Proactive Leadership: Health Care 2020
Five Top Environmental Trends

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Today's Agenda

• Top trends and implications for healthcare stakeholders and leaders
• HFMA’s approach to the new era of health care
A series of four reports examining how to prepare for major healthcare market trends over the coming years

- Transition to Value
- Consumerism
- Consolidation
- Transformative Innovation

hfma.org/healthcare2020
Unsustainable Debt

Reducing Outstanding Federal Debt to the Historic Average Would Require $4 Trillion in Deficit Reduction

Source: https://www.cbo.gov/publication/51580/
Health Care Spending as a Percentage of GDP, 1980–2013

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.

* 2012.

US Projected to reach 19.9% of GDP by 2025.
U.S. HOSPITALS HAVE THE HIGHEST ADMINISTRATIVE COSTS

According to a study of 8 countries

25% of all U.S. hospital spending consists of administrative costs, including salaries for staff who handle coding and billing

This compares with hospital administrative spending of

20% Netherlands
16% England
12% Canada
Annual U.S. hospital administrative spending per person is twice that of the next-highest country

United States: $667
Netherlands: $323
England: $225
Canada: $158

If the U.S. lowered annual hospital administrative spending to the amount spent in the Netherlands, it could save $107 billion

The Shift Toward Value-Based Payment Will Continue

Will CMS’s mandatory value-based payment programs become voluntary? Maybe. But the private sector remains fully committed, in any event.

“We made solid progress in 2016 with over 45 percent of Aetna's medical spend currently running through some form of value-based care model, positioning us to achieve our 2020 goal of 75 percent.”

— Mark Bertolini, CEO, Aetna

“Our goal by 2018 is to hit 50 percent in shared savings programs. When you combine this with our P4P programs we will have well over half our spend in collaborative arrangements over the next few years.”

— Jill Becher, Anthem spokesperson

It’s Time to Put Your Strategies in Place

• **ACOs & bundled payments will evolve quickly.** New models will continue evolving as each proves or disproves its effectiveness in various situations.

• **Now is the time to prepare.** Once an organization begins to take on risk & adjust care delivery models, changes in utilization patterns & revenue can occur very quickly. Those that are prepared will be well-positioned to succeed as the pace of change accelerates.

“There’s no question that shared risk is going to become more prevalent. If I were a healthcare provider, I would want to get ahead of that curve and figure out how to handle it before it becomes more than a small portion of my payment.”

— Suzanne Delbanco, PhD, executive director, Catalyst for Payment Reform, a coalition of employers and other healthcare purchasers
# Value Transition

## Shifting Risk

*Payment System Reforms Will Require Providers to Bear Greater Population-Based Financial Risk*

### Degree of Population Risk Transferred to Provider by Payment System

<table>
<thead>
<tr>
<th>Low</th>
<th>Fee for Service</th>
<th>Pay for Coordination</th>
<th>Pay for Performance</th>
<th>Episodic Payments</th>
<th>Shared Savings</th>
<th>Capitation</th>
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<tbody>
<tr>
<td></td>
<td>Paid for each unit of service w/o constraint on spending</td>
<td>Additional per capita payment based on ability to manage care</td>
<td>Payments tied to objective measures of performance</td>
<td>Payment based on delivery of services within a given timeframe</td>
<td>Shared savings from better care coordination and disease management</td>
<td>Providers share savings from better care coordination and disease management</td>
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High
Group Discussion: Volume to Value

Living in “both worlds” for the next several years – what are some of the strategies and tactics your organization could/should employ?

A. ________________________________
B. ________________________________
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Value-BaseEd Insurance Design (VBID) Will Gain Traction

VBID embeds financial incentives into benefit design to encourage high-value decision making.

Clinically nuanced cost sharing encourages consumers to use more high-value services and providers, but discourages the use of low-value ones.

In a Typical Benefit Design, Consumer Out-of-Pocket Costs Are the Same…

| For Every Clinician Visit Within a Network | Cardiologist Post Heart Attack | = | Dermatologist Mild Acne |
| For All Diagnostic Tests | Blood sugar monitoring | = | CT Imaging for Back Pain |
| For All Drugs Within a Formulary Tier | Statins | = | Toenail fungus Rx |

Adapted from: A. Mark Fendrick, MD, University of Michigan Center for Value-Based Insurance Design, Value-Based Insurance Design: A Bipartisan Approach to Improve Health Savings Accounts, Medicare Advantage, and TRICARE, House Briefing, Feb. 7, 2017
Value Transition

But Not in VBID!

- For Every Clinician Visit Within a Network
  - Cardiologist Post Heart Attack ≠ Dermatologist Mild Acne

- For All Diagnostic Tests
  - Blood sugar monitoring ≠ CT Imaging for Back Pain

- For All Drugs Within a Formulary Tier
  - Statins ≠ Toenail fungus Rx

Adapted from: A. Mark Fendrick, MD, University of Michigan Center for Value-Based Insurance Design, Value-Based Insurance Design: A Bipartisan Approach to Improve Health Savings Accounts, Medicare Advantage, and TRICARE, House Briefing, Feb. 7, 2017
VBID Also Seeks to Differentiate Among Providers on the Basis of Service-Specific Value

Clinical benefit depends on where care is provided…

Hospital VS. Ambulatory Care Center

…and who provides it

High Performer VS. Low Performer
Realignment Is Erasing Traditional Healthcare Boundaries

Driven by demands for care transformation, the healthcare industry is realigning at an unprecedented pace.

**SHARED GOAL**

**The IHI Triple Aim**

Population Health
Experience of Care
Per Capita Cost

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*The Triple Aim framework was developed by The Institute for Healthcare Improvement in Cambridge, Mass. (www.ihi.org).*
What Does VBID Mean for Providers?

• **VBID will speed patients’ understanding of variation in cost and quality among providers.** Health systems that cannot offer high value in certain specialties may need to seek partnerships or consider exiting some service lines.

• **Cost tiers will encourage patient loyalty to high-value providers.** For example, the Aetna Leap plan has a lower deductible for members who choose Tier 1 providers (i.e., those designated by Aetna as high-value).

• **Patients will be rewarded for making high-value choices.** For example, a cancer patient may be pointed to an oncology practice that uses chemotherapy appropriately and prevents unnecessary hospitalizations, while rewarding the patient for choosing that provider.
To Make High Value Choices: An Actionable Definition of Price Transparency

Readily available information on the price of healthcare services, that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.
Guiding Principles

Price transparency information should:
Empower patients and other care purchasers to make meaningful price comparisons
Be easy to use and easy to communicate
Be paired with other information that defines the value of services for the care purchaser
Enable patients to understand the total price of their care and what is included in that price

And price transparency will require the commitment and active participation of all stakeholders.
Roles for Key Stakeholders

**Health plans** should serve as the principal source of price information for their members.

**Providers** should be the principal source of information for uninsured patients and out-of-network care.

**Physicians and other practitioners** should use price information to benefit patients.
Price Transparency in Healthcare

Clarifies basic definitions that are often misused

Sets forth guiding principles

Establishes roles for payers, providers, others

Reflects consensus of key stakeholders

http://www.hfma.org/dollars
Allowing patients to see physicians’ schedules in real time via a mobile app and jump into a slot that opened up because another patient canceled.

They do this at Virginia-based Inova.

Having a patient call your nurse triage line for a minor complaint and referring the patient to a grocery store clinic close to home.

They do this at Memorial Hermann (Texas).

Featuring outcomes reported by patients (such as pain relief months after knee surgery) on your website to help other patients make healthcare decisions.

This is in development at Partners HealthCare (Boston).

A healthcare system centered around consumer needs and wants, like retail services are.

That will be what consumers expect from hospitals, physicians, and health plans, going forward.
What Will It Take to Compete with Disrupters?

- Listening to consumers
- Realizing that consumerism is here to stay
- Collaborating with other stakeholders
- Committing to partnering with consumers
Develop Processes to Get Input from Patients

My organization…

1. Actively and sincerely solicits patient input on both clinical and operational processes through formal structures (e.g., patient advisory council)

2. Welcomes patients’ feedback on their experience, but has no formal structures for receiving this input (beyond HCAHPS)

3. Does not effectively seek patient input

Source: HFMA Thought Leadership Retreat, October 2015
HFMA’s Healthcare Dollars & Sense®

HFMA Has Developed A Suite of Tools to Help Navigate Consumerism

Tools and resources for developing a patient-centered approach to financial interactions with patients and other healthcare consumers

hfma.org/dollars
Consumerism

Make Sure Your Fundamentals Are Solid

Selected Adopter Hospitals & Health Systems

- Cedars-Sinai, Los Angeles, CA
- CHRISTUS Health, Irving, TX
- Duke University Health System, Durham, NC
- Geisinger Health System, Danville, PA
- Henry County Health Center, Mount Pleasant, IA
- Intermountain Healthcare, Salt Lake City, UT
- Legacy Health, Portland, OR
- Sharp HealthCare, San Diego, CA
- Stormont Vail Hospital, Topeka, KS
- UnityPoint Health, West Des Moines, IA

Plus more than 200 others!

hfma.org/communications
Group Discussion: Consumerism

What are some of the strategies and tactics you could/should employ to “get ahead” of the consumerism movement?

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Merger Mania Will Keep Going…

ANNOUNCED HOSPITAL MERGERS AND ACQUISITIONS, 1998–2015


(1) In 2004, the privatization of Select Medical Corp., an operator of long-term and acute-care hospitals, and divestiture of hospitals by Tenet Healthcare Corporation helped to increase the number of hospitals affected.

(2) In 2006, the privatization of Hospital Corporation of America, Inc. affected 176 acute-care hospitals. The acquisition was the largest healthcare transaction ever announced.

(3) In 2013, consolidation of several investor-owned systems resulted in a large number of hospitals involved in acquisition activity.
…But Successful Mergers & Acquisitions Will Be Those That Improve Value

The tension between forces promoting consolidation and forces resisting it will continue unabated.

- Hospital & health system consolidation will continue to build, significantly remaking the delivery system landscape
- Small, independent physician practices increasingly are becoming an endangered species
- The health insurance sector will remain highly consolidated for the foreseeable future.

“As a lot of what we hear from different participants is that they need to merge because other people are becoming big—and antitrust regulators have never permitted organizations to consolidate just because they need to get larger to battle against other firms.”

— David Balto, antitrust attorney

Successful mergers will improve value to care purchasers.

Although hospital consolidation historically has not added value from the consumer’s perspective, value-based payment and an emphasis on price transparency may motivate merging organizations to pass along their savings.
Innovation

The Pace and Impact of Innovation Will Accelerate

IMAGINE...

What will it mean for pediatric groups when parents can use a smartphone attachment to diagnose their child’s ear infection without a doctor visit?

What will be the impact on health systems when a mobile app can detect sleep apnea events, eliminating the need for in-hospital sleep studies?

What are the implications for health plan coverage policies when genomic sequencing, which can better match patients to the right treatments, drops below $1,000?

In fact, these developments are already here and will contribute to strategic changes by physician groups, hospitals, and health plans as the pace of innovation accelerates over the next three to five years.
Every Provider Can Be a Partner in Innovation

Health care is different. Giving patients digital tools like Kayak or Expedia doesn’t mean that everything will go smoothly. Managing health is more complicated than managing travel plans.

“What we need to do is build not just the digital tools but also the workflow and processes. If patients are using a tool to manage their diabetes, there has to be a health system on the other side to make sure they get the care they need if they are not doing well.”

— Robert Wachter, M.D, University of California, San Francisco
To Foster Innovation, Be Strategic About It

- Use innovation to solve pressing problems. Align your goals around innovation to your overall strategy so your work on innovation does not feel like a one-off process.

- Partner strategically. Recognize that innovation means bringing different thinking into the organization, whether it be from a university, an incubator, a tech company, or another group that can help you achieve your innovation goals.

- Recognize that ROI is different with innovation. Don’t think that with your first innovation, you are going to generate more volume, revenue, or a spin-off company. Avoid unrealistic expectations. Realize that innovation takes time.

- Michelle Conger, Chief Strategy Officer, OSF HealthCare
What’s Your Innovation Story?
For More Information

hfma.org/healthcare2020
HFMA’s Approach to the New Era of Health Care
Promoting Collaboration

"HFMA is uniquely positioned in this new era. Because we represent the finance perspective and aren’t limited to representing people who work in certain settings or have particular credentials, we can build coalitions and convene groups from across the industry to work on solutions. Our members have an opportunity to reach out to stakeholders in all three circles of health care—hospitals, health plans, and physicians—to share the finance perspective and to learn more about other perspectives."

— Joseph J. Fifer, FHFMA, CPA
President and CEO, HFMA
Opening Membership to Organizations

Now, organizations can offer HFMA benefits and resources to all of their employees and physicians.

hfma.org/enterprise

What It Means for Current HFMA Members

• Your individual membership and benefits will not change
• You will have common ground and shared experiences with a wider range of people
• You will have new opportunities to collaborate with the three circles
Listening to Our Members

Through our new Voice of the Customer Team—and our Voice to Value program—we are looking for ways to:

- Leverage best practices of other associations
- Understand the different needs and interests of different groups within our membership
- Build on and expand our current feedback mechanisms
Staying on Top of Innovation in the Field
How You Can Help: Introduce Your Physician Colleagues to HFMA

- Special discounted membership pricing for physicians and those who work in physician groups: Only $150 with use of code PHY2017 for membership through May 2018.

- Invite physician colleagues to attend ANI to enjoy a curated conference experience.
  
  hfma.org/ani/physicians

- Sign up for *Physician Business Adviser*, a free e-newsletter, & forward it to your physician colleagues so they can subscribe too.
  
  hfma.org/physician/blog

- Suggest that physicians check out HFMA’s webinars on topics of interest to them, such as MACRA
  
  hfma.org/webinars
How You Can Help: Welcome Your Health Plan Colleagues to the HFMA Community

Special discounted membership pricing for health plans: Only $150 with use of code HP2017 for membership through May 2018.

Invite health plan colleagues to attend ANI to enjoy a curated conference experience.
hfma.org/ani/healthplan

Suggest that health plan colleagues attend other educational events such as the National Payment Innovation Summit, which is focused on innovative payment models and provider/plan collaboration.

Share HFMA reports focused on industry collaboration to deliver greater value to patients while ensuring financial sustainability for organizations.
The New ANI 2017

Register by May 5
Save $100

@hfmaorg Twitter Feed

Does bundle delay signal the end of mandatory models? Carter Paine, COO, shares his thoughts via @hfmaorg ow.ly/CHyo30aoQam

RT @hfmaorg: What's new at #HFMA2017ANI? Attendee Choice Sessions, new networking events, & more. Register by 5/5, save $100. https://t.co/...

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Keynote Presentations

Joe Scarborough And Mika Brzezinski

Joe and Mika from MSNBC’s Morning Joe will share their thoughts on how working collaboratively and inclusively will serve you, your organization, and the industry as a whole. Learn more.

Session Spotlights

Using Data to Improve Patient Outcomes

Harlan Krumholz, MD will share his experience using data from EHRs and claims to improve care delivery. His approach focuses on “asking” the right questions and choosing measurable metrics that will illuminate operational improvements that result in better clinical outcomes at a lower total cost of care.

More information >
Progress always involves risk.
You can’t steal second base by keeping one foot on first.

Frederick B. Wilson