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UNDER HEALTH CARE REFORM

The Value Mandate: What It Means
for Your Organization and How to Deliver It

a white paper by Veralon



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Despite eight consecutive year-over-year declines in the rate of spending growth, the United States spends more on health care than any other country in the world, both on a per capita basis and as a percent of gross domestic product (GDP). According to data compiled by the Organization for Economic Co-operation and Development (OECD), health care expenditures in the United States were 2 ½ times higher than in other developed nations in 2009 (OECD 2012). After adjusting for differences in per capita income between countries, the McKinsey Center for U.S. Health System Reform concluded that in 2009, 23 percent of total spending in the United States was above expected levels (Bradford et al. 2011).

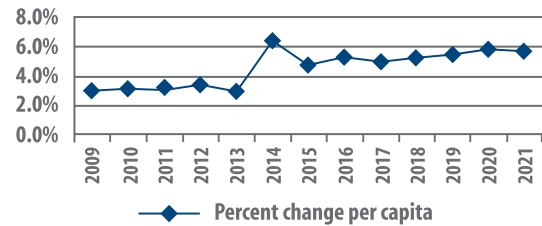
National health expenditures grew much less slowly during and immediately following the recent recession, with 2009-2011 per capita national health spending growing about 3 percent annually compared to the average of 5.9 percent annually during the previous decade. Debates are now underway regarding the temporary or permanent nature of the spending slowdown (Cutler and Sahni 2013). Some health care experts predict that the slowdown is temporary, driven by lost insurance coverage and incomes during the recession, while others have argued that we are seeing the impact of structural changes that will continue to slow spending growth in the future.

While the slowdown, either as a temporary or more permanent trend, is welcome news, passage of the Affordable Care Act (ACA) will create additional upward pressure on health care expenditures in the next few years because of two key components of the legislation:

1. The individual mandate that requires most Americans to have health insurance or pay a financial penalty
2. The extension of Medicaid eligibility to all citizens with incomes up to 133 percent of the poverty level

The anticipated effects of the ACA on health care spending can be seen in the most recent national health expenditure projections released by the Centers for Medicare & Medicaid Services' Office of the Actuary in January 2012, which shows a 6.4% increase in per capita national health expenditures in 2014, followed by annual increases ranging from 4.7 percent to 5.8 percent every year thereafter.

Annual Percent Increase Per Capita Health Care Spending



Note: 2009-2011 actual, 2012-2021 projected
Source: Centers for Medicare & Medicaid Services, Office of the Actuary

The resulting expansion of Medicaid and the concurrent creation of state-administered exchanges will make it less expensive for individuals and small businesses to purchase health insurance and are expected to reduce the number of uninsured Americans from 50 million to 18 million persons. Because the uninsured receive, on average, about half the care of the insured population, adding 32 million people to the insurance rolls could create a 5+ percent surge in the demand for health care services.

Growing Pressure to Demonstrate Value

While health care providers will benefit from the increased demand that accompanies the expansion of insurance coverage, growing pressure to lower national health care expenditures will require hospitals and health systems to be more vigilant than ever to ensure that care is provided in the most efficient manner in the most cost-effective settings. The implications for health care providers are layered with complexities and uncertainties as decisions are made about how to transform health care delivery and navigate the financial challenges posed by the post-reform era. Simply put, the new mantra for health care providers is to deliver value, meaning that quality and outcomes must be improved while per capita health care costs are lowered.

The Value Mandate Improve outcomes while lowering total health care costs



The Challenge of Delivering Value: Three Keys to Success

#1 - Eliminate Unnecessary Services

Significantly lowering the utilization of high-cost, discretionary, often unnecessary services, many attributable to the practice of defensive medicine, is one key to solving the value equation. A major shift away from fee-for-service payment for individual services toward bundled payments to multiple providers for a specific care episode or a specified period of time (e.g., 30 days; a year) will help make this happen.

#2 – Better Manage Chronic Diseases

Chronic diseases such as heart disease, stroke, cancer and diabetes account for about 75 percent of national expenditures on health care according to data from the Centers for Disease Control and Prevention (CDC 2009). Better management of chronic diseases and conditions will result in fewer emergency room visits, fewer hospital admissions (and readmissions), and improved health status. A comprehensive study of the direct and indirect cost of seven of the most common chronic diseases, published by the Milken Institute, included an optimistic scenario (characterized by “reasonable improvements in health-related behavior and treatment”) that would reduce treatment costs for these seven diseases by \$217 billion in 2023, and total costs (including lost productivity) by \$1.1 trillion (DeVol and Bedroussian 2007).

#3 – Improve Coordination of Care

Changes in care delivery patterns, including a focus on population health management, will require providers to deliver coordinated, multidisciplinary, patient-centered care across a broad spectrum of services and settings. This new approach to patient care will require true clinical integration, timely information sharing, and shared accountability for both quality and cost management. Few providers have the information and management systems in place to do this well.

Three Keys to Successfully Delivering Value Under Health Care Reform




Let's further examine these three keys to successful delivery of value under health care reform.

Eliminate Unnecessary Services

Experts have estimated that unnecessary, ineffective, and sometimes harmful care accounts for up to one third of health care costs in the United States. Expensive diagnostic tests and procedures of limited value to the patient, avoidable hospitalizations, and care provided in the last six months of life are leading examples. Several factors contribute to unnecessary utilization: defensive medicine to protect against malpractice lawsuits, poor management of chronic conditions, and the prevailing fee-for-service payment system that rewards providers for the quantity, not the quality, of the services they deliver.

A surprising acknowledgement by a broad spectrum of physicians that overutilization is a widespread problem, but one easily addressed by altering treatment standards, occurred on April 4, 2012 when nine medical specialty boards recommended that 45 common tests and procedures (five in each specialty) be performed less often.



The recommendations, stemming from the Choosing Wisely campaign conducted under the auspices of the ABIM Foundation, included less frequent use of antibiotics for sinusitis, imaging for low back pain, screening colonoscopies, cardiac screening tests for asymptomatic low-risk patients, and CT scans for several different conditions (ABIM 2012).

Although some physicians and consumer advocates expressed concern that applying the Choosing Wisely guidelines too broadly could result in undertreatment of patients, the prevailing view is that the specialty societies deserve praise for taking the lead to identify tests and procedures that provide little benefit at considerable cost. “Overuse is one of the most serious crises in American medicine,” a recent *New York Times* article quoted Dr. Lawrence Smith, physician-in-chief at North Shore-LIJ Health System and dean of the Hofstra North Shore-LIJ School of Medicine, who described the recommendations as a “very powerful message” (Rabin 2012).

Two other studies published in 2012 provide additional evidence that expensive procedures are performed far more often than medically necessary. A study presented at the annual meeting of the American Academy of Orthopaedic Surgeons estimated that the practice of defensive medicine by orthopedic surgeons led to \$2 billion in unnecessary spending per year, with 24 percent of tests ordered defensively (Sethi et al. 2012). A study of non-emergency angioplasties performed in hospitals in New York State in late 2009 and 2010 concluded that the procedure was inappropriate for 14 percent of the patients and fell into the uncertain category for 50 percent of the patients (Hannan et al. 2012).


Medical leaders and management teams at several prominent hospitals and health systems have also taken aggressive action to eliminate unnecessary care and curtail unnecessary spending according to another recent *New York Times* article. Successes reported by Virginia Mason Medical Center in Seattle included reducing CT scans for sinus conditions by 27 percent and reducing MRIs for headaches by 23 percent by requiring physicians to use a computerized check list of medical circumstances to justify that those tests were needed, and collaborating with Starbucks and Aetna to find less costly ways to treat Starbucks’ employees with uncomplicated back pain (*New York Times* 2012).

Physician leaders and management executives should view these studies as evidence that health care providers can be better stewards of limited health care resources. And while there will be continued efforts to further reduce the unit cost of care, many of those gains have already been realized. Instead, far greater returns can be achieved by reducing the services provided per episode of care, and by coordinating care across the continuum of services, so that care is provided in the least costly manner and in the least costly settings.

Better Manage Chronic Diseases and Conditions

The potential payoff of simple interventions with respect to chronic diseases and conditions is enormous. The profound influence of one initiative, greater adherence to diabetes medications, was reported in a recent issue of *Health Affairs*. Using retrospective data from the information warehouse of a large pharmacy management firm, the authors of the study found that improved adherence to diabetes medications was associated with 13 percent lower odds of subsequent hospitalizations or emergency department visits, with potential cost savings of \$4.7 billion on a national scale (Jhal et al. 2012).

A recent federal health analysis by the CDC demonstrates that the care of chronic care patients should not default into a discussion of the insured versus non-insured or under-insured. The study found that 36 million adults in the United States have high blood pressure that is not being controlled even though 32 million of them get regular medical care and 30 million of them have health insurance (CDC 2012). Without systems in place to provide care and education to patients who could benefit from intervention but fall through the cracks, even at highly respected institutions, patients suffer medical harm and the sizable costs of their care are added unnecessarily to national health care expenditures.



What complicates efforts to manage chronic diseases and conditions more effectively is that many of the critical interventions -- disease monitoring (e.g., checking blood sugar or blood pressure levels), assuring adherence to and/or adjusting medications, and providing advice on lifestyle changes -- need to occur on a regular basis between doctor visits. Instead, far too often, critical interventions occur intermittently, between episodes of emergency room or inpatient hospital care, or not at all.

Research and evidence from clinicians in the field now indicate that chronically ill patients are best cared for by primary care physician-led teams that maintain frequent contact with patients where they live (or in group settings) and provide the support and surveillance services needed to prevent or significantly reduce acute flare-ups. Translating the theory into practice remains a challenge. The American College of Physicians has indicated that meeting the complex needs of patients with chronic illness or impairment is the single greatest challenge facing organized medical practices (American College of Physicians 2013). Chronic disease patients need planned regular contact with caregivers who focus on function, prevention of complications, and supporting the patient's role in self care. Primary care practices, which provide access to care for patients with acute and varied problems, with a focus on short appointments, diagnosis and treatment of symptoms, brief patient education, and follow-up that is initiated by the patient, are not designed to meet the needs of chronically ill patients.

Acute care organizations have not excelled at providing this level of support to chronically ill patients either. However, large integrated delivery systems (IDSs) such as Kaiser Permanente or Geisinger Health System, which can easily share patient information and coordinate care among multiple physician and non-physician providers, adhere to internally developed practice guidelines, and have the financial incentive (by virtue of their insurance products) to provide needed care, and only needed care, in the most cost-effective manner are leading change in chronic care management in their markets.


In theory, accountable care organizations (ACOs), networks of providers accountable for both the quality and the cost of the care they provide to Medicare beneficiaries they are responsible for, will function as integrated delivery systems. In reality, while ACOs are likely to improve quality (as measured by adherence to care processes), the fact that Medicare patients will be allowed to see any Medicare provider, either inside or outside the ACO accountable for their care, will challenge ACOs to deliver care that resembles the coordinated, cost-effective care provided within Kaiser, Geisinger, or any other well-developed IDSs today.

Improve Coordination of Care

Eliminating unnecessary services and better managing the care provided to people with chronic diseases and conditions are essential cost-reduction strategies, but other opportunities and incentives are also emerging. The ACA promotes development of new payment models and creation of ACOs, which can share the cost savings they achieve for the Medicare beneficiaries they care for, subject to quality thresholds. Private insurance companies have begun to adopt similar pay-for-performance models that focus on coordinated care delivery and emphasize health outcomes.

Conceptually, ACOs offer great promise for both improving quality and lowering costs. Their focus on population health management, coordinated care, a greater role for primary care physicians and physician extenders, reliance on evidence-based medicine, alignment of financial incentives among providers, and the opportunity for shared savings all have the potential to positively affect both parts of the value equation.

An article in the November 2012 issue of *Health Affairs*, authored by Lawton Burns and Mark Pauly, health care management experts at the Wharton School of the University of Pennsylvania, suggests, however, that ACOs "may have difficulty avoiding the failures of integrated



delivery networks of the 1990s.” Burns and Pauly structure their analysis around a 2011 publication of the Brookings Institution that identifies several principles key to the success of both Medicare and private-sector ACOs. Burns and Pauly researched government, academic, medical, and health services literature in an attempt to determine whether and how each of the capabilities listed below affected cost and quality.

Burns and Pauly conclude: “The evidence ... suggests that components of accountable care organizations have limited and uncertain impact, especially on cost savings ... If the organizations increase ‘value’ (quality or outcome divided by cost), at best they raise the numerator but do not lower the denominator.” And while the Centers for Medicare & Medicaid Services want ACOs to assume both upside and downside risk within three years, Burns and Pauly’s research suggests that five to seven years is a more realistic window (Burns and Pauly 2012).

While the rate of change may be slower than desired, it seems clear that the prevailing fee-for-service payment system, which encourages overutilization of health services, will eventually give way to payment mechanisms that reward providers for managing the health of enrolled populations in a cost-effective manner. Coordinating care across a broad spectrum of services and settings will be essential to achieve the desired outcomes at lower cost.

Delivering The Value Mandate: Getting Started

Providers, insurers, and government organizations all agree that the nation must take aggressive action to cut health care expenditures, not just slow the rate of growth. Industry observers estimate that hospitals and health systems must reduce direct costs per case by as much as 25 percent as increases in expenses outpace the rate of revenue growth and as payor mixes shift. This revolutionary call to action demands more than the traditional cost-reduction initiatives such as supply chain management, capital spending freezes,

and reductions in force that many organizations have pursued numerous times. What is needed instead is a fundamental restructuring of the cost base via the redesign of care delivery and administrative processes.

To succeed in this value-based environment, health care organizations will need

A large, geographically distributed network of primary care physicians, supported by adequate numbers of advance practice clinicians, including nurse practitioners and physician assistants

Easily accessible, community-based ambulatory services, including medical and surgical specialist offices, diagnostic and treatment services, and preventive and rehabilitative services

A robust clinical information system that facilitates sharing timely, patient-specific clinical information among multiple providers, ranging from medical and surgical specialists to home health providers, with the primary care team at the hub

An organizational culture that values patient-centered, team-based care, with physician leadership that strongly advocates multidisciplinary care and actively supports an increased role for primary care providers as both caregivers and care coordinators

There is no doubt that the required organizational changes will be expensive and time consuming. The University of Pittsburgh Medical Center recently announced a five-year, \$100 million investment to create a sophisticated data warehouse that brings together clinical, financial, administrative, and genomic information to foster personalized medicine (UPMC 2012).

At the same time, first movers who get it right – who build the necessary infrastructure and create a culture that supports change – will thrive, broadening the population base they serve at the expense of competitors struggling to survive. The challenges are great. So are the opportunities for health care organizations with bold and visionary strategic plans that forge a path to new solutions.

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