward health coverage. Utah and Virginia are contemplating private insurance coverage options, similar to the Arkansas expansion plan that was approved by CMS and implemented in 2014. Other states are assessing a variety of options, from traditional Medicaid to premium-assistance models.

Federal budget

The Administration has presented to Congress a budget proposal for 2015 that reduces federal deficits to 1.6% of GDP over 10 years. It also adheres to the spending levels agreed to in the Bipartisan Budget Act of 2013 while shifting spending toward domestic initiatives President Obama would like to implement during the remainder of his term. House Budget Committee Chair Paul Ryan has released a budget proposal that cuts more than \$5 trillion in spending over 10 years and would balance the federal budget. It includes many of the same initiatives proposed in prior-year Republican budget proposals. It is unlikely that either of these comprehensive proposals will proceed.

The rough waters of the past several years surrounding the federal budget – with fiscal cliffs, sequesters and battles over the debt ceiling – are today much calmer. An improving economy and impacts of the last several budget battles have significantly decreased the federal deficit. The CBO now predicts the 2014 federal deficit will be \$514 billion,

a significant decrease from the 2009 high of \$1.4 trillion. However, the CBO also projects that health care spending will be the key driver of a return to increasing deficits in just a few years. The federal debt ceiling has been suspended through March 15, 2015, raising the possibility that renewed attempts to rein in health care spending may arise next year – and bring turbulence to the calmer seas.

Greater transparency

In April 2014, the Administration released for the first time physician payment data showing procedures provided and payments received by 880,000 distinct health care providers. This data enables comparisons by physician, specialty, location, and types of services and procedures provided. The release adds a new level of transparency to health care costs, supplementing the hospital inpatient and outpatient charge data released last year.

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“Data transparency is a key aspect of transformation of the health care delivery system.”

Marilyn Tavenner
Administrator
CMS
.....

Health care issues and the upcoming elections

Another wave to dismantle the ACA could arise after the fall elections if the Republican Party retains a majority in the House and gains control of the Senate. As the campaign season gets

under way, the ACA appears to be a major issue in a number of races across the country and is expected to play heavily in candidate debates.

Vigilance and visibility: sailing with the wind

Health care provider and payer organizations have a broad range of federal and state legislation and regulation to monitor, understand and comply with – from the PAMA to the continuing, although delayed, move toward EHR Stage 2 MU. Also, they need to keep up with ongoing initiatives in health care payment, delivery, IT and compliance discussed in this edition of *New horizons*. Regardless of the challenges ahead, staying informed can help health care organizations see clearly through any conditions.

As new regulations are issued throughout the year, EY will continue to keep you informed. For an analysis of the latest developments, visit www.ey.com/US/en/Industries/United-States-sectors/Health-Care

Frequently used acronyms

| | | | | | |
|-----|--|--------|--|--------|--|
| ACA | Affordable Care Act | HIE | health information exchange | M&As | mergers and acquisitions |
| ACO | accountable care organization | HIMSS | Health Information Management Systems Society | MU | meaningful use |
| CMS | Centers for Medicare & Medicaid Services | HIT | health information technology | OIG | Office of Inspector General |
| DOJ | US Department of Justice | HIX | health insurance exchange | ONCHIT | Office of the National Coordinator for Health Information Technology |
| DOL | US Department of Labor | ICD-10 | International Classification of Diseases, 10th edition | PAMA | Protecting Access to Medicare Act of 2014 |
| ED | Emergency Department | ICHOM | International Consortium for Health Outcomes Measurement | P4P | pay-for-performance |
| F&A | fraud and abuse | IOM | Institute of Medicine | RWJF | Robert Wood Johnson Foundation |
| FCA | False Claims Act | IT | information technology | SBC | summary of benefits and coverage |
| FFS | fee-for-service | LTC | long-term care | | |
| HHS | US Department of Health and Human Services | | | | |

EY thought leadership publications

Along with *New horizons*, EY provides a variety of other thought leadership resources to keep our provider care, payer and life sciences clients up-to-date on government activities and market developments:



Health Care Industry Posts

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- ▶ “Shaping your telehealth strategy: leveraging telehealth technologies to lower costs, improve quality outcomes and enhance the patient experience” (SCORE No. EC0023)

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A quarterly publication highlighting critical issues for today’s audit committees across industries worldwide. For example:

- ▶ “Balancing the risk and rewards of digital technology” (SCORE No. CJ0237)

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Progressions: global pharmaceutical report 2014

EY’s 10th pharmaceutical industry report, “Navigating the payer landscape,” focusing on the critical relationship between pharma companies and health insurers (EYG No. FN0137)

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Beyond borders: global biotechnology report 2013

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Pulse of the industry: medical technology report 2013

EY’s sixth annual report on the state of the medical technology industry, highlighting and analyzing current trends and a future of industry innovation (SCORE No. CW0076)

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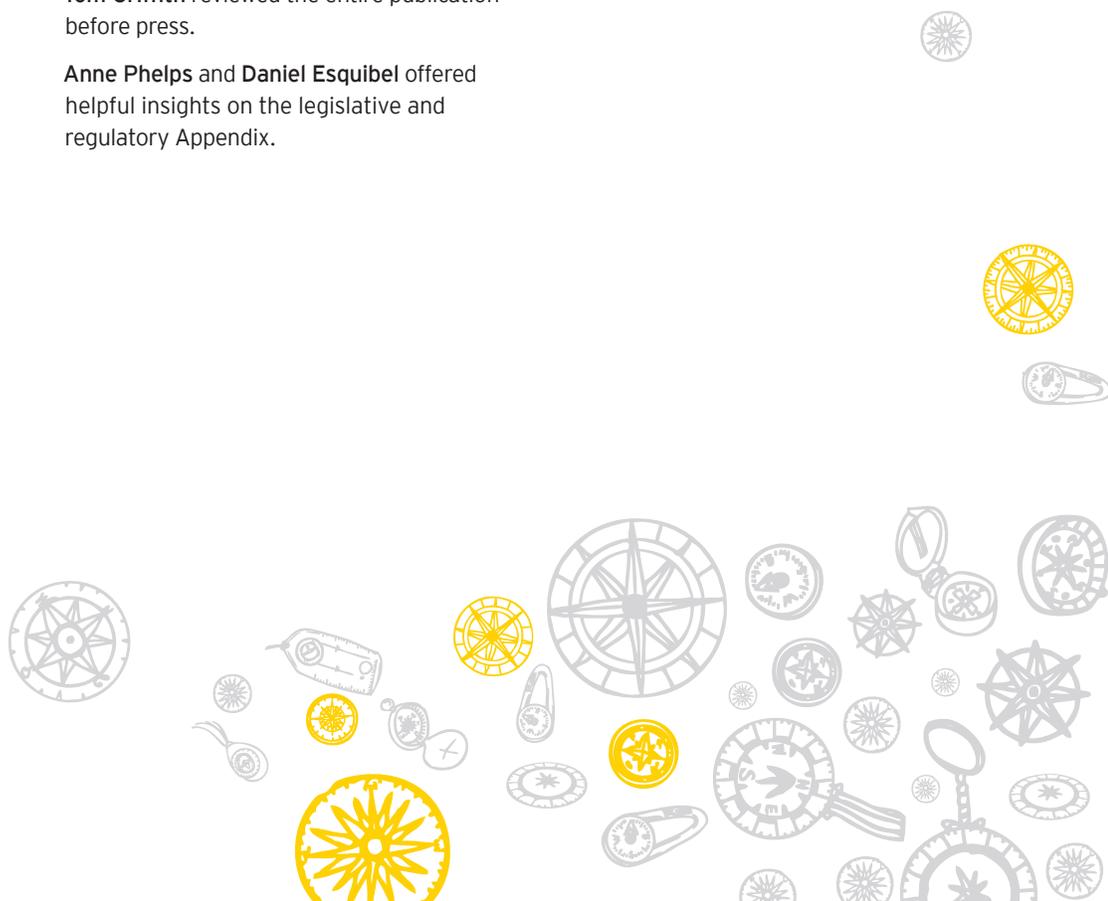
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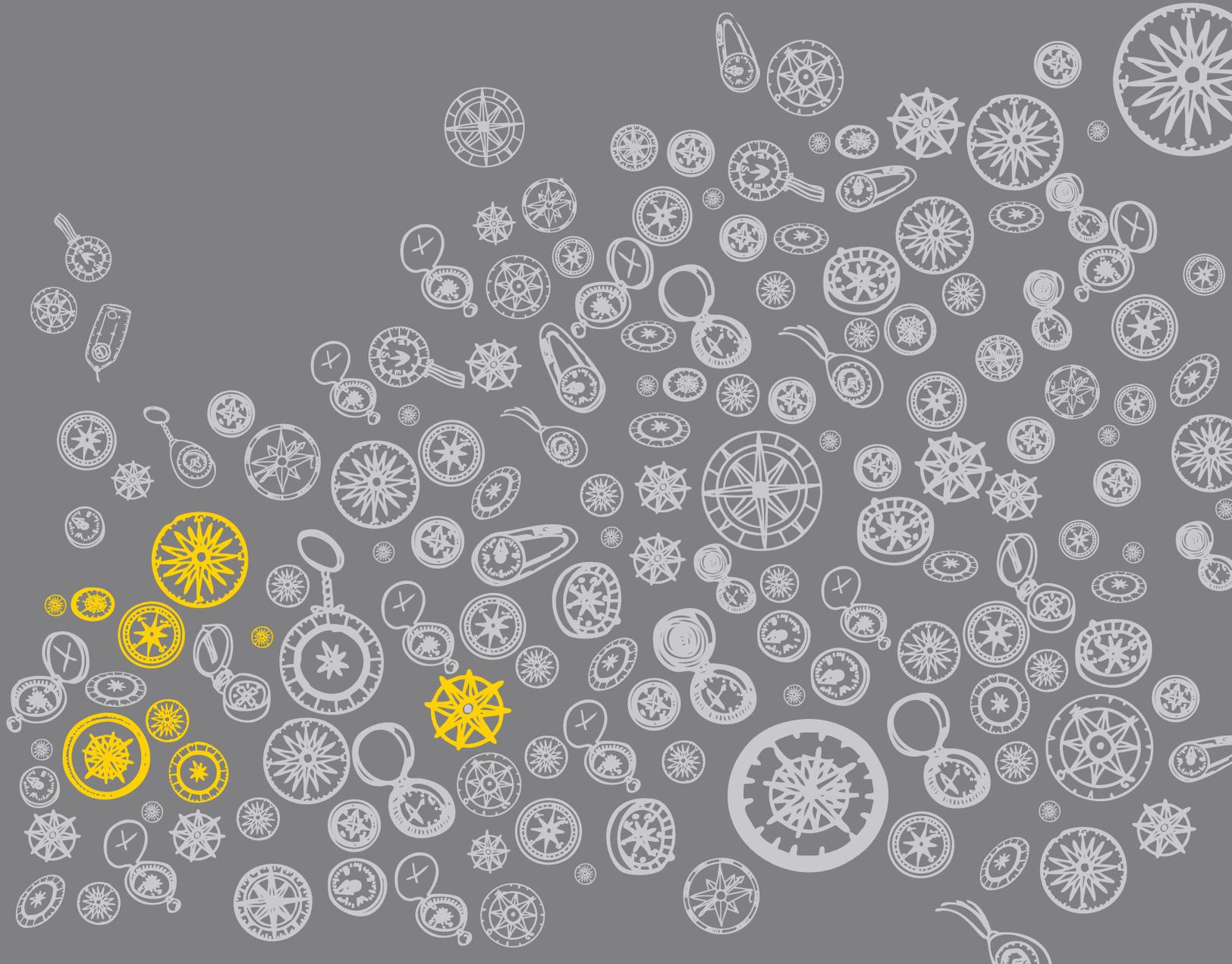
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