MUTUAL CONCERNS

How clinical and financial interests increasingly are coming together in:

+ Price transparency efforts
+ Top-performing CINs
+ Physician-led ACOs

Vivian Lee, CEO of University of Utah Health Care, describes a cutting-edge effort to help clinicians truly understand the costs of care. Page 8

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COMING IN 2017: A CHANGE IN LEADERSHIP

Starting in January, Leadership will showcase an expanded library of free digital content to aid healthcare executives during a time of transformative change, while the magazine will be converted to a bimonthly newsletter with premium content for subscribers.

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AVAILABLE ONLINE

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A NEW FOCUS AND NEW RESOURCES FOR LEADERSHIP READERS

Daniel R. Verdon is vice president, Publications and Digital Assets, HFMA (dverdon@hfma.org).

Solving health care’s many business challenges will take the collective efforts of a community. While market leaders have noted the rapid change of traditional roles related to healthcare finance, clinical medicine, and health plans, the current economic reality means far greater collaboration is required to address some of the most vexing problems facing our industry.

The shift heading into 2017 is about alignment and experimentation related to trying and testing new business models or programs focused on lowering cost and improving care.

It is with this understanding that the Leadership publication and website will both be repositioned to better meet the changing needs of the industry. This will be the last edition of the magazine as you know it, but the Leadership brand will continue to produce a plethora of digital content to help build dialogue around solutions, and a print subscription newsletter will be launched in January 2017. (For subscription information, go to hfma.org/leadershipsubscribe.)

Here is a closer look at the many improvements in the works:

A DEEPER WELL OF ONLINE CONTENT
The Leadership website is building a rich repository of content to help the industry share ideas, highlight case studies, and collaborate on bold, innovative solutions that help industry leaders position health systems, health plans, and clinical programs to excel in a dynamically changing environment.

This web-first approach to publishing aims to offer readers pioneering, collaborative, and bold solutions from a diverse cross-section of market thought leaders. Leadership’s website (hfma.org/leadership) and a free monthly e-newsletter offer timely updates on health care’s transformation and feature projects that showcase innovation and ideas.

Leadership’s website will feature unique content and multimedia geared to bringing together healthcare finance professionals, clinical leaders, and health plan executives. The website will feature:
- Frequent, timely, and authoritative article posts
- Blogs from healthcare leaders
- Multimedia
- Free monthly e-newsletter content for a readership of 75,000

REDEFINING PRINT SOLUTIONS
Starting in January 2017, the print newsletter, distributed six times a year to an audience of healthcare executives, will offer subscribers enhanced insight regarding approaches for successfully navigating health care’s transition to value-based care, the introduction and use of technology, the need for unique collaborative approaches, population health management, and many other industrywide trends.

Some of the new feature stories/departments in development include:
- Healthcare Challenge Roundtable: A unique approach to discussing healthcare problems from leaders in healthcare finance, clinical medicine, and health plans
- Mergers and acquisitions: A recap of strategic moves in the market
- Consumerism: Coverage of this important trend that is reshaping healthcare business and delivery
- Transformative innovation: Health care’s adoption of technology and/or operational improvements to improve care and lower costs
- Regulatory/policy trends: An issues detailer to help executives understand the impact of policy decisions
- Expanded custom-publishing (sponsored) content

EXCITING TIMES FOR HEALTH CARE
The editorial staff is excited about our industry’s future, and we understand that it will take a community working together in thoughtful ways to flourish amid the many changes facing the business and delivery of health care. Leadership will continue to fill an important market role by connecting leaders on important industry issues that require strategic insight, experimentation, and a lot of dialogue on ways to help health care better serve patients. Experience the dialogue at hfma.org/leadership.
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BRINGING COSTS OUT OF THE DARK

Somewhere, a Millennial with a high-deductible health plan is searching online to find the highest-value imaging test in the community. Will your organization be ready when greater numbers of empowered patients “shop” for their care?

By Laura Ramos Hegwer

Healthcare organizations have been warned that a new breed of healthcare “shopper” will demand clearer information on the cost and quality of care. Although a large-scale shift in consumer behavior has yet to occur, some forward-thinking providers, health plans, states, and technology companies have flooded the market with a variety of transparency tools to make cost and quality data less opaque. While some initiatives may not prove to be long-term solutions, others may become important tools that empower consumers and providers to make educated decisions.

The time is right for these efforts, says Neel Shah, MD, MPP, founder and executive director, Costs of Care, Boston. “This is the least affordable that health care has been in the past half-century,” says Shah, who is also an assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School. “Because patients are increasingly in high-deductible health plans, even patients who are not traditionally considered underinsured could wind up spending thousands of dollars unexpectedly.” That is, if they can actually pay their portion of the bill—otherwise, hospitals face the prospect of an increase in bad debt.

Shah says the failure to educate patients on their costs at the point of care is inflicting financial harm on patients. “We don’t tell people what services cost, but equally often we don’t tell people if the care is worth it,” he says. “Occasionally, services are expensive and worth it. We may have multiple options to make the care more affordable, but we often don’t tell people about the alternatives until it is too late.”

Proponents of the transparency movement believe that by providing clearer data on costs and quality, they can ensure more judicious utilization of healthcare resources while educating both consumers and clinicians about what healthcare value truly is.

For additional resources in the effort to make healthcare pricing more transparent, visit hfma.org/transparency.
Vivian S. Lee, CEO of University of Utah Health Care, led the implementation of a tool that has helped the organization’s clinicians get a handle on healthcare costs. See page 8.
AN INTERVIEW WITH VIVIAN S. LEE

LEADING THE PUSH TO UNDERSTAND THE TRUE COST OF CARE

The researcher-turned-CEO discusses her organization’s cutting-edge strategies for engaging clinicians and consumers in the drive for better value.

By Laura Ramos Hegwer

Trained as a researcher, Vivian S. Lee, MD, PhD, MBA, the CEO of University of Utah Health Care (UUHC) in Salt Lake City, tends to approach problems by asking questions. So when she joined the organization back in 2011, her strategy to bend the cost curve started with a simple question to her department chairs: Where is the costing tool to help providers understand costs at the patient-visit level? When no such resource was available, she led her organization’s efforts to create what is now called the value-driven outcomes (VDO) tool.

Leaders at UUHC had been bending the cost curve before rolling out the tool but recognized they could do even better. Today, UUHC has an annual growth rate in total facility expense per case mix index-adjusted discharge of -0.5 percent, compared with 2.9 percent for other academic medical centers.

UNDERSTANDING COSTS AT THE POINT OF CARE

The VDO tool analyzes labor, supplies, imaging, pharmacy, lab, and other services to understand costs at the patient-visit level. The tool even breaks down procedure costs to the amount of each supply and minutes of provider time spent on a procedure to reveal variation that can raise costs and have a negative impact on quality.

A recent study in the Journal of the American Medical Association found that the VDO tool helped cut costs by 10 percent among hip and knee replacement patients. Leaders also saw similar cost reductions with in-hospital lab testing after clinicians reduced unnecessary tests.1

Engaging clinicians with actionable data. “One of the biggest lessons that we have learned is just how powerful engagement of our physicians can be in helping us transform our healthcare delivery system,” says Lee, who is also senior vice president of University of Utah Health Sciences and dean of the School of Medicine.

After viewing the costing data from the VDO tool, most physicians want to understand the root causes of variability and are motivated to outperform their peers, Lee says. To help them achieve this goal, business professors at the David Eccles School of Business at the University of Utah have trained physician-led provider teams in Lean and other process improvement principles. Armed with training that is not typically offered in medical schools, physicians can develop evidence-based practices and clinical pathways aimed at improving quality while lowering costs, Lee says.

Creating a “perfect care” index. Lee and her team have engaged physicians and other clinicians to develop measures of quality called the “perfect care index,” a weighted average of several different criteria—some that affect payment and some that are simply measures of good care. Sample measures for joint replacement patients include 30-day readmission rate, early mobility rate, and emergency department visits within 90 days of discharge.

“By creating the perfect care index, we are able to have it both ways,” Lee says. “We are able to value and prioritize process measures, and we also are able to introduce some of our own metrics that the physicians feel are better predictors of good patient outcomes. The measures they choose are all evidence-based, so by enabling the physicians to help define what perfect care is, we get a lot more buy-in.”

To further achieve compliance with these measures, leaders incorporate some of the key metrics into the electronic health record (EHR) via pop-ups, reminders, and check-offs so they become part of routine care.
Targeting outpatient outcomes. To shed more light on cost and quality metrics in outpatient settings, leaders at UUHC are working with their employed primary care providers to develop costing tools for better population health management. “Where we have the greatest potential benefit in the future is in primary care,” Lee says. “We know the vast majority of dollars are spent on patients with chronic diseases, so putting a quality and costing tool into the hands of a primary care provider will be very valuable.”

BRINGING TRANSPARENCY TO THE PUBLIC
Another step toward transparency is helping patients understand the price of their healthcare services—specifically, what they need to pay out-of-pocket. This past August, UUHC launched an online tool that had been in development for two years. Consumers can select from among 100 common procedures; choose their type of insurance coverage (commercial, Medicare, Medicaid, or self-pay); and then enter specifics such as deductibles, copays, coinsurance, and out-of-pocket maximums. The tool provides users with their estimated financial responsibility and links to financial advocates and providers who offer the service requested.

“Putting prices online was a huge challenge because there is so much variability across the health plans,” Lee says. Another concern was creating misinformation for consumers based on their own potentially incomplete knowledge of their benefits. “We want to be as accurate as we can be, but we also recognize that we are providing information that depends on the consumer’s knowledge of what their health plan does and does not do,” she says. By initially focusing on well-defined procedures such as Caesarean sections and imaging tests, leaders hope to sidestep some of these issues, Lee says.

The new pricing tool builds on the organization’s other transparency efforts. In 2012, UUHC became the first academic medical center in the United States to publish physician reviews online. Since then, patient satisfaction has jumped from the 28th to the 85th percentile. With UUHC’s help, organizations such as Geisinger, Duke, Stanford, and Cleveland Clinic have begun posting patient satisfaction scores online.

Encouraging resource stewardship. Despite the challenges associated with making data available to patients, Lee says her team recognizes that putting this information in the hands of consumers is an important first step. “What happens when you make costs more transparent to patients and clinicians is that they begin to take more responsibility for costs expended for care,” Lee says. “Having the cost and price data often helps people behave more responsibly.”

Interviewed for this article: Vivian S. Lee, MD, PhD, MBA, CEO, University of Utah Health Care; senior vice president, University Health Sciences; and dean, School of Medicine, Salt Lake City (publicrelations@hsc.utah.edu).

FOOTNOTE:
RESOURCES IMPROVE CLINICAL UNDERSTANDING OF COST AND QUALITY

In the effort to improve the quality of care and increase affordability, health systems are acquiring key information by implementing tools ranging from internal cost-accounting systems to population-based measures.

By Elizabeth Barker

Cost-accounting systems have become fundamental tools for healthcare organizations to reduce clinical variation. Key to the success of these initiatives are partnerships with clinicians to improve the quality of care while using resources more effectively, as seen in the initiatives of organizations such as Yale New Haven Health (YNHH) and University of Pittsburgh Medical Center (UPMC).

One of the ways YNHH has used its cost-accounting data is by drawing from the Centers for Medicare & Medicaid Services’ (CMS’s) Bundled Payments for Care Improvement internal cost savings program to launch its Shared Value Program (SVP), piloting in hip and knee replacement for Medicare patients. Launched in October 2015 and spanning 18 months, SVP engages surgeons both from Yale School of Medicine and in private practice to decrease spending and improve clinical outcomes. For the hip and knee replacement program, YNHH compares the total actual cost of implants used with the SVP baseline to determine the difference. As of June 30, YNHH had decreased spending by approximately 15 to 17 percent, totaling $1.35 million since October 2015. This sum includes $650,000 in Medicare-related savings, 44 percent of which has been shared with participating surgeons who use the approved vendors and reduce QVIs. YNHH aims to expand the program to non-CMS bundle and non-bundle patient groups, including spine surgery.

“The goal is to create more alignment and more engagement to make it a triple win,” O’Connor notes. “It has to be a win for the patient, the surgeon, and the hospital.”

UPMC has also identified opportunities to reduce variation through its cost-accounting system, partnering with its physicians to examine quality and cost data and identify inefficiencies. “This cost information acts as a proxy for identifying all the points of variation in a system,” says Robert DeMichiei, executive vice president and CFO. “Part of this is understanding what everyone’s doing and how it differs and trying to identify best practices.”

The health system has seen success in areas such as hysterectomies, reviewing data by type of procedure (e.g., open, robotic, vaginal, laparoscopic). Using this information, UPMC’s Women’s Health Department noted
that 28 percent of noncancerous hysterectomies were performed as open procedures, costing approximately $2,000 more than minimally invasive hysterectomies and resulting in increased complications, transfusions, infection rates, readmissions, and lengths of stay.

Better understanding of the cost and patient outcomes of the different types of hysterectomies has helped to reduce open surgeries for hysterectomies by 34 percent. This decrease contributed to other improvements for hysterectomies, such as a 20 percent reduction in inpatient length of stay over three years and a 28 percent reduction in 30-day readmissions.

With these cost-accounting tools in use throughout their organizations, YNHH has partnered with Strata Decision and UPMC has partnered with Health Catalyst to commercialize their quality-driven cost-accounting methodologies for use by other organizations.

**POPULATION-BASED MEASURES**

In addition to cost-accounting models, healthcare organizations have implemented cost-transparency resources for a range of users, as seen in HealthPartners’ Total Cost of Care and Total Resource Use (TCOC) methodology, a population-based measurement framework that examines the resources and costs of patient care (adjusted for illness burden). The framework, when coupled with healthcare quality and patient experience measures, can be applied on multiple levels, such as for patients to access information about providers and services, for health plans to determine benefits packages, and for providers to estimate their overall costs.

Deploying TCOC methodology throughout its provider network, the Bloomington, Minn.-based HealthPartners’ total cost of care, adjusted for illness burden, has been 17 percent lower than Minnesota costs, 7 percent lower than regional costs, and 2 percent lower than national costs. Since the National Quality Forum endorsed this framework in January 2012, more than 190 health systems have licensed it in 35 states, as have a number of national and regional organizations.

“We had stress-tested measures for improvement work in our own delivery system,” says Sue Knudson,

**USING COST ACCOUNTING TO IMPROVE QUALITY**

By leveraging a combination of service line management and activity-based costing, the Women’s Health Department at University of Pittsburgh Medical Center (UPMC) achieved the following results:

- **20 percent reduction in inpatient length of stay for hysterectomies from FY12 to FY15**
- **34 percent reduction in open surgeries for hysterectomies from FY12 to FY15 (including a 9.3 percent reduction between 2014 and 2015)**
- **28.3 percent reduction in 30-day readmissions for open hysterectomies from 2014 to 2015**

Other major quality metric improvements between 2014 and 2015 for hysterectomies are attributed to the reduction in the use of open surgeries, including:

- **37.1 percent reduction in seven-day readmissions**
- **33.5 percent reduction in transfusions**
- **9.8 percent reduction in surgical site infections**

Source: UPMC. Used with permission.
MAKING PRICES TRANSPARENT TO CONSUMERS

As some healthcare organizations take steps to make costs more transparent for clinicians, some commercial health plans and state governments also are making costs and prices more comprehensible for consumers. But more work needs to be done.

By Laura Ramos Hegwer

Forty-four states received an “F” in a 2016 report card on state transparency laws by the Health Care Incentives Improvement Institute and Catalyst for Payment Reform. New Hampshire was one of just three states—along with Colorado and Maine—to earn an “A.” The state’s NH Health Cost website, which has been online for 10 years, is considered by some as the gold standard among state-level price transparency initiatives.

Tyler Brannen, health policy analyst at the New Hampshire Insurance Department, credits his state for having the foresight to make claims data publicly available rather than limiting their use to state agencies, as is the practice in most states. The NH Health Cost website uses actual claims data and rates paid to provide estimates on the most common services to consumers, based on their insurance plan. “We are not using provider charges nor potentially unreliable sources that may post prices using different methods, data, and assumptions,” Brannen says. “We also bundle the rates together to make estimates more useful for consumers, who may not realize that an anesthesiologist may not be employed by a hospital or that pathology is even part of the service they need.”

In 2014, the New Hampshire Insurance Department took down the website for several months while waiting for a vendor to update data that were nearly two years old, Brannen says. Since the website has been back online, the department has expanded the number of service estimates it provides for consumers from 44 to more than 100. The department also has...
enhanced the website with cost information on prescription drugs and dental services, as well as quality information based on Centers for Medicare & Medicaid Services (CMS) data.

To help providers and insurance companies understand the current market rate for services, the New Hampshire Insurance Department also posts a spreadsheet that includes detailed cost information on more than 1,000 services at the Current Procedural Terminology (CPT) level. Brannen says his team plans to update the cost data for consumers and for providers and insurers each quarter.

As with other transparency tools, consumers have been slow to access NH Health Cost. A 2014 study found that approximately 1 percent of the state’s residents used the website, typically to search for costs for outpatient visits, imaging, and emergency department visits.2 Today, NH Health Cost is accessed by approximately 3,000 users each month. Brannen says his department plans to focus on outreach to help increase utilization of the tool, rather than relying solely on word of mouth as it has in the past.

Waiting for consumers to catch on. “Right now, there is a lot of churn with so many different tools and approaches being developed, so the question is: Which ones will be the most useful for consumers?” says Dena Mendelsohn, JD, MPH, staff attorney at Consumers Union, San Francisco.

Transparency tools like those from Castlight Health are typically made available to consumers through their employers. Some, like Aetna’s WellMatch, are affiliated with health plans, while HealthSparq and some others are not. Some tools incorporate physician reviews or integrate with other web-based tools, such as online scheduling.

Despite the flurry of activity on the development side, consumer awareness is still low, Mendelsohn says. “In many cases, consumers still do not know that the tools exist,” she says. But demand will likely grow as deductibles become higher. “As we see the cost of care being shifted more and more to consumers, consumers will become more inclined to do their research,” she says. “What we need is for these transparency tools to become more robust, accurate, and user-friendly in time for consumers to make decisions about what health care is right for themselves and their families.” Health plans may be in the best position to engage consumers around transparency tools by marketing them to policyholders and making them easily accessible on their webpage, Mendelsohn says.

The “typical” user of transparency tools is the cost-conscious Millennial, according to a study of Aetna’s WellMatch price transparency tool published in Health Affairs.3 Repeat users who searched the tool for more than one service were more likely to be women, be younger than age 34, and have a higher deductible. Still, only 3.5 percent of members used the tool during the 2011-12 study period.

At press time, the team at Consumer Reports was evaluating price transparency tools and had not released its results. In general, Mendelsohn says the value of these tools hinges on the quality of their data and their usability. “Healthcare cost and quality data should be free, timely, and reliable and should reflect consumers’ personal needs and insurance coverage,” she says. “A site that just gives general information is not going to be that useful for consumers.”
In 2015, Consumers Union and several California universities launched a state-based price transparency tool called California Healthcare Compare, sponsored by the California Department of Insurance. Based on feedback from test users, the site offers “layered” information—first, editorial content to explain the data, and then the actual pricing data. “We wanted to make sure that consumers understood what they were seeing and then help them know how they could use the information to improve their own health care,” Mendelsohn says.

Making progress through personalization. Castlight Health, headquartered in San Francisco, offers a health benefits platform used by more than 190 customers, primarily large self-insured employers, to help their employees make better decisions about their care. Founded in 2008, the company launched its initial cost and quality transparency tool in 2010, making the tool one of the oldest on the market.

Today, the platform leverages user behavior data and analytics to help benefits leaders match employees to resources that meet their specific needs, such as second opinions, maternity health, and diabetes management programs.

“We realized we needed to do more than provide passive information to consumers and assume that they would use it,” says Howard Willson, MD, MBA, head of clinical strategy, Castlight Health. “We needed to understand the users and engage them with a more personalized approach, which all of us expect these days given our interaction with sites like Facebook, Amazon, and Twitter.”

A 2014 study found that although consumer uptake was low, searching for providers using the Castlight platform prior to getting a service was associated with lower claims payments, even among patients without cost sharing. The greatest difference was for advanced imaging services, saving nearly $125 per claim. 4

However, the Health Care Cost Institute estimates that consumers may experience only modest cost savings as the result of price shopping via such tools. The institute says current benefit designs still limit the degree to which consumers can reduce how much they pay for “shoppable” services. 5

LESSONS LEARNED

Experts in price transparency offer the following strategies for healthcare organizations that are developing tools to make cost, price, and quality information more meaningful to consumers.

Take a proactive approach. Brannen of the New Hampshire Insurance Department believes providers should encourage consumers to use these tools—even if they are concerned that their staff are ill-equipped to answer consumer questions. “Provider organizations need to deliberately act to inform consumers about the variability in costs as well as the choices they have,” he says. “They also should develop policies and procedures to empower consumers to use their benefits more effectively.”

Explain what the cost information means. Mendelsohn of Consumers Union says price transparency tools need to provide clear definitions of what costs mean and explain which data are being used to create the estimates. Typically, costs can represent billed charges from the chargemaster, negotiated charges, or the net cost to the patient—ideally, the last of those would be the standard for price transparency tools, Mendelsohn says.

Accurately reflect the price of preventive care services to consumers. Under the Affordable Care Act, services such as screening colonoscopies are required to be covered with no cost sharing. However, some existing tools erroneously display the full cost of the screening even for covered patients, which is misleading and may discourage patients from seeking care, Mendelsohn says.

Keep it simple. To make difficult-to-understand quality concepts more meaningful to consumers, the Castlight platform uses icons that indicate when a provider has outcomes that are better than most, worse than most, or average. “This summarizes a complex data set in a way that allows consumers to make decisions fairly easily,” Willson says.

Interviewed for this article: Tyler Brannen, health policy analyst, New Hampshire Insurance Department, Concord, N.H. (Tyler.Brannen@ins.nh.gov); Dena Mendelsohn, JD, MPH, staff attorney, Consumers Union, San Francisco (dena.mendelsohn@consumer.org); Howard Willson, MD, MBA, head of clinical strategy, Castlight Health, San Francisco (press@castlighthealth.com).

FOOTNOTES:

BRINGING IT ALL TOGETHER

One expert believes it is time for the industry to bring together efforts to make costs more transparent for both clinicians and consumers.

By Laura Ramos Hegwer

For Neel Shah, MD, MPP, founder and executive director, Costs of Care, Boston, the solution to price transparency hinges not on technology but rather on open and honest conversations at the front line. “Right now, medical and nursing professionals do not consider talking about costs as part of their professional scope,” says Shah, who is also an assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School. Such a role is typically reserved for case managers, financial counselors, and others responsible for billing and patient intake.

Yet Shah believes clinicians should “screen” for financial harm in the same way they screen for population health risks. As an obstetrician/gynecologist, Shah asks his patients one simple question that he believes detects most cases of domestic abuse: Do you feel safe at home? When he suspects abuse based on a patient’s response, he can refer her to appropriate community resources.

“When it comes to detecting financial risk, I have no simple question that is universally accepted that I can ask my patients,” he says. “The number of people I detect who are at risk for financial harm is probably zero percent. And even if I did detect a patient at financial risk, I do not know what I would do next.”

Shah predicts such a screening tool will be available to the industry within five years, thanks to converging factors such as the growth of high-cost technology and increased pressure on providers to be more accountable for the services they provide. An optimal solution would be integrated into the clinical workflow so that it fits within clinicians’ time constraints, Shah says.

Organizations also need to educate frontline physicians on how to think and talk about value. In the same way that organizations develop multidisciplinary teams to empower staff to focus on quality improvement, they might develop multidisciplinary committees to work on value improvement, Shah says. Or they might develop trigger systems similar to those used for medical errors that create an opportunity for clinical and financial leaders to review events that cause financial harm to patients. “Delivery systems are already crowd-sourcing ideas around patient safety, and they should be doing the same thing around value,” Shah says.

How medical students are trained also needs to change. “When I was in medical school, I was only ever chastised for what I didn’t do, not for what I did do when I didn’t have to—and people get harmed both ways,” Shah says. “One of the cultural shifts I have seen is that we recognize that people can get harmed when we do too much physically or financially. We are starting to think of resource stewardship as part of our professional responsibility.”

Talking with patients about medication costs may be a good place to start because physicians using EHRs already can tell whether a drug will be in a more expensive tier compared with the alternatives. Typically, there are many pharmaceutical options to treat the same condition. “Clinicians can often think of ways to make treatment more affordable if they have that information,” Shah says. The startup Gemini Health, for example, aims to put patient-specific drug cost and coverage information in the hands of clinicians. “We have the technology and the will among stakeholders to do this,” he says.

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HEALTH CARE 2020, PART 1: THE TRANSITION TO VALUE

Examining the healthcare industry’s ongoing transition to value, including trends in payment reform, consumer choice, mergers and acquisitions, and innovation that are altering the healthcare business model.

The following are excerpts from “Health Care 2020: The Transition to Value,” which is the first in a four-part series on how hospitals, physician practices, and health plans can prepare for changes that will transform the healthcare industry over the next several years. Download this free report and others in the series at hfma.org/healthcare2020.
As the healthcare industry continues its journey to value, two things about the near-term future are clear: First, healthcare providers will increasingly face both upside and downside financial risk in their arrangements with health plans, whether through traditional contracting mechanisms, new partnerships with insurers, provider-sponsored plans, or direct-to-employer arrangements. Second, consumerism will influence a provider’s success or failure to a greater degree, requiring providers to meet the increasing demand for convenience and for quantifiable information about the value of services offered by their organizations.

The healthcare industry is spinning through a cycle of payment experimentation. As a result, providers will assume greater risk for outcomes, and collaboration between health plans, physicians, and hospitals will become increasingly important. “There’s no question—between what public purchasers like Medicare are doing and what the commercial payers are looking to do—that shared risk is going to become more prevalent,” says Suzanne Delbanco, executive director of Catalyst for Payment Reform, a coalition of many of the nation’s largest employers and other healthcare purchasers. “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.”

**REFORMS THAT WORK BEST**

Mark McClellan, MD, PhD, a senior fellow and director of Health Care Innovation and Value Initiatives at the Brookings Institution, thinks the new models will continue evolving in the foreseeable future as each proves or disproves its effectiveness in various situations.

For example, he thinks accountable care organizations (ACOs) that include hospitals and physicians that wish to lead in the value movement should move toward at least partially capitated payments. As long as they are paid through the fee-for-service system, ACOs are challenged to fully embrace high-value access points such as telemedicine because the shared savings that comes from avoiding a hospitalization does not fully offset the net revenue that comes with an admission.

On the other hand, physician-only ACOs win financially every time they prevent a hospitalization. “Over the next few years, you might see some smaller primary care groups continuing to succeed with this shared-savings model, but the large organizations really are going to need to move to more

**HFMA EXECUTIVE SUMMARY**

In conjunction with the release of the *Health Care 2020* report on the transition to a value-oriented healthcare system, HFMA issues the following guidance for stakeholders:

Health plans, hospitals, and physician practices need to collaborate to create equitable payment models that reward all stakeholders only when high-quality, resource-efficient, cost-effective care is provided to the patient. Successful models will require the flow of financial and clinical data among internal and external stakeholders to efficiently manage care, transfer the appropriate type and amount of risk to providers based on their financial wherewithal, and engage patients in care processes.

Hospitals and physician practices need to accurately determine the true internal cost of producing their portion of the care provided under an outcomes-based payment model. Sharing this information with those on the front lines of care delivery will allow them to eliminate operational inefficiencies. Freeing up these funds in turn will support the investments in infrastructure necessary to manage outcomes. Further, as hospitals and physicians systematically reduce their internal costs, a portion of that savings should flow through to purchasers (individual consumers, employers that provide coverage to their employees, and taxpayers) in the form of a decreased per member year-over-year trend.

*For more of HFMA’s executive guidance on transitioning to a value-based healthcare delivery system, download the report at hfma.org/healthcare2020.*

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downside risk and farther away from fee-for-service in order to succeed,” McClellan says.

Similarly, bundled payments for procedures as they are currently configured may not prove to be the most effective approach to reducing unnecessary utilization, McClellan says. “Hip and knee bundles as CMS has created them will probably have some impact in the next few years on reducing readmissions and reducing high-cost post-acute care. But it’s not going to have a more fundamental impact on the way that patients with degenerative joint disease are really treated.”

That’s because the bundled payment approach applies only to joint-replacement surgery cases. Many patients would probably forgo surgery if they were led through a shared decision-making approach that allowed them to evaluate all their options. Moreover, if patients had access to a good degenerative joint disease management program, McClellan says, replacement surgery might not even be needed.

“You need an episode that goes further back and is really about the diagnosis itself, based more on patient symptoms or functional status rather than whether or not you’re getting a procedure,” McClellan says. “Doing a bundled payment episode more at the person-level rather than a procedure-level is harder, and it’s a farther shift away from fee-for-service. But I think we’ll eventually see those kinds of episode models become more prevalent.”

THE PACE OF CHANGE
The traditional Medicare program used alternative payment models—many of which were upside-risk only—for 20 percent of its payments in 2014. On the private-payer side, 40 percent of payments were funneled through “value-oriented” contracts, according to the National Report Card on Payment Reform, issued by Catalyst for Payment Reform in 2014. But only 1 percent of payments were in shared-risk arrangements and just 0.1 percent were bundled payments.

Delbanco expects those shares to go up when multiyear health plan-provider contracts come up for renewal. “We’re on the verge of more, but not a lot more yet,” she says. “What it will take to get there is providers having the infrastructure to monitor their quality performance and their financial performance in near-real time, so they can truly afford to take on risk.”

For much more insight from industry experts on the transition to a value-based healthcare delivery system, download the report at hfma.org/healthcare2020.
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CASE STUDIES IN CLINICAL INTEGRATION

Many health systems and physicians are using the clinically integrated network model to facilitate their transition from volume-based payments to value-oriented care delivery.

By Lola Butcher

A study published nearly a decade ago using data from 2000 remains the siren song for clinical integration: In one year, Medicare patients saw a median of two primary care physicians and five specialists working in four different practices.1

That analysis documented the highly fragmented nature of America’s healthcare system and fueled the push to find a better way. Operating in their traditional silos, healthcare providers are destined to duplicate tests and treatments, make decisions without information from other providers, and run up costs.

The antidote is clinical integration that allows providers to work together seamlessly, providing better care for patients and reducing the waste that drives up the nation’s healthcare tab. Indeed, any successful move to value-based payments and population health management will require clinical integration among an array of providers.

In recent years, the term clinical integration has become an industry catch phrase used to describe everything from vague collaboration among longtime rivals to mergers that bring hospitals and physicians under single ownership. The term clinically integrated network (CIN) refers to a specific legal arrangement that allows competing providers to jointly contract with payers without running afoul of the Department of Justice and the Federal Trade Commission. To stay on the right side of antitrust laws, a CIN can be a physician-hospital organization, an independent practice association, or the subsidiary of a health system, but it must have physician leadership baked into the governance model. All CIN members must formally commit to complying with clinical guidelines and working on performance improvement activities. Data sharing and performance monitoring are required. And the CIN must demonstrate that it is improving value, not just using its size to wrangle better rates from payers.

Christiana Care Health System started exploring the CIN model as it considered the implications of the Affordable Care Act.

“We want to make the transition from being a very successful acute care hospital to a healthcare system that is contributing to the health of the community,” says Alan Greenglass, MD, CEO of Christiana Care Quality Partners (CCQP), a statewide CIN in Delaware. “And we know that just doing more things for the sickest people is not going to be the future, so we needed to find a way of providing as much value in our care as possible.”
The Advisory Board counted about 500 CINs nationwide at the end of 2012, and more have launched since. “We are not going to be successful unless we have a strong partnership with the physicians in the community,” Greenglass says. “What is the best way of doing that? We said it is clinical integration around the Triple Aim.”

REGIONAL REACH

The Vanderbilt Health Affiliated Network (VHAN)—started by Vanderbilt University Medical Center (VUMC) and four other hospital systems in 2012—includes 12 health systems that encompass more than 50 hospitals and 3,500 clinicians. While Tennessee is VHAN’s primary market, the network’s clinical practice improvement and consulting activities reach into Georgia, Alabama, Mississippi, Arkansas, and Kentucky, and may go even further afield.

“We have lofty aims,” says David Posch, VUMC’s executive vice president of population health. “Our intent is really to transform how healthcare delivery across the mid-South occurs so that we improve the health of millions of people in the region.”

The Centers for Medicare & Medicaid Services (CMS) thinks VUMC and VHAN are up to the task. CMS recently gave VUMC a contract for up to $28 million over four years to help more than 4,000 VHAN participants and other clinicians transform their practices by spreading the use of informatics tools and other supports. The contract is part of CMS’s Transforming Clinical Practice Initiative, which seeks to help 150,000 clinician practices develop comprehensive quality improvement strategies.

Focusing on care for patients with chronic diseases, the contract comes with big goals: reduce unnecessary testing and treatments by 5 percent and hospital readmissions by 20 percent by the fourth year of the program.

Such objectives directly support what Posch and his colleagues are working on. Clinicians and hospitals that belong to the network pay annual dues to support VHAN’s infrastructure and agree to participate in performance improvement activities, data sharing, and care coordination. “We have a fairly elaborate medical director structure that meets with our practices and engages them in these efforts,” Posch says.

One focus is the use of cost-effective pharmaceuticals, which is monitored on dashboards tailored to regional dynamics. “Pharmacy is approaching 30 percent of the cost of insurance premiums, so that is a very important element of where we work,” he says.

VHAN is rolling out a health information exchange that will allow electronic health record (EHR) data to be shared among providers—and promote evidence-based care.

Source: Christiana Care Health System. Used with permission.
“Our aim is not just to be able to exchange data but also to embed clinical decision support into those electronic medical record systems so we provide real-time support about the best evidence-based practice,” he says.

The network currently provides care for more than 110,000 patients, the majority of whom are from self-insured employers, including the 12 health systems that participate in the network. By 2020, VHAN leaders expect to be responsible for at least 1 million lives.

The sales pitch is compelling: The CIN’s pediatric program cost 17 percent less than the market trend in 2014, the latest year for which information is available. In adult services, VHAN and its participants saved employer and commercial health plans about 5 percent—or $10 million—in 2014.

Originally envisioned as a much smaller entity that would serve central Tennessee only, VHAN has grown quickly as other health systems and physician practices have sought to be included. The move to value-based payment methods transfers financial risk to physicians and hospitals, which requires managing patient care across providers and over time.

“Everybody realizes we need to organize ourselves in such a way that we can understand the care of our patients and do a better job of it as we go forward,” Posch says. “The idea of a provider-driven organization that is dedicated to those principles has resulted in a fairly rapid growth.”

PHYSICIANS COME ABOARD

Christiana Care, the biggest health system in Delaware, likewise found physicians eager to sign up when it launched its CIN in 2014.

The health system initially invited all physicians on its medical staff to participate at no expense—and CCQP quickly grew to include 1,500 primary care and specialty physicians, most of whom are in independent practices.

That worked well for CCQP’s first patient population—Christiana Care’s employees and their family members. “That almost guaranteed that every physician in the geography would be in the network and that there would be no out-of-network problem for our employees,” Greenglass says.

On the other hand, many physicians signed up to be part of CCQP without considering or committing to the practice changes—such as robust data sharing, care coordination, and standardized care protocols—that are needed for the CIN to succeed.

That’s why CCQP selected a much smaller group—about 200 primary care physicians—with which to pursue a Medicare Shared Savings Program ACO contract. “It is really hard to change the behavior of 1,500 physicians,” he says.

That said, the large network has its benefits. CCQP’s governance and committee structure gives value-oriented physicians a chance to emerge as leaders with responsibility for understanding how healthcare delivery must change and for making decisions on how CCQP physician practices must respond to industry trends.

“We are seeing the next level of healthcare leadership coming from the private physician community—people who did not know how to participate in the past,” Greenglass says. “That is a strength because, for our community to change, those private physicians need to be engaged.”
CCQP’s third-party administrator analyzes claims to create quarterly performance reports for CIN physicians. And the CIN has developed a fledging pay-for-value model that rewards primary care physicians and some specialists for their performance on customer service, preventive care, and chronic care measures.

Scott T. Roberts, MD, a partner at Christiana Spine Center, serves on a CCQP committee and thinks the CIN will realize its potential only when electronic data sharing supports true integration. CIN participants use different EHRs and, with no platform that allows data to be exchanged, faxing remains the most common mode of communication. “That is the single largest limitation to our ability to actually be integrated, to improve patient care, to decrease redundancy, to share outcomes data, and to develop appropriate standard-of-care pathways,” he says.

THE RISE OF THE SUPER CIN

In Michigan, Together Health Network (THN) has emerged as a “super CIN” composed of nine local CINs that cover the state. THN was formed in 2014 by two large health systems, Ascension and Trinity Health. The University of Michigan Health System joined as an equity partner and quaternary care provider this year.

The network includes more than 5,000 physicians and 29 hospitals, and its leaders estimate that 75 percent of Michigan residents live within 20 minutes of a THN provider. THN’s vision is to be the preferred partner of anyone—patients, physicians, or payers—looking for care models that deliver on the so-called Quadruple Aim: better care for individual patients, better population health, lower healthcare costs, and better experiences for healthcare providers.

“We want to be the recognized entity that is able...
to deliver on that consistently across the state,” says Scott Eathorne, MD, president and CEO of THN.

While some CINs use a top-down approach to set and achieve their goals, THN is using an incremental strategy that builds on the progress of the nine local CINs. Eathorne relies on the individual CINs for leadership, governance, data sharing, and support for the physicians and hospitals in their respective groups. Although each CIN has its own priorities and processes, status as a CIN demonstrates the shared goal of improving the value of care delivery in the local community, he says.

Over time, THN will develop its own capabilities on top of what each individual CIN maintains. “We are striving for more clinical integration, and that is why we are spending the time to understand where folks are currently and where we have the opportunity to integrate our clinical informatics systems, our network analytic systems, and our performance improvement processes,” he says.

Eventually, THN will implement a dashboard that supports performance improvement throughout the super CIN.

“We are working to establish a common care model by which we work with each of the groups to decrease variation in the care that is provided,” he says. “That will be largely managed at the local level.”

So far, THN has only one contract—a Medicare Advantage HMO contract sold in an 11-county region that includes the Detroit area plus Kalamazoo County—but it is positioning itself to add more. As value-based contracts become more common, the individual CINs will be increasingly attractive to payers and employers if they are part of a statewide network. “We are not looking to replace existing contracts that our local CINs have, but as we look for value-based opportunities, we anticipate that there will be a shift to the statewide network over time,” Eathorne says.

Payment reform ultimately will determine which care transformation models deliver on their promises, Eathorne says.

“We know that there is not going to be any one single model that is going to be the solution to all of our healthcare woes,” he says. “We think that in our community and our marketplace, we are fairly well poised to demonstrate our value proposition over time.”

Lola Butcher writes about healthcare business and policy topics for several HFMA publications (lola@lolabutcher.com).

Interviewed for this article: Alan Greenglass, MD, CEO, Christiana Care Quality Partners, Newark, Del. (agreenglass@christianacare.org); David Posch, MD, executive vice president-population health, Vanderbilt University Medical Center, Nashville (David.Posch@Vanderbilt.edu); Scott T. Roberts, MD, partner, Christiana Spine Center, Newark, Del. (scottrobertsmd@yahoo.com); Scott Eathorne, MD, president and CEO, Together Health Network, Southfield, Mich. (seathorne@togetherhealthnetwork.org); Kenneth W. Kizer, MD, MPH, director, Institute for Population Health Improvement, UC Davis Health System, Sacramento (kwkizer@ucdavis.edu).

FOOTNOTE:
PHYSICIAN-OWNED ACOs CAPITALIZE ON BUILT-IN ADVANTAGES

Better workflow, better coordination of care, and less dependence on revenue from filling hospital beds are key factors that may help physician-led ACOs thrive.

By Ed Avis

To Steven Strongwater, MD, the advantages of a physician-owned accountable care organization (ACO) are clear. After all, who is more “accountable” for the care of a patient than that patient’s own physician? And who understands the way physicians work better than physicians themselves?

“I believe we, as physicians, understand the workload and workflows that are necessary for patient care, and we can design the system in a way that makes it easier for patients to improve their outcomes and makes it easier for the physicians to do their work,” says Strongwater, CEO of Atrius Health, a Medicare Pioneer ACO based in Newton, Mass.

Strongwater’s optimism about physician-owned ACOs is based in fact. Data released in late August by the Centers for Medicare & Medicaid Services (CMS) show that ACOs led by physician groups or jointly by physician groups and hospitals were about 40 percent more likely to have achieved a shared savings bonus than ACOs led by hospitals alone.¹

“The evidence is out that providing health care that patients need in an independent physician-led ambulatory environment is much less expensive than doing it in a hospital-led ambulatory environment,” says Jim Walton, DO, president and CEO of TXCIN, an ACO that includes 500 primary care physicians and 600 specialists across the Dallas/Fort Worth area. “Physicians who don’t have an ownership in a hospital can provide more efficient, high-quality care in a nonhospital environment.”

Hospital-based ACOs certainly have their own advantages—access to capital and greater control of the discharge process chief among them—but with all the questions facing the healthcare industry, many are betting on the success of physician-owned ACOs.

BETTER WORKFLOW

Atrius Health, which has 750 physicians across 29 clinical locations, was founded in 2004 as an alliance that included two of the groups that make up Atrius Health today: Dedham Medical Associates and Harvard Vanguard Medical Associates. Granite Medical Group joined in 2005 and VNA Care in 2013.

The organization has performed near the top among Pioneer ACOs in the majority of quality outcomes since the Pioneer program began in 2012. Atrius Health earned shared savings of $4.4 million for the 2015 performance year.²
That success is due, at least in part, to factors that speak to the advantages of physician-owned ACOs.

For example, Atrius Health has put an emphasis on smoothing the workflow for its physicians. A hospital-led ACO would surely strive to do the same, but Strongwater feels physician leaders simply have a better understanding of how to do it.

A seemingly minor example, but one that has a positive impact on physicians every day, is the implementation of a system that manages the physician’s e-mail. “We have hundreds of thousands of patients who participate in a HIPAA-approved portal, and all of their emails go into the physicians’ inboxes,” Strongwater says. “We are using an extended workforce to clean out the inbox—to answer questions, handle preauthorizations, etc.” The staff handling these e-mails are advanced practice nurses or other nonphysician clinical personnel who are qualified to deal with the issues.

A similar approach is applied to a task of much larger scope: managing population health. Population health outreach managers gather data on high-risk populations, coordinate care for those individuals, track their care, and otherwise make sure those patients get the attention they need to keep them well and out of the emergency department (ED).

“That has taken some of that workload off the plate of the doctors,” Strongwater says, adding that Atrius Health now evaluates and develops ideas in its Innovation Center, a year-old department designed to keep fresh ideas flowing. As with the e-mail management personnel, the population health managers are not physicians. “We are trying to have people work at the top of their license,” he says. “The primary care doctor is leading the group but delegating the work.”

CHANGING THE SEQUENCE

Walton says another advantage of physician ownership of the ACO is increased cooperation among the physicians themselves.

“Philosophically, the independent physicians have come together to create a tighter functional alignment across specialties to basically accelerate improvements in efficiency and patient satisfaction,” Walton says. “The traditional fee-for-service model has not rewarded physicians for working together collaboratively.”

Walton hypothesizes that specialists and primary care physicians who are equal partners in an ACO can work together to determine in advance what evaluation and treatment patients need, rather than acting as separate parties in the chain of care events.

“We know from experience that patients experience better care when primary care and specialists work in concert on how patients are evaluated for selected conditions before they are sent to specialists,” Walton says. “This would help explain some of the reduction in costs and improved patient experience seen within physician-led ACOs.

“By working together, we can change the sequence in which we manage disease states. Patients would experience the same or better quality, even though we
may be doing less for them. That’s the promise of this initiative.”

One example would be the diagnostic work-up sequence of a patient with acute low back pain. If the patient presents to the primary care physician, and the examination reveals no evidence of neurological injury, it would be appropriate for the primary care physician to decide against referring the patient to a specialist or for an advanced imaging test such as a CT or MRI scan. Instead, the patient could be directed to a short course of physical therapy and medication management, increasing his or her satisfaction and reducing the amount of testing and costs.

TXCIN, which was founded in 2014, is launching a clinical integration committee to consider these types of issues. ACO medical directors and support staff will review and evaluate the evidence base regarding interventions and make recommendations to the committee, enabling the creation and approval of TXCIN Care Guidelines for selected conditions.

Early examples might be: “How will we recommend the management of care for patients with diabetes and ischemic heart disease? Or migraine headaches or a history of strokes? That all can be evaluated to see what the best evidence shows and to create care guidelines,” Walton says.

Like Atrius, TXCIN has seen above-average results. The company had one ACO contract in 2015, with Cigna, and finished the year with 7.5 percent lower costs than the overall North Texas market, Walton says. It has since added an ACO contract with Blue Cross and expects to add one with UnitedHealthcare before the end of 2016.

NOT FOCUSED ON FILLING BEDS
Another advantage of the physician-based ACO is vastly reduced overhead. Hospitals are expensive facilities with leaders who have a financial incentive to utilize those facilities.

Sometimes, in fact, hospitals have a mixture of incentives from various payers that creates conflicting priorities. If a hospital-based ACO is in a shared savings plan that pays 50 percent of a cost reduction, for example, it may benefit by keeping beds empty. But that incentive may not exist with all payers, so someone has to keep track of which cases are impacted by which incentives.

“We don’t have beds to fill and we don’t have emergency rooms that we want to make sure stay busy, and I think that gives us an advantage,” says Barbara Newton, executive director of Quality Independent Physicians, an ACO in Louisville, Ky. “And because our independent practitioners are not employed by the hospital, they don’t have to send their labs to the hospital lab. They can choose others.” Labs outside the hospital are typically much less expensive, Newton adds.

Quality Independent Physicians, which has 45 participating physicians from two independent physician organizations, is a Medicare Shared Savings ACO. The organization earned a $6 million shared savings bonus in 2014 while scoring in the top 10 percent of all participating ACOs in 17 of the 33 quality measures.

“In the second year of the program we met the minimum threshold for shared savings, and we repaid everything we owed on the advance payment model [Medicare’s program for helping ACOs fund themselves] and had enough left over to fund the operation and distribute money to participating doctors,” Newton says. “Aside from the monetary benefits, most of our doctors feel they are practicing better medicine. They are better able to be proactive and educate the patients on diseases states and options for treatment, evidence-based medicine guidelines, etc. They are practicing the way they were trained.”
LESS MONEY, LESS CONTROL
Hospital-based ACOs do have several key advantages. For one, they have much deeper pockets and superior cash flow. One notable benefit of having cash in hand is that hospitals, in general, have developed superior electronic health records (EHRs) compared with physician practices.

“Hospitals have the head start regarding data warehouses with extensive patient information,” Gardner notes. “While we are seeing physician groups implementing electronic medical records, hospitals are further down that road. And the economics of scale allow hospitals to invest in more advanced technology, such as search functions that can identify high-cost patients and needy populations and help them implement preventive measures.”

Hospitals also have significantly more influence over a major cost area—discharge procedures. When and in what condition patients are discharged can play a key role in overall costs, and the physician-owned ACO does not ultimately control those decisions.

And while overhead costs are considered a disadvantage of hospital-based ACOs, the fact that they have the beds, imaging facilities, pharmacies, and many other potential revenue centers under their control means they can direct the dollars spent on the patient more thoroughly than can a physician-owned ACO. Bottom line: It’s easier to trim costs you control than costs you don’t control.

“Hospitals control a lot of the procedures that are high-cost, and essentially that means they have more room to make big gains in efficiencies,” Gardner says. “I think what’s important is for the ACO to align its approach with its capabilities.”

Keeping patients out of hospitals and skilled nursing facilities is one way physician-based ACOs can keep tighter control on those costs. For example, Atrius Health has a program called Care in Place that dispatches nurses to patients’ homes when they call about a problem that might otherwise result in an ED visit and are unable to come in for an office appointment.

“It’s a patient delighter,” Strongwater says. “Imagine calling someone and worrying about a trip to the ED, and instead we send someone there to take care of it. For us it’s worthwhile because we might be able to prevent a hospitalization.”

ALIGNED INCENTIVES
Ultimately, physician-based ACOs must work closely with hospitals, so a good relationship is essential.

A given patient can be attributed to only one ACO, so any ACO-related benefits arising from the care of that patient accrue to only one party. But many incentives—such as preventing readmissions within 30 days—are not specific to ACOs.

Newton says Quality Independent Physicians works closely with the hospitals in the area to prevent such readmissions.

“A readmission is a very negative experience for everyone,” she says. “So we really try to make sure our patients see their doctor within 14 days following hospitalization. They get their medications reconciled, make sure everything is going OK, and see what needs to be done differently.”

Naturally, a physician-owned ACO can help prevent readmission only if it is aware of the hospitalization in the first place. Thus, notification from the hospital, at both admission and discharge, is an important part of care coordination.

Atrius Health has developed EHR interoperability with 16 hospitals in the Boston area, giving the ACO’s clinicians direct access to patient activity in the hospitals. Additionally, the ACO receives automated feeds from most of its hospital partners when its patients are admitted. “We know immediately when someone
is admitted, so we can deploy to prevent re-hospitalization," Strongwater says.

In another program, Atrius Health has placed transitional care nurses from its VNA Care subsidiary in four of the preferred hospitals. These nurses work with ACO patients to ensure smooth transitions to home or to the right post-acute care.

Relationships between physician-owned ACOs and hospitals vary, Gardner notes.

“One case could be where there is no interaction with the physicians outside of the normal exchange,” he says. “In those cases, the patients go to the hospital when they need to, receive services, and when they are discharged the physician in the ACO works with them and ultimately that ACO is responsible for the cost of the hospital visit.

“On the other end of the spectrum, hospitals are involved as partners with the [physician-owned] ACO, much in the same way specialists are. They follow certain protocols, deliver care in a certain way, and have some financial stake.” For example, the hospital could share in the ACO’s savings bonus.

The best-case scenario for a physician-owned ACO is for the hospital to follow all of those protocols and keep costs to a minimum without sharing in the ACO’s bonus, Gardner notes. “That may not be possible based on the situation, but the principle is that physician groups leading ACOs have a strong motivation to make sure that what happens in the hospitals is done efficiently and appropriately.”

MORE NIMBLE
The role of ACOs in health care likely will continue to grow. Leavitt Partners data show that there were 854 ACOs as of late August, compared with 645 at the end of 2014. About 23 million people were covered by ACOs at the end of 2015, and Leavitt Partners predicts that number could increase to as much as 177 million by 2020.4

And physician involvement in ACO ownership is expected to remain strong—Leavitt data show that 39 percent of ACOs are solely owned by physician groups and another 33 percent are jointly owned by physician groups and hospitals.

Physician ownership of ACOs simply makes sense, Walton believes. “In a physician-owned ACO, the actual practice of medicine is the central interest,” he says. “Physician owners are not preoccupied with other business lines that might compete with their attention. That allows for more nimbleness to make decisions regarding utilization and care delivery.”

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Interviewed for this article: Steven Strongwater, MD, CEO, Atrius Health, Newton—Mass. (info@atrius.health.org); Jim Walton, DO, president and CEO, TXCIN, Dallas (jim.walton@genesisdocs.org); Paul Gardner, project manager, Leavitt Partners, Salt Lake City (paul.gardner@leavittpartners.com); Barbara Newton, executive director, Quality Independent Physicians, Louisville, Ky. (BNewton@phdelivery.com).

FOOTNOTES:
3. PulsePilot, “Quality Independent Physicians, LLC.”
Cerner RevWorks: Helping Providers Boost Their Bottom Line

Tell us a little bit about your organization.
Cerner RevWorks™ provides revenue management services for acute and ambulatory organizations, including large health systems, community hospitals, and physician practices, as well as outreach laboratories and diagnostic imaging centers. We offer three broad lines of service. The first is an enterprise-wide outsourcing model, which covers everything from scheduling and registration through coding and documentation, claims submission and follow-up, payment, collections, and account resolution and closure.

Our second service line delivers comprehensive business office services for the ambulatory market, ranging from claims generation through payment collection. This includes a consumer call center that takes calls from patients who have questions about statements and account balances.

Finally, we have a shared services offering in which we provide staff augmentation for clients that may not need a long-term arrangement but require some temporary help with specific projects, such as retiring legacy work-downs, liquidating aged accounts receivable, and performing eligibility verification.

What are some of the biggest challenges you see affecting healthcare organizations?
The industry faces a number of challenges; however, there are three that repeatedly come up during conversations with our current and prospective clients.

The first relates to how healthcare organizations are preparing for the shift from what’s largely been a fee-for-service reimbursement environment to one characterized by alternative payment models. The Centers for Medicare & Medicaid Services has a goal that by 2018 more than half of Medicare payments will be tied to quality. Although some may argue that the timeline is aggressive, there is no question that the shift is coming, and organizations must get ready.

The second challenge is navigating a volatile regulatory environment. We’ve seen a significant amount of new programs introduced over the last several years, such as quality reporting initiatives, penalty programs, risk-sharing models, and so on.

To stay afloat amidst these pressures, organizations are having to invest in people and technology, and that can be problematic, especially if the organization is not in a financial position to afford a large outlay.

The third hurdle is with the overall shift to high-deductible health plans, and the burden that’s putting on individual consumers. Each year, when insurance plans reset and patients figure out they are going to owe more money, our clients get a lot of questions about consumer responsibility, as well as requests for information, which take time and resources, putting even more cost on the providers.

In this business profile, Jason Rawlings, vice president, ambulatory and revenue cycle for Cerner, talks about leveraging third-party management services to improve revenue cycle health.
How does your product or service help address these needs?

Our clients are interested in increasing revenue while controlling their cost-to-collect—with a high degree of quality. Although we provide the solutions and technology to manage the revenue cycle, what sets us apart is our high level of service and expertise, which allow us to cost-effectively achieve our clients’ goals. This is due in part because we have the scale to absorb issues that arise. For example, if a single provider runs into a problem with a particular payer, and there’s a backlog in claims processing, the organization may have a hard time absorbing the flood of payments that come in once the issue is resolved. However, we have the ability to redeploy and redirect resources to address unforeseen events, so we keep the business running smoothly.

We also make certain that our goals and objectives are in continuous and complete alignment with those of our clients in terms of approach and performance metrics. To this end, we assign a regional practice manager to each account. This individual acts in concert with the client to handle any problems and look for ways to further optimize front-, middle, and back-end processes. In certain cases, we also provide financial alignment executives, who act as peers of our clients’ revenue cycle executives. They focus on strategy, determining the best ways to improve top and bottom line metrics across the enterprise. So, even though we’re providing an outsourcing arrangement, we work in tandem with our clients to identify and capitalize on improvement opportunities to enhance revenue cycle health.

What are some key considerations for healthcare leaders when choosing this type of product or service?

Obviously, the economics are important—organizations should know exactly what they’re getting for the price. For example, is the outsourcing company responsible for accounts until resolution, or does it expect you to handle some of the follow-up? Making calls and tracking down payments are a huge part of the cost-to-collect, and organizations should be clear on who is responsible for what.

There should also be defined metrics and benchmarks to which both parties agree. You should know how the outsourcing partner calculates its metrics, when it calculates them, and—probably most importantly—is the company willing to guarantee certain performance? Your partner should have some skin in the game, and there should be mutually aligned goals for higher collections, lower costs, and other key metrics. For instance, early on in an engagement, we establish benchmarks for monthly cash, the distribution of insurance versus patient responsibility, A/R days greater than 90, clean claim rates, and denial rates.

You should also seek out a partner that is committed to managing and protecting your brand within your community. We work closely with our clients to make sure our teams are interacting with consumers in a way that mirrors their approach to customer service and overall patient experience, minimizing any impact to their brand and reputation.

As healthcare organizations implement use of your product or service into their day-to-day operations, what advice would you give so they can set themselves up for success?

Culture is extremely important. To be successful, organizations have to have an appetite for change. Are you open to recommendations for improving the health of the revenue cycle? Are you willing to listen to suggestions and objectively review them? These are examples of some of the questions we ask our clients when they’re seeking this type of partnership. If you don’t have a culture that’s amenable to new practices, it can be hard to materially affect performance.

Communication is also key. Organizations should have a defined communication plan that details who the stakeholders are, what information they need, and how frequently they need it. This ensures that everyone in both organizations is on the same page and working toward the same goals. Even more important is a governance plan that outlines the guiding principles of how you’re going to do business together, implement change, and sign off on any recommendations.

Are there any educational materials you would like to share to help healthcare providers in these efforts?

Each fall, Cerner hosts the Revenue Management Symposium as a part of the Cerner Health Conference as a way to network, share best practices, discuss industry themes, and learn about new and emerging revenue cycle solutions. To learn more, go to Cerner.com/chc/rms. For additional revenue cycle resources, go to Cerner.com/RevWorks.
BLURRING THE LINES: PROVIDERS, HEALTH PLANS INTEGRATE IN RESPONSE TO VALUE-BASED CARE

As rates for managed care services decline and cost reduction intensifies, providers seek ways to build efficiencies and keep cost savings, while health plans hope to gain greater control of costs.

By Karen Wagner

Started in 2013, Northwell Health’s CareConnect health plan was not the health system’s first venture into the insurance business.

About 10 years ago, Northwell Health (then known as North Shore-LIJ Health System) tested the waters with a managed care initiative, says Robert Shapiro, executive vice president of finance and CFO for the New Hyde Park, N.Y.-based multihospital health system.

As it turned out, the waters were a bit too cold, and the health system retreated from the insurance business for a few years. But that first venture brought several lessons, one being that starting up a health plan involves a long learning curve.

Many healthcare organizations are learning similar lessons as the line between provider and payer grows increasingly blurry. To ensure optimal clinical-financial integration as the foundation of value-based care, health plans are developing care delivery capabilities and vice versa. Between 2012 and 2015, according to Avalere, provider-sponsored plans represented 54 percent of entrants into the Medicare Advantage market.¹

The reasons are clear enough. As rates for managed care services decline and cost reduction intensifies, providers are looking for ways to protect revenue and keep the cost savings. Health plans, meanwhile, want to control care delivery as a way to control costs of care at a time when medical underwriting is largely restricted and profits are limited under the Affordable Care Act (ACA).

In the process of moving to the other side of the table, providers and health plans are taking steps to develop new expertise in areas such as managing risk, managing costs, and leveraging clinical input to produce better financial and quality outcomes.
HIRING INDUSTRY EXPERTISE

Northwell Health’s first venture into insurance was with a Medicare managed care product. Its current product, CareConnect, offers individual and employer-sponsored health insurance and covers 10,400 lives.

One of the mistakes Northwell Health’s leadership made in that earlier start-up was not seeking expertise directly from the insurance industry, Shapiro says. “Setting up an insurance company is not an easy thing to do,” he says. “You need to bring in people who have done it before.”

Phoenix-based Banner Health also learned that lesson the hard way. The health system, which includes 29 hospitals, has been active in the insurance space since 2008, when it acquired a Medicare Advantage plan as part of a larger acquisition, says Dennis Dahlen, Banner’s senior vice president and CFO.

Dahlen says leadership was late to recognize the need for dedicated insurance subject-matter experts. “We cannot sustain good performance by repurposing team members with strong experience in the acute care space to the insurance marketplace,” Dahlen says. “We have recently brought in a significant number of leaders from the insurance industry—former CEOs, former CFOs, former provider network managers, and risk adjustment experts to populate our internal infrastructure.”

Dahlen says leaders from the insurance industry can provide expertise in key areas of benefits design, risk assessment, and transactional infrastructure. “Benefit design drives sales but can also drive adverse selection,” he says. Some benefits may attract members who are more likely to use services and drive costs. When appropriately designed, benefits should attract the right mix of high-risk and low-risk members. “That’s a skill set we didn’t initially bring to the table.”

Assessing the financial risk of health plan members requires assessing their health status. Under the risk adjustment factor that applies to Medicare Advantage plans and to ACA marketplace plans, the Centers for Medicare & Medicaid Services (CMS) adjusts a plan’s premium payments based on the health status of its enrollees. To fully assess a member’s risk in an effort to avoid losing Medicare reimbursement, insurers must appropriately document the medical history of all plan members.

After acquiring members from health plans that had folded and failing to obtain appropriate documentation of the members’ health histories, both Northwell Health

CARECONNECT COMMERCIAL ENROLLMENT

January 2014–September 2016

ASO: Administrative Services Only plans

Source: Northwell Health. Used with permission.
and Banner Health sustained millions of dollars in losses as a result of risk adjustment. “You can give up all profits at the end of the year if you don’t properly document healthcare conditions and do healthcare assessments on every patient,” Dahlen says, noting the difficulty of estimating the risk adjustment factor in the ACA marketplace plans in particular. Without proper documentation, he adds, a plan is guaranteed to not be paid appropriately.

A health plan’s claims processing system should also be up to contemporary standards and include all the appropriate checks and balances, such as prior authorization filters, to prevent providers from taking advantage of weaknesses in benefits design that can produce material increases in claims costs, Dahlen says. “We’ve actually been quite surprised at how resourceful providers are in finding gaps in our prior authorization design and our claims system filters to deluge us with claims,” he says.

OUTSOURCING EXPERTISE
Incorporating industry expertise internally is necessary but not always sufficient. Banner Health just recently outsourced a large part of its insurance infrastructure to a company that provides support for provider-sponsored health plans, particularly with risk adjustment and contractual compliance. Dahlen says the company has mature tools, processes, and approaches and the expertise “to make us better, faster.”

Dahlen says large employers and health plans have been very interested in Banner Health’s value-based products, helping its insurance premium revenue grow quickly to $1 billion. However, during the last fiscal year, the health system lost about $50 million on the insurance operation, mainly due to the risk adjustment program, and will probably lose that much again this year, he says.

“We’re at scale and can’t afford to continue to be suboptimal, so we need to improve performance of the insurance operation quickly—and bringing in a partner is the best way to do that,” Dahlen says.

IMPROVING COST MANAGEMENT
Inefficient cost management can also spell doomsday for a health plan—another major factor in the demise of Northwell Health’s earlier product, Shapiro says. The Medicare product was covered with a per member/per month premium, and problems arose when members

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**CAREMORE: HOSPITAL OUTCOMES (2015)**

<table>
<thead>
<tr>
<th></th>
<th>Average inpatient admissions per thousand beneficiaries</th>
<th>Average inpatient bed days per thousand beneficiaries</th>
<th>Average inpatient length of stay (in days)</th>
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<tr>
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<td>5.0</td>
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<tr>
<td>CareMore RAF* Adjusted</td>
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<td>812</td>
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<tr>
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Results compared to Medicare fee-for-service (FFS) average

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<tr>
<th>CareMore vs. Medicare Average</th>
<th>CareMore RAF* Adjusted vs. Medicare Average</th>
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</thead>
<tbody>
<tr>
<td>20% fewer admits</td>
<td>40% fewer admits</td>
</tr>
<tr>
<td>4% lower length of stay</td>
<td>19% lower length of stay</td>
</tr>
<tr>
<td>23% lower bed days</td>
<td>44% lower bed days</td>
</tr>
<tr>
<td>18% fewer readmissions</td>
<td>39% fewer readmissions</td>
</tr>
</tbody>
</table>

Source: CareMore Health System. Used with permission.

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*Risk Adjustment Factor

Source and methodology: CareMore Health System 2015 year-end data. Admissions and days are rates per 1,000 beneficiaries; inpatient length of stay is in days; readmissions are 36-day acute hospital readmissions. Medicare averages from most recent data available, 2013 HHS Health Information Warehouse (www.healthindicators.gov). Statistical data is not endorsed by Medicare.

CareMore Health Plans operate multiple plans under three federally approved Medicare Advantage contracts. The plans serve a total of more than 60,000 Medicare members throughout Southern and Northern California; Las Vegas; and Phoenix and Tucson, Ariz. CareMore specializes in healthcare services that help Medicare beneficiaries who are chronically ill and/or frail.
sought care at hospitals outside the health system. For example, a member who sought emergency care at a nonsystem hospital would then be admitted to that hospital, leaving North-Shore LIJ unable to control cost drivers such as length of stay.

Northwell Health’s current health plan uses a narrow network of providers, including hospitals that are not part of the health system but are willing to accept the health plan’s rates. While noting the goal is to grow the network over time, Shapiro says this approach balanced the cost equation. “If I had to pick one thing that mattered, it was the narrow network,” he says.

Another way to gain a better handle on care costs is by controlling care delivery. In 2011, health insurer Anthem, Inc. (then known as WellPoint) acquired CareMore Health System, a Cerritos, Calif.-based medical practice group that began by offering Medicare Advantage plans targeting high-risk elderly patients and then expanded to Medicaid patients. CareMore is operationally and strategically independent from Anthem but supports Anthem’s overall senior business growth and healthcare value strategies.

Rather than relying primarily on specialists to treat high-risk, chronic patients, the CareMore model uses a high-touch, team-based approach at its care centers to treat patients in a primary care-like setting. The focus is on prevention and highly coordinated care with the aim of delivering higher-quality care at lower costs. Outpatient visits at these centers last anywhere from 25 to 45 minutes, compared with a national average of eight to 12 minutes, says Sachin H. Jain, MD, president of CareMore. The extra time allows for better patient engagement, he says.

Both the number and length of patient visits help to delay progression of chronic diseases such as diabetes, obesity, and congestive heart failure, Jain says. For example, 51 percent of CareMore’s high-risk outpatient diabetes patients have optimal control of their condition, meaning they have hemoglobin A1C levels of less than 8.

In 2015, Jain says CareMore members on average had 20 percent fewer hospital admissions, 23 percent fewer bed days, and 18 percent fewer readmissions than Medicare fee-for-service beneficiaries.

“It’s really about staying close to patients with chronic disease,” says Jain, formerly a senior adviser to Donald Berwick when Berwick was administrator of CMS. “We view our job as preventing them from going to the hospital in the first place.”

When patients are admitted, CareMore uses “extensivists” to improve care transitions. These physicians manage the care of patients from acute care to post-acute care settings to better improve their conditions and maintain a patient-centered relationship, Jain says.
ENGAGING CLINICIANS

Jain believes the CareMore model represents the wave of the future in both how care is delivered and the nature of the relationship between provider and health plan.

“One of the things that hamstrings traditional provider organizations is that benefits don’t always align with what you should do for patients,” Jain says.

CareMore physicians were instrumental in developing the care centers and also are involved in benefits design. One result of that clinical input is a free toenail clipping service for elderly patients. The service may seem minimal, but Jain says wounds that arise when seniors attempt to trim their toenails and that subsequently get infected are a primary cause of foot amputations in that population.

Jain says CareMore is also in the process of integrating dental care into the care centers.

“What’s happening is the intelligent design of healthcare delivery that’s just not possible without that conversation between payer and provider,” Jain says.

“I think you’re only going to see more blending and blurring of these industries that historically have been very siloed.”

SECRETS TO LONG-TERM SUCCESS

Presbyterian Healthcare Services (PHS) first started a health plan in 1986. The plan, which is owned by the not-for-profit, eight-hospital health system, currently covers about 470,000 lives.

Jim Hinton, president and CEO of Albuquerque-based PHS, says there have been years when the underwriting cycle has favored ownership of a health plan, which has been a good business strategy on a stand-alone basis.

“But I think the real reason why we’ve stayed in the health plan business is we have seen the value of the payer and provider having a common perspective, and not working at cross purposes but trying to align what is best for the payer—whether that’s a business or the government—with the actual member who uses the care,” he says. “We can identify opportunities that we’ve been able to pursue that would not have been possible without close alignment among parts of our system.”

Some of these opportunities include the development of programs to reduce costs of care, such as an emergency department navigator to transfer patients not requiring emergent care into more appropriate care settings. Hinton says if the organization consisted of only a hospital, it would lack the financial incentive to develop such programs in a fee-for-service environment. Because of the health plan, the organization benefits from reduced costs of care while the patient receives care in a more appropriate setting.

INTEGRATION OPTIONS VARY BY CIRCUMSTANCE

Whether provider/payer integration favors developing a health plan, acquiring one, or partnering with an existing plan depends largely on market and organizational characteristics.

In markets where risk contracting is prevalent, getting to scale quickly may be necessary, so an acquisition may make sense.

“But the good health plans that are doing well are hard to acquire because they’re expensive,” says Jim Hinton, president and CEO of Presbyterian Healthcare Services, which consists of eight hospitals and a separately run health plan that was started in 1985.

Before starting its own plan in 2013, Northwell Health explored the possibility of partnering with or acquiring a plan but decided that revenue would be greater with its own product. “Consider what your future revenue will look like and see if that’s the right thing to do for your company,” says Robert Shapiro, the health system’s executive vice president of finance and CFO.

For CareMore Health System, becoming part of a large health plan like Anthem, which acquired CareMore in 2011, has enabled the provider group to branch into the Medicaid business and involve physicians in the design of benefits plans to better serve chronic patients, says Sachin H. Jain, MD, the system’s president.

“Being able to have that engaged dialogue internally within the company has created new opportunities for us to serve patients and serve population health,” he says.

Partnering, on the other hand, can provide expertise quickly without the complexities of full acquisition. Banner Health’s general strategy is to engage in joint ventures with health plans as a way to align incentives between the provider and plan to create an integrated, consumer-centric product, says Dennis Dahlen, senior vice president and CFO. “Don’t be afraid to partner,” he says.

“It’s not that the independent payers aren’t willing to have those discussions,” Hinton says. “But they tend not to be quite as receptive because of how their underwriting models work. Having your own plan really creates more openness to that type of innovation.”
Other PHS steps have been effective as well. One is a call center for the hospitals, clinics, and health plan that serves as a one-stop shop for members, allowing them to call only one number to inquire about clinical and insurance matters. “I think that may be one of the highest-value areas in our whole organization,” Hinton says.

An electronic health record has enabled more efficient communication of data between the provider and the health plan for individuals who are both patients of the delivery system and members of the health plan, and better data access among all parts of the organization. “When you start putting all these pieces together, you can really have a more robust patient experience than in a fragmented model,” he says.

FOCUSING ON PATIENTS
Even with the need for healthcare organizations to remain financially viable in a changing environment, that patient experience, in essence, is the fundamental driver of health plan/provider integration and should be an integrated system’s North Star, Hinton says. Achieving a smooth patient experience in the ambulatory and inpatient settings and within the health insurance function is the grand prize.

“In getting to the prize, you have to recognize that each of these businesses is slightly different,” Hinton says. For instance, providers and health plans have different regulatory, financial, and technical environments that must be managed through expertise specific to that industry.

“Making sure that you respect the differences is the first step to creating integration,” he says. “Get the expertise you need to succeed in the business and then create a journey towards a more seamless customer experience.”

Karen Wagner is a freelance healthcare writer based in Forest Lake, Ill., and a member of HFMA’s First Illinois Chapter (klw@klw.ms).

Interviewed for this article: Robert Shapiro, executive vice president, finance, and CFO, Northwell Health, New Hyde Park, N.Y. (bshapiro@northwell.edu); Dennis Dahlen, senior vice president and CFO, Banner Health, Phoenix (dennis.dahlen@bannerhealth.com); Sachin H. Jain, MD, president, CareMore Health System, Cerritos, Calif. (sachin.jain@caremore.com); Jim Hinton, president and CEO, Presbyterian Healthcare Services, Albuquerque (jhinton@phs.org).

FOOTNOTE:

“We have seen the value of the payer and the provider having a common perspective, and not working at cross purposes but trying to align what is best for the payer with the actual member who uses the care.”
— Jim Hinton, president and CEO, Presbyterian Healthcare Services
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USING DATA AND ANALYTICS TO IMPROVE CLINICAL AND FINANCIAL PERFORMANCE

Access to data and to robust analytics helps provider organizations target areas of unwarranted variation in care and craft a strategy to deal with the issue.

A column by Walter W. Morrissey, Robert W. Pryor, and Anand Krishnaswamy, Kaufman, Hall & Associates, LLC

Data and analytics are no longer nice-to-have tools. Instead they underpin an organization’s ability to achieve high-value care, which we define as patient-centric care with improved quality and outcomes, at lower costs. Because healthcare reform—particularly Medicare payment reform under the Medicare Access and CHIP Reauthorization Act—puts all providers at risk financially if they fail to improve value, data and meaningful analytics are critical elements of the cost of doing business. With such tools, hospitals and health systems can drive the performance improvement needed to succeed in a value-based environment.

For most hospitals and health systems, unwarranted variation in care is a significant source of suboptimal patient outcomes and unnecessarily high costs. Such variation is present in clinical practice when there is a gap between the desired best practice and current practice. An analysis that excludes outliers and is risk- and severity-adjusted can indicate when quality outcomes and/or costs differ significantly by physician or other care provider. This apples-to-apples analysis produces actionable data that can be used to eliminate or decrease the performance gap.

Causes of unwarranted or inappropriate variation may include:

- Suboptimal clinical practices or processes (e.g., not implementing an accelerated mobilization protocol, which is a practice expected of care providers for patients following hip or knee replacements, except in rare cases1)
- Overuse of supply-sensitive care, (e.g., higher use of specialists in regions where more specialists practice, such as by obtaining cardiology consults for all patients with chest pain)
- Misuse of preference-sensitive care (e.g., use of a high-cost orthopedic prosthesis or drug when a lower-cost version would be equally effective or appropriate for a particular patient)
- Underuse of proven effective care (e.g., not using prophylaxis for deep venous thrombosis with surgical patients)
- Provision of services or procedures that are not clinically indicated (e.g., unnecessary diagnostic testing)

Challenges to reducing unwarranted variation include gaps in clinicians’ knowledge, lack of economic incentives to drive desired clinical behaviors, concerns about malpractice risk, physicians’ desire for the ability to go with personal preferences, and inadequate decision-support tools.2

Hospitals and physicians typically have been compensated for the care they provide even if such care creates unwarranted variation in quality or cost. The value mandate from both private and public purchasers and payers is rapidly changing this situation, putting a high-intensity spotlight on unwarranted variation in care and providing incentives to reduce such variation.

ENSURING CREDIBLE DATA

An organization-wide approach to reducing clinical variation must be supported by a commitment from the leadership team to aggregate, analyze, and disseminate credible data related to quality, outcomes, and cost. Benchmark data and advanced analytics that use such data enable the organization’s leadership and quality teams to compare performance against a variety of factors:

Historical trend performance and/or performance targets. This assessment looks at the performance of the hospital or health system using the organization’s own data, either overall or by hospital, department, physician, treatment type, patient diagnosis, or other considerations.
Peer group comparisons. Data from public and commercial sources enable comparison of the organization’s performance with that of an appropriate peer group, defined as of similar type with like functions, services, operating revenue, or other factors.

Using benchmark-based reports and scorecards, hospital executives and managers are able to observe patterns of performance based on factors such as diagnosis, comorbidities, treatment type, department, and physician. Areas of undesirable variation can be explored and targeted for improvement.

DETERMINING EARLY AREAS OF FOCUS: CASE STUDY

One health system with three hospitals and approximately 300 affiliated and employed physicians sought an assessment of its performance compared to peer organizations on selected measures of utilization, quality, cost, and patient safety. The goal of the assessment was to enable the health system to identify areas where it should focus early efforts to reduce clinical variation.

The health system used data from its own performance records and from public and proprietary databases. It obtained a robust analytic platform with more than 2,000 performance indicators, which enabled a view of how the system performed internally over time and comparatively with other organizations regionally and nationally (peer organizations were selected from among more than 5,000 hospitals nationwide). Measures included length of stay (LOS), mortality rate, critical care utilization, emergency department admissions, hospital-acquired conditions, and cost.

Based on all-payer data for the most recent 12-month period, the organization was performing below the 50th percentile in LOS (see the exhibit on this page) and mortality rates and below the 25th percentile in critical care utilization compared with all hospitals and with a regional community hospital subset nationwide (the data were severity- and risk-adjusted). Analytics identified the sources of the greatest performance variance by department, clinical condition, and physician.

Data credibility is the essential foundation for driving behavioral change. Physicians who receive reliable data with evidence of unwarranted variation in their own care—whether related to quality, outcomes, or cost—typically need no further inducement to bring their practices in line with their colleagues.

WHERE TO START

Building a sustainable program to eliminate unwarranted clinical variation can be undertaken one step at a time. The focus initially may be on an individual DRG or on use of a certain drug, device, test, procedure, condition, work process, clinical program, or other element of patient care. Prioritization of which areas to tackle first can be based on a number of factors, including likelihood of early success, magnitude of the benefit or opportunity, resources required to effect change, and expected implementation timing.

Following such a prioritization exercise, the organization can focus on the categories of data or measurement that typically reflect the most significant opportunities to reduce unwarranted care variation. For example, some of the major categories of resource utilization are:

- Medical/surgical supplies: Physician preference items often have high cost differentials.
- Pharmacy: Brand-name drugs, as opposed to generic drugs, and drugs for certain therapies have high cost differentials—and sometimes may be no more effective.
- Accommodation: LOS can indicate physician and staff practice patterns and processes that positively or negatively affect how patients move through the hospital and discharge.
- Laboratory and pathology: Standing orders for daily tests, as an example, may or may not be needed or appropriate.
- Imaging: The physician’s choice of imaging options, including MRI, CT, ultrasound, and X-ray, has a large impact on cost.
For one $3 billion hospital system, benchmark data of a peer group of large hospitals in the Northeast indicated the size of the improvement opportunity in these and other categories (see the exhibit on this page). For the top five categories, the hospital system’s costs were approximately $135 million higher than those of its peers.

Looking at its own data across the top five measure categories and overall, the organization was able to identify which physicians had the most significant opportunities to reduce variations in care. All Patients Refined DRG data were severity-adjusted, and outliers were excluded.

When compared with their peers, three physicians in different specialties accounted for nearly $2 million in potentially unwarranted care variation. This variation represented 10 to 20 percent of the total variation and spend in each of their service lines. The opportunities to reduce variation and costs in medical/surgical supplies and imaging were particularly notable. Further assessment of spending by category indicated specific products that might be adding unnecessary cost or varying from patient protocols.

Physician 1, for example, used more anesthesiology supplies per minute than did his peers—and the highest-cost surgical mesh. As was the case in this instance, often physicians simply are unaware of the cost of the items, tests, or drugs they order and can shift their ordering behavior without affecting their patients.

**DRILLING DEEPER**

Even more powerful analytic work looks at the relationship between care quality, patient satisfaction, and cost indicators by hospital and physician. For example, reducing unwarranted variation in knee and hip joint replacements presents an important area of organizational focus in the current regulatory environment. Effective April 1, 2016, the Centers for Medicare & Medicaid Services rolled out a mandatory bundled payment program in 67 markets. Known as the Comprehensive Care for Joint Replacement, it involves approximately 800 hospitals. By making hospitals responsible for all charges within 90 days of discharge, the program incentivizes hospitals to optimize inpatient care, streamline postoperative care, and discharge patients to lower-cost settings or directly to home when appropriate.

In the context of knee joint replacement, a best-practice analysis for one multihospital system identified the best-performing hospital in the system based on indicators including length of stay; total cost; a risk-adjusted patient safety index including pressure ulcer...
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<th>APR-DRG</th>
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<th>Operating Physician</th>
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<th>LOS Opportunity</th>
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Source: Kaufman, Hall & Associates, LLC. Used with permission.
rates, postoperative infections, and other measures; the hospital-acquired condition rate; and a patient satisfaction rating. The benchmark was based on all-payer data for short-term acute care facilities nationwide.

Drilling down within the best-performing hospital, the analysis identified the best-performing operating physician for knee joint replacement using the same indicators. Based on data covering a two-year period, the top exhibit on page 46 shows the results for 10 physicians, highlighting that Physician 1 performed above the national all-payer benchmark on all dimensions.

Further analysis established what the improvement opportunity might look like if the lowest-performing physicians performed at the level of Physician 1. The bottom exhibit on page 46 shows those results, which would bring a cost-reduction opportunity of nearly $10 million.

The health system’s chartered clinical improvement team closely studied the clinical practices of Physician 1 to learn specific means by which he was able to ensure patient safety and quality while reducing surgical and related hospital costs. Directed by physicians with participation from nurses and other clinical team members, this is the hard work that needs to be done to reduce unwarranted clinical variation in hospitals and other facilities nationwide. The benchmark data and analytics identified the target and set the stage for the work that followed.

**IT’S ALL IN THE TOOLS**

Hospital leaders need access to credible and accurately attributed data and analytics that enable them to identify both significant opportunities to improve financial and clinical performance and the root causes of suboptimal performance that require corrective action. Armed with the ability to simultaneously access data on utilization, quality, patient satisfaction, and cost, and benchmarks of internal and external best-practice care, executives can quickly identify underperforming areas to which attention should be directed.

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**FOOTNOTES:**

2. Ibid
When a physician recommends an MRI to a patient, the patient doesn’t usually say, “Hold on, Doc. I have a $6,000 deductible. Let me see where I can get the best price on this,” and consult an app on her smartphone. Even though such apps exist, many can’t yet provide personalized—that is, accurate—information. Getting a specific, detailed out-of-pocket price estimate typically requires about an hour of a consumer’s time, according to the consumer financial advice site Nerdwallet. 1 (Anecdotally, it often takes longer.) HFMA offers consumers a guide that walks them through the price estimate process (hfma.org/consumerguide). However, an informed consumer still needs effective tools to use.

Despite the “hassle factor,” we, as an industry, should encourage consumers to get estimates for elective care and to factor price and quality information into their decisions. Doing so helps people manage their out-of-pocket expenses while helping the healthcare industry become more responsive to consumer needs.

In addition, we should work on reducing the hassle factor and making it easier for physicians and patients to have these crucial financial conversations. This will necessitate improving price transparency tools, integrating them into everyday clinical encounters, and—perhaps most important—making financial conversations part of the culture.

**Improving transparency tools.**
Recent years have seen a proliferation of price transparency tools. The more useful tools incorporate a consumer’s own insurance information into the estimate. For example, an article in this issue of *Leadership* highlights an online tool developed by the University of Utah Health Care that allows consumers to select a common procedure, choose their type of insurance coverage, and then enter specifics such as deductibles and copayments to get an estimate of their financial responsibility.

**Integrating financial conversations and tools into everyday clinical encounters.** In light of time and other constraints on office visits, the Robert Wood Johnson Foundation (RWJF) is funding research studies designed to establish best practices for embedding tools and resources that support cost-of-care conversations into the clinical workflow and the patient/caregiver “life flow.” As RWJF states: “Cost-of-care conversations have the potential to transform care delivery, moving our health care system toward higher-value care and enabling patients to make the best choices for their needs. But first, we need to figure out how to get that conversation right.” 2

HFMA has developed guidelines for revenue cycle staff to handle sensitive financial conversations with patients (hfma.org/communications). It’s time for clinical and nonclinical leaders alike to help make financial conversations between physicians and patients a routine part of clinical encounters, when appropriate. Physicians aren’t expected to be experts in revenue cycle, insurance coverage, or where to comparison-shop, but it is not unreasonable to have staff who are. Patients will come to expect the opportunity to make healthcare purchasing decisions the way they make other purchasing decisions, and they deserve nothing less. +

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