HIMSS New York State

Health Reform and I.T.

November 16, 2016

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Retired CIO & HIT Advisor

AGENDA

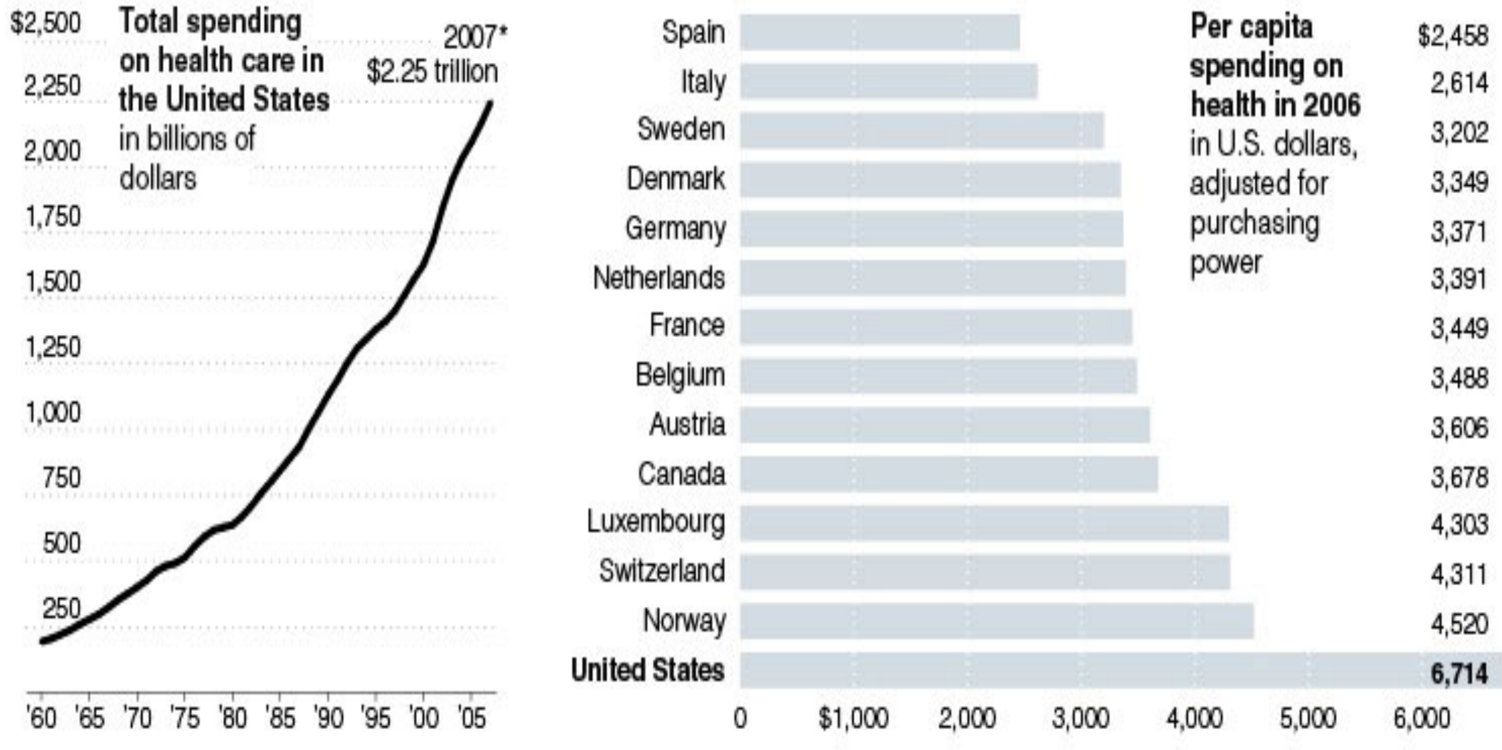
- Is Fee-for-Value a passing fad or here to stay?
- Why is Health Reform so difficult?
- Where should IT be focusing our efforts?

My background . .

- Upstate New York farm kid
- Young adult experiences: tire changer, credit manager, Navy electronics technician
- 40 years in healthcare
  - 10 years in finance, 5 as a hospital CFO
  - 30+ years in IT, 18 as CIO
- Sharp HealthCare (San Diego) 35 years
  - Regional integrated delivery network since 1980's
  - **Progressive payment 'reform' model**
    - **Capitation**, **bundled pricing** . . .
    - **Provider-owned health plan since 1991**
  - Broad apps portfolio: Cerner, Allscripts, GE, Fuji, Lawson, EPSI . . . .
  - Enterprise master patient index since 1991
  - Robust integration strategy: CCOW, SSO, Data warehouse, Enterprise HIE. . .
  - Most Wired for 14 of 16 years
  - 2007 Malcolm Baldrige award
  - 2009 John E Gall Jr CIO of the Year
  - 2013 CHIME Public Policy Award

Spending Far More on Health Care

Medical spending in the United States has continued to soar, reaching an estimated $2.25 trillion in 2007. The nation now spends 50 percent more on health care per capita than the next closest industrialized country, often with no better outcomes for patients. One reason is overuse of medical technology.



**2007 data are available only as an estimate.*

Sources: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services; Organization for Economic Cooperation and Development

THE NEW YORK TIMES

Bill Clinton: U.S. Healthcare costs too much!

- 2009 – paraphrased:
  - Healthcare costs factored into the prices of goods and services produced by the U.S. represents a $900 billion competitive disadvantage in the global marketplace annually.

Commonwealth Fund 2014: U.S. still spends the most, with the poorest results.

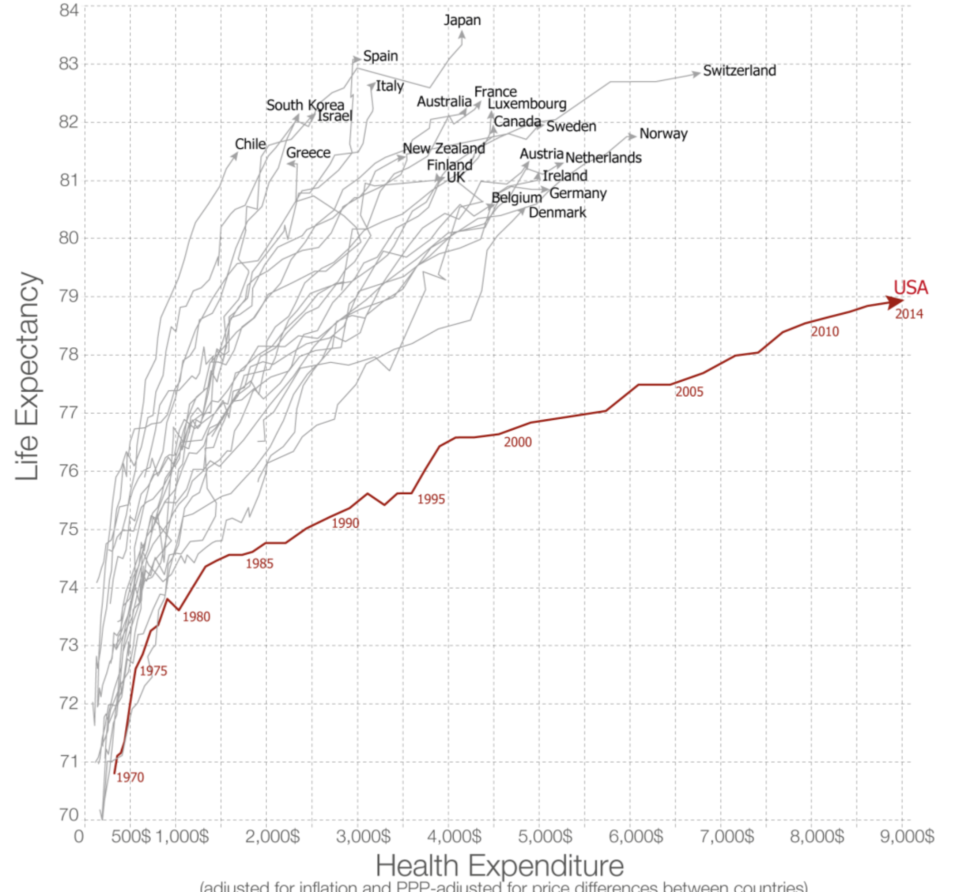
EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

- Top 2*
- Middle
- Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).



Life expectancy vs. health expenditure over time (1970-2014)
Our World in Data
Health spending measures the consumption of health care goods and services, including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments. Shown is total health expenditure (financed by public and private sources).
Life Expectancy
Health Expenditure
(adjusted for inflation and PPP-adjusted for price differences between countries)
84
83
82
81
80
79
78
77
76
75
74
73
72
71
70
0
500$
1,000$
2,000$
3,000$
4,000$
5,000$
6,000$
7,000$
8,000$
9,000$
Japan
Spain
Italy
South Korea
Israel
Chile
Greece
Australia
France
Luxembourg
Canada
Sweden
Switzerland
Norway
New Zealand
Finland
UK
Austria
Netherlands
Ireland
Germany
Belgium
Denmark
USA
1970
1975
1980
1985
1990
1995
2000
2005
2010
2014
Data source: Health expenditure from the OECD; Life expectancy from the World Bank
Licensed under CC-BY-SA by the author Max Roser.
The interactive data visualization is available at OurWorldinData.org. There you find the raw data and more visualizations on this topic.

This didn't just happen overnight . . .

- 1932: Blue Cross and Blue Shield Insurance
- 1946: Hill-Burton Act
- 1965: Medicare Act (& Medicaid)
- 1970's: Efforts to slow the growth in Medicare/Medicaid spending
  - Routine cost limitations, Lower of cost and charges, State rate-setting, etc
- 1973: Health Maintenance Organization Act
- 1982: Diagnosis-Related Groups (DRG)
- Mid-80's – 2000+-: Managed Care
- 1996: Health Insurance Portability and Accountability Act (HIPAA)
- 2009: HITECH Act: Government funding & regulation of EHR's
- 2010: Health Care Reform: Patient Protection & Affordable Care Act (ACA)
  - MSSP, Pioneer ACO, Bundled payment initiatives . .
  - Readmission penalties

Today: Accelerated, Unprecedented Change & Regulation

Healthcare Timeline: Policy to Reality

1900-1929 – Public Health
- Focus on building hospitals & formalizing medical education
- Ensuring public health (safety of water supply, sanitation, etc.)

1930-1940 – Depression Era
- Committee on the Costs of Medical Care (CCMC) reports on the unfairness in the distribution and costs of private medical care, recommends greater governmental role, HMOs
- Blue Cross and Blue Shield plans formed

1940-1950 – WWII Era
- Expansion in employee health benefits
- Expectations for timeliness and appropriateness of care
- Hill-Burton Act passed to bolster nation's hospital system
- Dramatic post-WWII "baby boom"

1965 – Medicare & Medicaid
- Begins government financed healthcare
- Declining physician policy and organizational influence
- Advent of administrative/financial experts to control hospitals

1970s – Health Maintenance Organizations (HMOs)
- Health Maintenance Organization Act of 1973
- Too sophisticated for data, aggregation, expertise

1980s – Diagnosis Related Groups (DRGs)
- Related payment to outcomes
- Introduced need for clinical & financial data systems & governmental demands for outcomes, quality measures, etc.

1990s – Insurance Company Consolidation
- The hundreds of health plans created in '80s forces incumbent insurers to consolidate to reduce costs
- Publicly traded
- Increased bureaucracy

1990s – Hospital Consolidation
- Reduction in inpatient demand leaves hospitals with excess capacity forcing wave of consolidation
- 5,000 to 100
- Increased capital, talent, vision, corporate organization

2000s – Healthcare Reform
- Accelerate government influence
- Politicize healthcare delivery vs. politicize spending of dollars

1900 - 1930 | 1930 - 1940 | 1940 - 1950 | 1950 - 1960 | 1960 - 1970 | 1970 - 1980 | 1990 - 2000 | 2000 - 2010

2010
- RAC expansion
- Healthcare workforce initiatives
- Medicaid expansion #1
- Patient Centered Outcomes Research Institute
- HHS quality measure infrastructure development
- Rebates for Part D donut hole
- Initial Medicare reductions
- Insurance plan design reforms #1
- Establishes temporary high-risk pool

2011
- Medicaid paymnt adjust for HACs
- Medicaid patient health home plan
- Federal health care quality website established
- Pharma manufacturer fee begins
- MA payment reductions begin
- Community Care Transition & community based service projects begin
- Center for Medicare & Medicaid Innovation
- Investments in public health & primary care

2012
- Medicare full productivity adjustments
- Medicaid bundled payment pilots (8 states)
- Hospital readmission reduction programs
- Hospital value based purchase program start
- ACO incentive programs begin

2013
- Medical device manufacturer fee begins
- FSA limitations begin ($2500)
- Hospital payment bundling pilot
- Medicaid primary care rate match

2014
- DSH payment reductions begin
- Quality reporting programs for ASC, LTC, rehab, psych & cancer ctrs.
- Medicaid expansion #2
- Employer & individual mandates
- Health insurance exchanges begin
- Health insurance regs reforms

2015
- Medicare payment adjust for HACs
- PQRI penalties begin
- Physician value-based purchase program
- Independent Payment Advisory Board

2016
- State demo programs for tort reform
- DMEPOS Round 2 expansion
- Value-based purchasing for post-acute

2017
- States to allow large group coverage in exchanges

2018
- Excise taxes on high-cost insurance plans

2019
- HHS launches physician comparison website

1900 - 2010 | **2010- 2019**

Pioneers in the Evolution towards ACO's

- Health Maintenance Organizations, Managed Competition:
  - Sidney Garfield, MD, CA Metropolitan Water Authority, 1933 and Kaiser Permanente, 1942
  - Paul Elwood, MD, Jackson Hole Group, 1970
  - Alain Enthoven, PhD, Stanford University
- Accountable Care Organization
  - Elliott Fisher, MD, Dartmouth Institute for Health Policy and Clinical Practice
- Affordable Care Act (Obamacare)
  - Ezekiel Emanuel, MD, Obama advisor,

HBR.ORG

Harvard Business Review

OCTOBER 2013
REPRINT R1310B

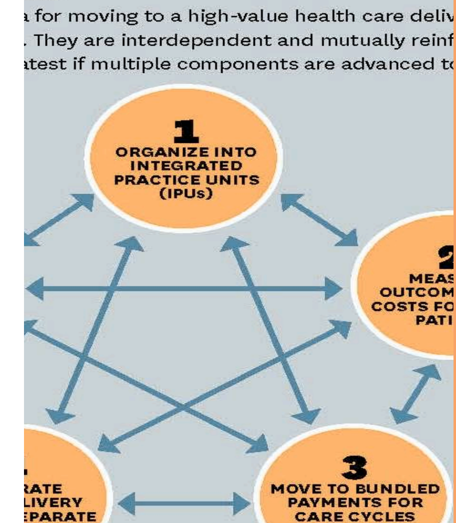
Michael Porter

THE BIG IDEA

The Strategy That Will Fix Health Care

Providers must lead the way in making value the overarching goal ***by Michael E. Porter and Thomas H. Lee***

"Unfortunately, most multisite organizations are not true delivery systems, at least thus far, but loose confederations of largely stand-alone units that often duplicate services."



Harvard Business Review

REPRINT R1607G
PUBLISHED IN HBR JULY–AUGUST 2016

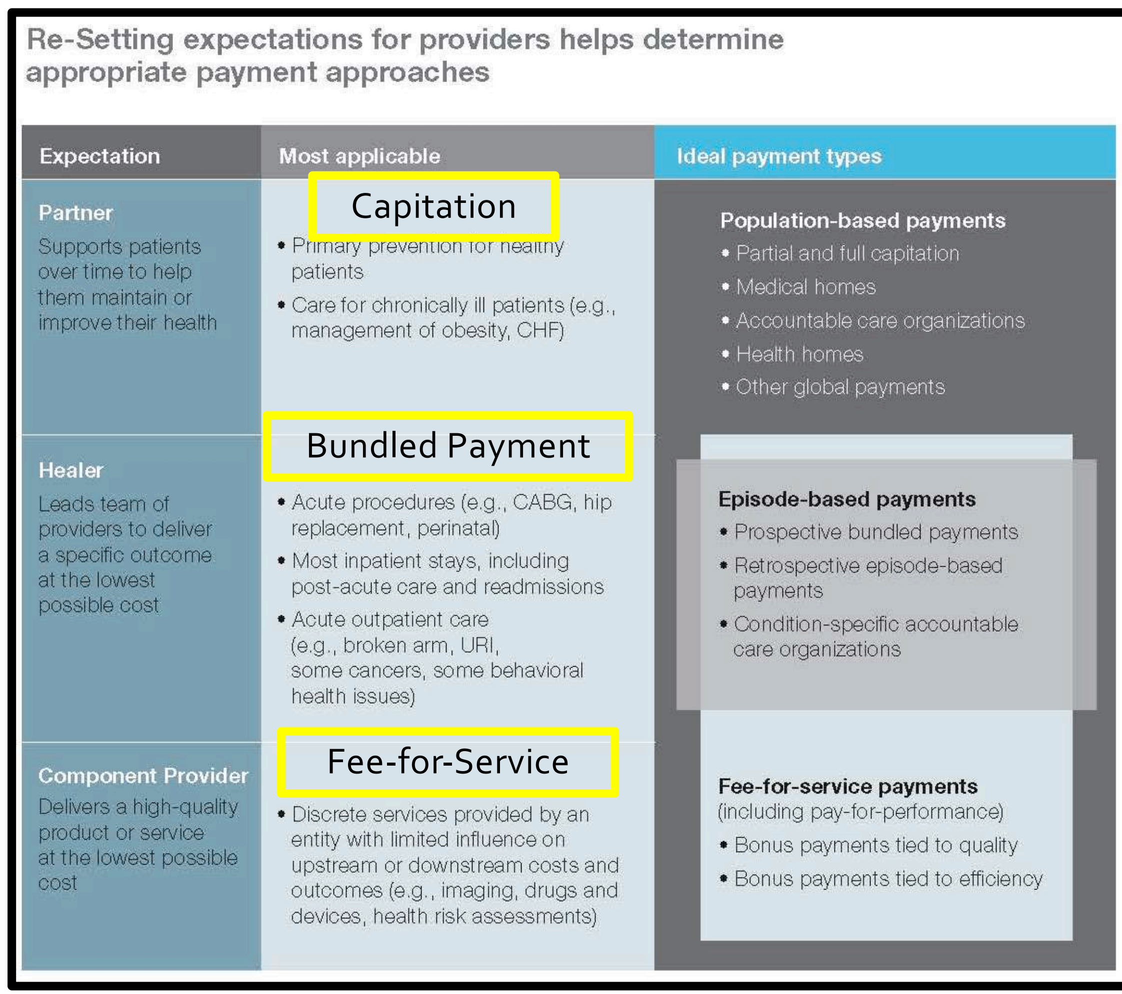
ARTICLE
HEALTH CARE

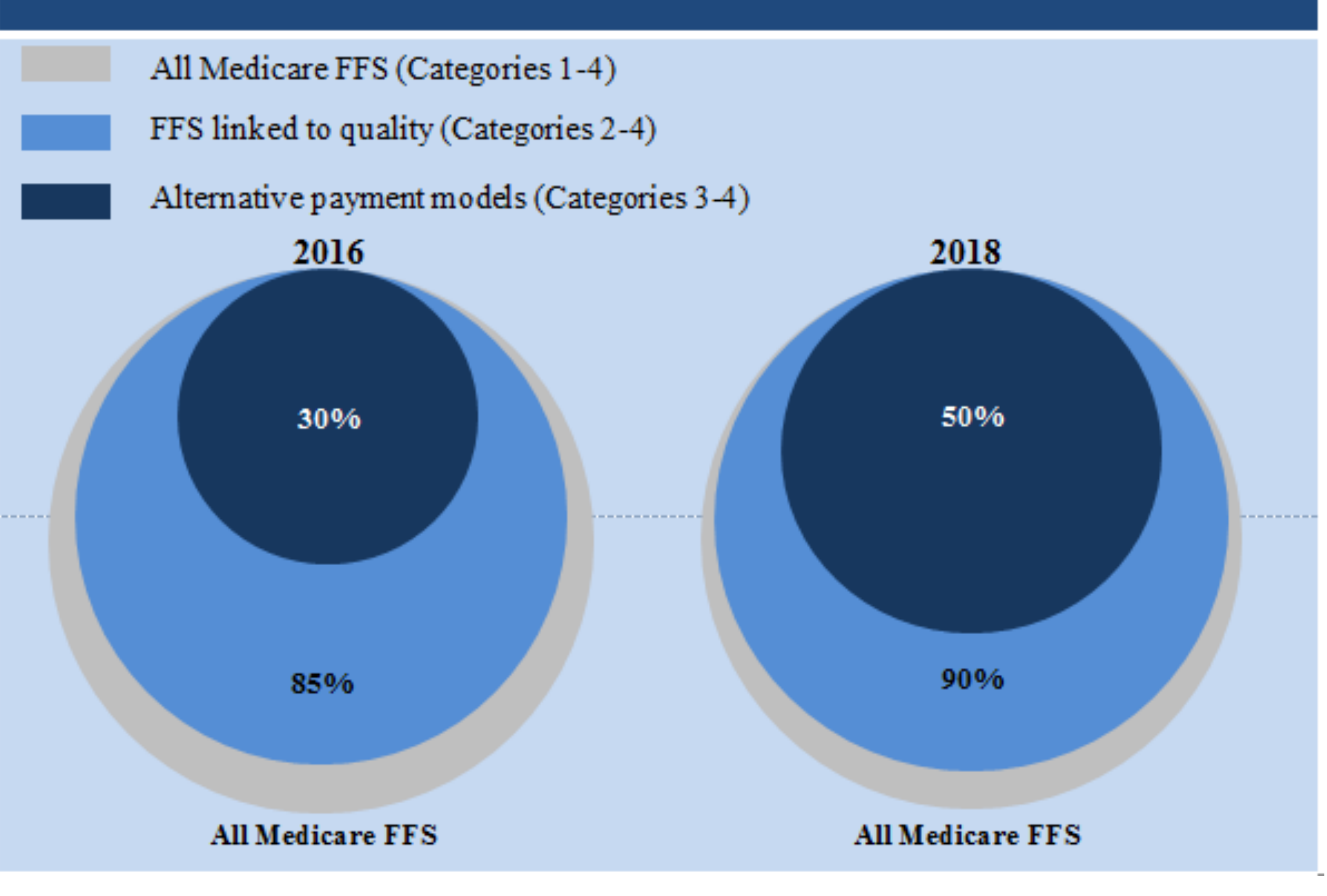
How to Pay for Health Care

Bundled payments will finally unleash the competition that patients want.

by Michael E. Porter and Robert S. Kaplan

McKinsey: 50% Outcomes-based payments by 2018 will save a Trillion Dollars




Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018
All Medicare FFS (Categories 1-4)
FFS linked to quality (Categories 2-4)
Alternative payment models (Categories 3-4)
2016
30%
85%
All Medicare FFS
2018
50%
90%
All Medicare FFS

Continuum of Medicare Risk Models

Mandatory		Optional		
Pay-for-Performance	**Bundled Payments**	**Shared Savings**	**Shared Risk**	**Full Risk**
• Hospital VBP Program • Hospital Readmissions Reduction Program • HAC Reduction Program • Merit-Based Incentive Payment System	• Bundled Payments for Care Improvement Initiative (BPCI)	• MSSP Track 1 (50% sharing)	• MSSP Track 2 (60% sharing) • MSSP Track 3 (up to 75% sharing) • Next-Generation ACO (80-85% sharing)	• Next-Generation ACO (optional full performance risk) • Medicare Advantage (provider-sponsored)

Increasing Financial Risk →

Comprehensive Primary Care Plus

Source: Health Care Advisory Board interviews and analysis.

Medicare ACO's – Early Results

Mixed results in 2015

- $466 million total savings
- Only 125 of 400 met savings and quality targets to earn bonus dollars
- Nearly ½ produced no savings at all
- 2015 ACO performance improved over 2014

Pioneer ACO's

- Down to 12 from 32 in 2012
- 8 of 12 generated $37 million savings, 6 earning shared savings bonus dollars
- 1 of the 4 losing ACO's owed shared savings loses

CMS paints an optimistic picture!

Commercial Health Plans are quite Active

- Aetna
  - 275 ACO agreements
  - Targeting 50% value-based by 2018
- United Healthcare
  - 800 +- ACO agreements
  - Recently announced nationwide ACO, targeting 15 markets in 2017
- Many others. . .

30 Large ACO's (enrollees)

ACO	Enrollees
Banner	460,000
Advacate Physician Partners	423,350
Ochsner Accountable Care Network	420,244
Unity Point Health	340,000
University Hospitals ACO	300,800
Partners Healthcare	245,000
MissionPoint Health Partners	233,310
Integrated Health Network of Wisconsin	215,000
MaineHealth ACO	178,000
NEQCA Accountable Care	170,000
Memorial Hermann ACO	140,911
Delaware Valley ACO	128,510
FamilyCare Health	125,000
University Hospitals Coordinated Care Organization	121,100
NYUPN Clinically Integrated Network	118,000
OneCare Vermont ACO	112,958
Rochester General Health System ACO	110,000
Physician Organization of Michigan ACO	104,508
Bronson Battle Creek Health System	100,000
UC Health	100,000
Henry Ford Physician Network	93,000
Allegheny Health Network	90,000
Heritage Pioneer ACO	90,000
Texas Health Resources	88,000
Palo Alto Medical Foundation	84,000
Triad HealthCare Network	81,000
Wilmington Health	80,000
Atlantic ACO	74,000
ACO of Texas	70,000
Franciscan Alliance ACO	60,000

What's your ACO ? - Important Success Factors

Ownership incentives. .

- **All**: Quality care, patient satisfaction
- **Hospitals**: Control via investment capital, employed MDs, full beds
- **Physicians**: Income, reduced hospitalization, patient loyalty
- **Insurers**: Market share, total cost per capita

Culture of collaboration, or not . . Culture vs strategy

- Clinically integrated networks
- Patient-centered medical homes

Balance: People, Process, Technology

- Care navigators or computers or both?

Effectiveness in engaging patient with primary care physician

Risk arrangement

Misleading Success Factor – the **Baseline**

- How much room for improvement exists? (Hard to quantify!)

Why is Health Reform so difficult?

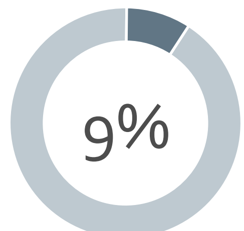
- Historical lack of collaboration
- Culture and complexity
- Difficulty in achieving common comparative benchmarks
  - Quality/outcome measures
  - Data standards
  - Evidence-based medicine
- Strong industry lobbying efforts diluting reform measures
  - AHA, AMA, AHIP, Premier, Pharma, Device manufacturers, HIMSS, CHIME, etc.
- Challenges of patient engagement and accountability
- Accepted view of an absolute requirement for enabling technology

Primary Care is fundamental to most ACO's, yet Most Patients Are Not Loyal to PCP

Percent of Consumers Highly Loyal in Each of Three Loyalty Measures

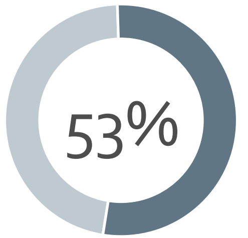
If your primary care moved to another clinic or practice, how likely are you to **follow** him/her to another clinic or practice?

(On a scale of 0 to 10, with 0 being "definitely would not follow" and 10 being "definitely follow")



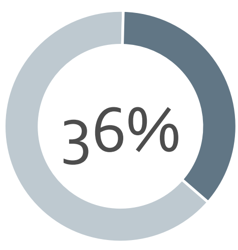
How likely are you to **stay** with your primary care physician over the next 12 months?

(On a scale of 0 to 10, with 0 being "definitely not staying" and 10 being "definitely staying")



How likely are you to **recommend** your primary care physician to friends or family members?

(On a scale of 0 to 10, with 0 being "not at all likely" and 10 being "extremely likely")



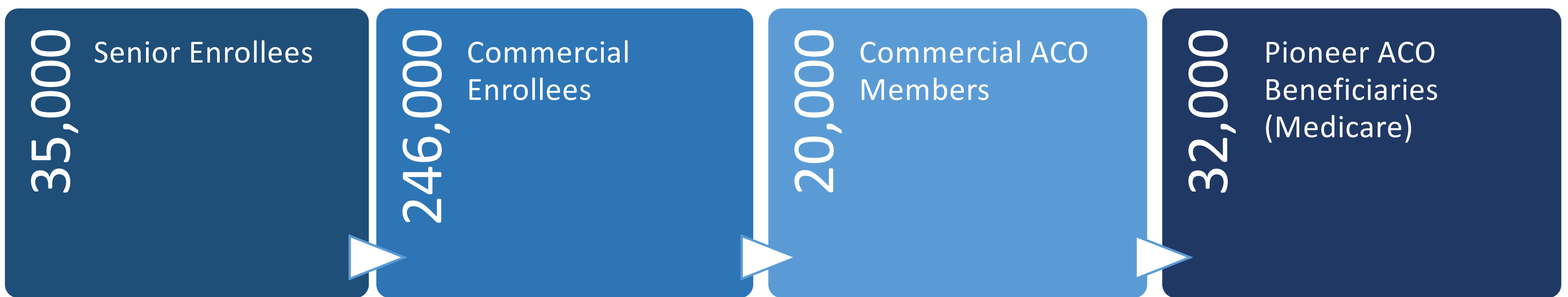
Source: 2015 Primary Care Physician Consumer Loyalty Survey, Market Innovation Center interviews and analysis.

Population Health – Where do I start?
How do I define the population?

- The community at large
- The patients I serve
- The patients I am at risk for – eg ACO or Bundled Payment patients
- My employees
- I'm thinking about starting with my employees
- I'm just thinking about it!
- There will never be managed care in my town!
- Some combination of the above
- Beats me!

Sharp HealthCare Population Health Journey *

30years of experience in managing care under population-based payment structures



Patient Enrollment (voluntary) ....
Narrow Network ....
Capitated Payment ....
Data-sharing among providers ....

Patient Assignment (attribution)
Open Network
Fee-for-service, with incentives
Data-sharing optional

* 2014 data

Sharp - 2016

Terminated the Pioneer ACO agreement in 2015, seeing little upside benefit and challenging hospital reimbursement

3 commercial ACO agreements in place

- Varied models – if you've seen one ACO, you've seen one ACO!
- Some benefit to the medical groups, with care management fees in some agreements
- Marginal benefit to the hospitals

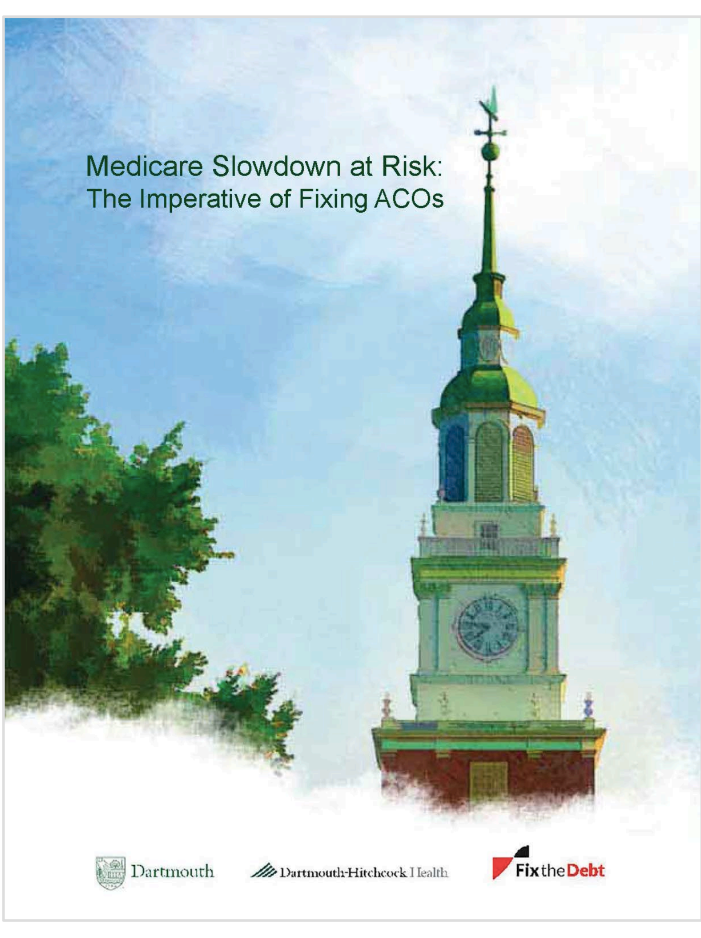
Approved as Next Generation ACO for 2017

Sharp Health Plan 'Covered California' product progressing, with 30,000 enrollees among 130,000 total insured lives

Prefers the capitated model

Dartmouth Summit on Medicare Reform

Elliott Fisher, MD et al, Feb. 2015



Strategies for greater ACO Success

- Improved financial model
  - More upfront savings go to providers
  - Incentives for low-cost providers to participate
- Stronger patient engagement
  - Beneficiary selection of ACO
  - Incentives to seek care within ACO network
  - Restrictions on non-ACO services

Questions for the new administration. .

- Will Medicare ACO's continue?
- What other forms may value-based purchasing take?
- How will you change Obamacare?
  - The Dems can still filibuster in the Senate so a total repeal is unlikely!
- Will Medicare Advantage grow/shrink/stay the same?
- Block grants to states for Medicaid?
  - What is the future of DSRIP?
- At what level will you fund the Office of the National Coordinator (ONC)?
- Who is Andrew Bremberg?
- How will my job be affected?

Trump View per Paul Keckley: “Let the markets work!”

- Rapid repeal, slow and complicated replacement
- Regulation and funding shifted to states over coming 18 months
- Alternate payment programs continue with different economics
- More permissive regulation enables continued insurer and provider consolidation
- Cost squeeze continues, with healthcare growing at 6%, with GDP increasing max 3 ½%
  - How to reduce cost over time?
- Bigger role for employers, all wanting to be 2nd to drop employee coverage
- While hospitals increase MD hiring, 3 private equity firms are investing in MD groups
- ACO’s have not saved money, Bundles have!
- Capital markets will be cautious
- MACRA and MU, not part of ACA, will continue

Priority I.T. Requirements for ACO's

Master Person Index - Registry

- Methodology for effective **patient identification**

Population Health/ Analytics

- Evaluate all aspects of quality, access and cost of care

E.H.R.

Patient Portal

- Advance patient engagement, "stickiness"

Health Information Exchange

- Complete record view across all providers
- **Collaboration vs Competition ??**

Case/Care Management

Revenue Cycle – Risk Management

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ACO-in-a-Box ??

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Revenue Cycle – Risk Management

Unprecedented Change

"When the winds of change blow, some people build walls and others build windmills."

Chinese Proverb