

# Finding the Future of Value

A REPORT FROM HFMA'S 11TH ANNUAL THOUGHT LEADERSHIP RETREAT

WINTER 2018

*Providers and health plans need to broaden their views to find and implement approaches that deliver greater value to the patient while ensuring the financial sustainability of the system.*

## EXECUTIVE SUMMARY

A growing number of innovative leaders in the healthcare industry are starting to pay more attention to the real drivers of healthcare costs: chronic health conditions, behavioral health and substance abuse, social determinants of health, and end-of-life care.

The complexities of addressing those issues, and the successes that some health plans and providers have had, were the focus of HFMA's 11th Annual Thought Leadership Retreat in October. The gathering brought together 100 thought leaders from across the healthcare industry

to share ideas on ways that providers and health plans can identify those underlying drivers of healthcare costs and find potential solutions.

### TOPICS ADDRESSED IN THIS REPORT INCLUDE:

- Responding to the consumer push for lower costs and high quality
- Addressing social determinants of health
- Coordinating an approach to changing patient behavior
- Measuring to ensure sustainable improvements

## A Message from HFMA's President and CEO

### DEAR COLLEAGUE:

Thank you for joining us for HFMA's 11th Annual Thought Leadership Retreat. In partnership with the Alliance of Community Health Plans, the American Association for Physician Leadership, and the American Organization of Nurse Executives, HFMA was pleased to provide a forum for more than 100 leading physician, hospital, and health plan representatives to convene in October to discuss the future of value.

We chose *the future of value* as the conference theme because the value transformation is at a crossroads. The trends that are driving change are now compelling us to "fix the airplane while we are flying it." Early experimentation with value-based care and payment models must give way to a laser-sharp focus on initiatives with the potential to move the needle on value improvement—even if those initiatives are outside our comfort zone.

Thought leaders who spoke at the retreat agree, and they weren't afraid to tackle the tough topics: How can health systems address social determinants of health, a highly impactful area that has traditionally been outside their purview?... How will the healthcare industry avoid further counterproductive proliferation of clinical quality metrics, and agree on measures that matter? ... What real-world factors can accelerate innovation and adoption of digital solutions?

These and other important issues of the day are explored in this report. As you read it, I hope you will be inspired to take a fresh look at your organization's approach to improving value and consider how to get to the next level on your value journey in 2018. While other priorities may seem more urgent, few, if any, are more important.

In closing, our sincere thanks go to our sponsors—Humana, Navigant, and Xtend Healthcare—for their generous support of this conference. Finally, I want to thank you for your contributions to the in-depth discussions that set this conference apart and help our industry move forward.

Best regards,



Joseph J. Fifer, FHFMA, CPA

President and CEO

Healthcare Financial Management Association

## INNOVATION DRIVEN BY CONSUMER DEMAND

As consumers take on more and more responsibility for paying for health care, alternatives for delivery will become more accessible both in the United States and internationally, says Jason C. Lineen, vice president of strategy for AVIA Health.

The United States spends twice as much as other developed countries to deliver health care, without significantly better outcomes, Lineen says. “We heard [at this retreat] that 12 million serious diagnosis errors occur every year.”

If author and famed Harvard economics professor Clay Christensen were commenting on the issue, Lineen notes, he might say the mechanism that can make health care more affordable is the same that has affected every industry from cell phones to air travel.

“We cannot expect the expensive incumbents to magically become cheaper,” Lineen says. “We need to bring together technology and innovation that enable lower-cost sites and lower-cost caregivers to do more sophisticated things.”

This premise has resulted in a model that is currently being tested and scaled in the Cayman Islands, having succeeded at the Narayana Hrudayalaya Hospital in Bangalore, India. The founder, Devi Shetty, a renowned cardiac surgeon, has opened Health City Cayman Islands, an advanced tertiary hospital that aims to deliver high-quality and affordable care. The project is supported by Narayana Health and Ascension.

Narayana Health has found a way to achieve scale and volume. For example, the heart hospital in India has built the infrastructure to

## NOTEWORTHY INDUSTRY TRENDS AND FACTORS

- The pace of digital technology is accelerating dramatically.
- Digital disruptors and enablers are blurring the lines between organizations that are trying to disrupt the healthcare sector or to facilitate the business of health care or the transition to value.
- Although healthcare organizations are conducting a wide range of pilots, it is taking the industry too long to scale impactful solutions that could bend the cost curve. “I would argue that incrementalism won’t get us where we need to be,” says AVIA Health’s Jason Lineen.

perform 60 heart surgeries a day while maintaining quality standards that are on par with U.S. metrics, Lineen says. The volume has dramatically lowered per-patient costs.

“As the affordability question becomes more and more of an issue, [models like this] become more and more of an option,” Lineen says.

“Consumerism is not a new topic for finance leaders, but we need to think hard about its implications,” he says. “One study released by the Health Care Cost Institute showed that 43 percent of the total healthcare spend in commercially insured populations is on what they consider ‘shoppable services.’”

Despite a recent *Health Affairs* study showing low adoption of price transparency tools by consumers, Lineen believes that “we are at a precipice. I think the tools are going to take off.”

*“Amazon didn’t kill the retail industry; they did it to themselves with bad customer service.”*

—Jason C. Lineen, vice president of strategy for AVIA Health

Health care is shifting from a business-to-business (B-to-B) industry to a business-to-consumer (B-to-C) marketplace. Although technology by itself is not really a disruptor, being “non-consumer-centric” is the biggest threat to any business.

Just consider the possible implications of the Whole Foods acquisition by Amazon, or Amazon’s “skunkworks” initiative—a healthcare technology laboratory of sorts—that is now making headlines. “Amazon didn’t kill the retail industry; they did it to themselves with bad customer service,” Lineen says.

Consider the power of technology, Lineen says. Microsoft published the results of a study in the *Journal of Oncology Practice*, presenting data that showed, with a high degree of predictive value, that Internet search queries by users could predict a diagnosis of pancreatic cancer.

How? By entering information into the search browser, users are in fact giving information and, likely, a brief health history of themselves or someone in their family. For example, search query results could determine that the person was a runner, and then he or she stopped running. A search may be initiated for lower back pain. A few weeks later, the search is for stomach pain, and a couple weeks after that, sudden loss of appetite, followed by yellowish skin. This string of searches can drive a high predictive value about a health condition even before a diagnostic test is initiated by a healthcare provider.

“I know for a fact there is a company being incubated that’s trying to pull together consumer purchase history, search data, and biometric data to become a personal surveillance tool. If a system was able to aggregate all this data about an individual, you could pretty reliably predict future health events or future health issues,” Lineen says.

But innovative disruption can surface in more traditional ways as well.

A Chicago-based company called Oak Street Health is an example. Oak Street Health has essentially flipped the model of primary care and has found a commercially viable way to deliver care for the most vulnerable elderly communities under a capitated structure.

They are doing it by leveraging technology in “a high-touch way, and they are getting some phenomenal results,” Lineen says.

#### Consider these features:

- **The average length of visit is one hour and 15 minutes.**
- **Oak Street’s waiting areas are like community centers and host events such as Bingo. This component is a key driver of satisfaction scores.**
- **High levels of engagement have reduced hospitalizations by 40 percent.**

While the company is currently managing only 20,000 lives, what happens when such a model manages 1 million lives in a Medicare Advantage plan?

The secret, Lineen says, hinges on three common features:

- Creating patient-centric cultures that drive high net-promoter scores
- Leveraging data in analytics and biometric modeling
- Understanding the patient’s needs in real time to enable early interventions

Healthcare organizations need to innovate to change the trajectory of the industry, Lineen says. For most organizations, in fact, long-term financial health will depend on that ability.

According to the American Hospital Association and AVIA Digital Innovation Survey, more than 75 percent of leaders believe the effective use of digital solutions is essential. And almost one-third of leaders have launched an innovation center or are planning to do so in the next 18 months.

**The survey also revealed the top five innovation priorities:**

- **Convenient patient access (including telemedicine)**
- **Operational efficiencies**
- **Patient-generated data and personalized services**
- **Referral management and in-network retention**
- **Social community support**

Healthcare leaders should invest in technology, Lineen adds, and set clear stage goals. If a pilot or program isn't performing, let it fail quickly. If it is performing, move quickly to scale it and replicate it across the organization.

**TAKING ON POPULATION HEALTH MANAGEMENT**

Health care is moving through an "age of experimentation" with a widening assessment of value-based payment models, says HFMA President and CEO Joseph J. Fifer, FHFMA, CPA.

But the ability of many of these models to truly bend the cost curve has been limited, largely because our society has not adequately addressed the prevalence of preventable diseases.

Consider that nationwide implementation by the Centers for Medicare & Medicaid Services (CMS) of a pilot project of bundled payments for joint replacements was projected to save Medicare only about



**INNOVATION BARRIERS**

FIG. 1

Source: Presentation by Jason C. Lineen, AVIA



**INNOVATION ACCELERANTS**

FIG. 2

Source: Presentation by Jason C. Lineen, AVIA

\$400 million, or 0.01 percent of national healthcare expenditures, in 2016.

In contrast, a 13 percent reduction in the number of people with uncontrolled high blood pressure would save the United States more than \$25 billion a year in healthcare costs.

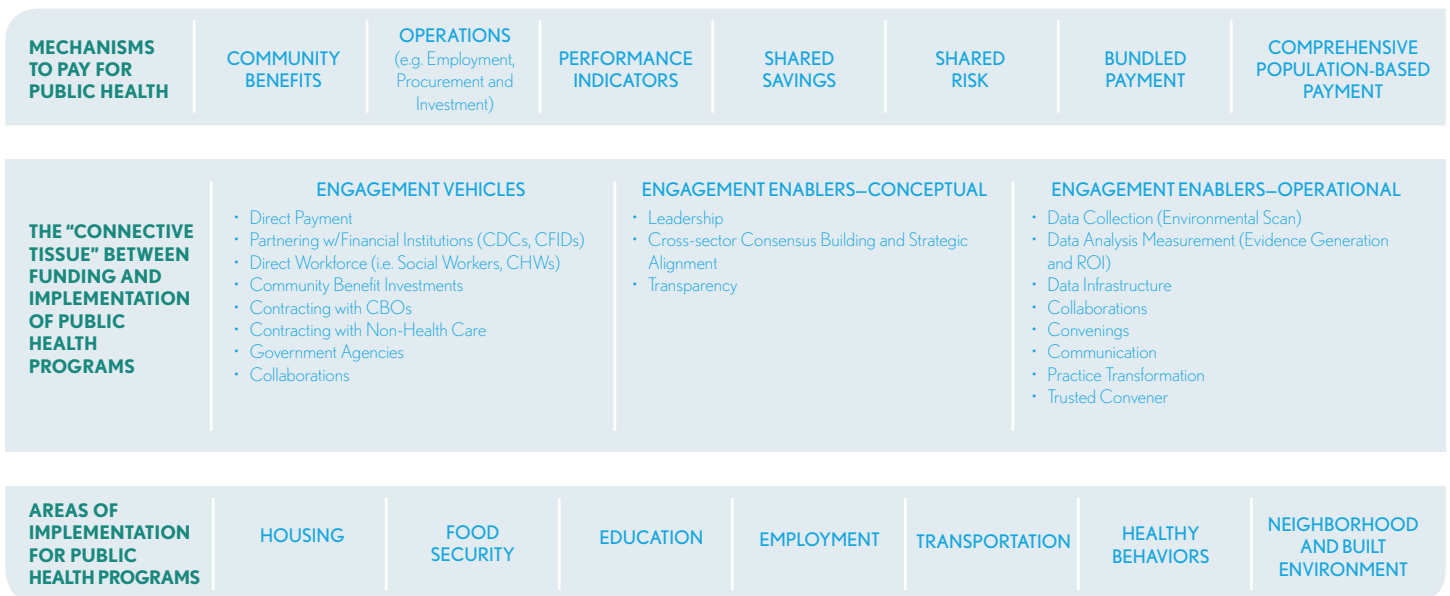
AcademyHealth has launched a project to identify ways in which communitywide population health can be improved through more a supportive healthcare payment system.

The project has found that alternative payment models generally lack the funding for broad population health improvement, says Enrique

Martinez-Vidal, vice president, state policy and technical assistance, for AcademyHealth. Instead, population health initiatives are usually funded through grants and community benefit structures of hospitals and not-for-profit health plans.

But various “enablers,” or “connective tissue,” between healthcare payment systems and traditional population health funding systems can help better support population health outside the walls of hospitals. That connective tissue includes data infrastructure, an environment of trust, payment and financing models, and alignment between clinical and community resources, Martinez-Vidal says.

### ALTERNATIVE PAYMENT MODELS



## PAY-FOR-PUBLIC-HEALTH ANALYTIC FRAMEWORKS AND ASSUMPTIONS

FIG. 3

Source: Presentation by Enrique Martinez-Vidal, AcademyHealth

# Key takeaways from speakers at HFMA's 2017 Thought Leadership Retreat:

Although individual-market insurance plans and Medicare Advantage (MA) plans have their respective advantages, **Gordon Edwards**, CPA, CFO of Marshfield Clinic Health System, highlights the benefits of higher retention rates in the latter. The national average retention rate among MA plans is about 89 percent, and as high as 95 percent in some local plans.

"Having a longer retention rate helps you do better case management," Edwards says. "You know this population. You know these members are going to stay with you for six, seven, or eight more years. You can build around that case management. They know your brand. They want to stick with your brand."

One secret to the success of Security Health Plan, according to **Krista Hoglund**, director of actuarial and risk adjustment services, is its ability to convert a high percentage of commercial and Medicaid plan enrollees into MA plans once enrollees become eligible for Medicare.

"We've been able to do that because we have really comprehensive plans around benefit pricing and really good customer service," Hoglund says.

Providers looking to launch a MA plan need to begin preparing 12 to 24 months in advance, says **Mary Anne Jones**, senior vice president and CFO of Priority Health. That lead time needs to be spent figuring out the provider's market and what products should be offered, and engaging with pricing.

"The actuarial step is key in ensuring that you've got a market-driven price, but also a sustainable price, and that all your assumptions that go into that pricing will be supported by the initiatives you plan to deliver on," Jones says.

**Puneet Budhiraja**, vice president and chief actuary with Capital District Physicians' Health Plan, has examined other not-for-profit health plans around the country and found that—like his organization's high-star MA plan—their operation tends to be concentrated in so-called double-bonus counties. In such counties, high-star plans can garner twice the available bonus.

Double-bonus counties are metropolitan statistical areas in which the population exceeds 250,000, at least 25 percent of eligible beneficiaries are enrolled in an MA plan, and Medicare fee-for-service costs are lower than the national average.

A unique component of the insurance plans offered by UCare Minnesota is the inclusion of a dental benefit, says **Elizabeth Monsrud**, CFO. All plans include preventive dental benefits, and individuals can choose to purchase more comprehensive benefits.

"The other thing that we do is when individuals enroll in our plan, we ask each individual to select a primary care clinic," Monsrud says.

"Going back to our primary-care roots, we actually have a prospective selection rather than assigning members through attribution."

"I really think that there's a way to sort of start blending and aligning the different payment models," Martinez-Vidal says. "What we've been starting to call this when we see this happening in communities is: How to create a portfolio of investment to improve population health."

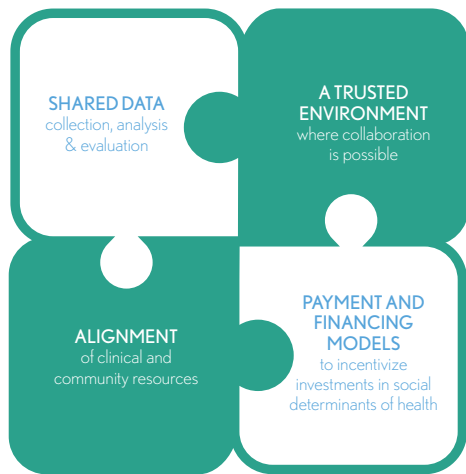
## AFFECTING SOCIAL DETERMINANTS OF HEALTH

Angela Sherwin, vice president of Medicaid accountable care for Steward Health Care, says building community-based partnerships has proven to be "mission critical."

"Importantly, we've tried to elevate those partnerships to make sure that community-based organizations know that they need to be equal partners at the table with us in this transformation," Sherwin says.

Instead of trying to bring many population health programs in-house, Steward has found success in supporting and working with organizations that specialize in providing behavioral health care, long-term services and supports (LTSS), and access to housing, food, transportation, and child care.

Steward has entered into contracts with such organizations, with a long-term vision of establishing shared-responsibility contracts for a specific patient population through clinical integration and financial alignment.



## WHAT ELEMENTS ENCOURAGE COLLABORATION AND SUPPORT FINANCING

FIG. 4

Source: Presentation by Enrique Martínez-Vidal, AcademyHealth

Among the lessons learned from these relationships are the importance of sharing data and information on an automated basis and the need for care coordination.

“We also worked on identifying some of the operational metrics that were needed to hold ourselves accountable to each other as part of the relationship,” Sherwin says.

“Some of the things that we funded and supported included basic data collection and infrastructure, to systematize asking questions about social determinants of health,” Sherwin says. “To make sure that we can effectively quantify and measure the problem, and identify where there is a problem and how to pair it to resources in the communities.”

The newest funding stream in Massachusetts will come through an 1115 Medicaid waiver, which goes into effect in 2018. That waiver

is expected to make “significant investments available for ACOs [accountable care organizations] to be able to transform these relationships,” Sherwin says.

The commonwealth is contracting directly with behavioral health organizations and LTSS organizations to bring in more resources around community-based care management and care coordination.

On the other end of such relationships are entities like Talbert House, a large behavioral health organization in southwestern Ohio.

Brad McMonigle, vice president of behavioral health at Talbert House, says the organization is part of the Ohio Medicaid program’s transition from a fee-for-service behavioral health model to one based on episodes of care.

“Instead of an incentive for that hour of care, we’ll start to shrink that down a little bit,” McMonigle says. “We’re going to have more value, shorter visits, less visits, and better outcomes. Ohio is trying to push us in that direction, which is the right direction.”

As part of that shift, the state is beginning to pay for “community treatment” for high-risk individuals, McMonigle says.

The shift had been financially challenging for Talbert House, but after three years the organization’s finances have begun to turn around—and, critically, it has been able to improve clients’ health enough to move them out of the institutional mental-healthcare system and back to community-based care.



*“We’re going to have more value, shorter visits, less visits, and better outcomes. Ohio is trying to push us in that direction, which is the right direction.”*

—Brad McMonigle, vice president, behavioral health, Talbert House

“Three years ago, we were averaging roughly about 300 or 400 discharges annually, and now we’re averaging around 2,500 to 3,000, which tells me we’re getting people through the [institutional] system,” McMonigle says.

Among federal efforts to support the increasing focus on addressing the social determinants of health is the Accountable Health Communities model.

Amy Bassano, acting director of CMS’s Center for Medicare & Medicaid Innovation, says such funding aims to help physician offices manage issues that may arise from social determinants of health by connecting patients to services in their communities.

The model, which was implemented earlier in 2017, inspired enthusiasm and excitement and is expected to improve clinical results and reduce Medicare spending, Bassano says.

### MEASUREMENT KEY TO SUSTAINABLE IMPROVEMENTS

A critical component of the ongoing shift to value-based payment is the ability to measure improvements in safety and performance.

Among changes planned by the National Quality Forum (NQF), a leading developer of quality metrics, is accelerating and ensuring greater stakeholder access to the quality-measure endorsement process, says Shantanu Agrawal, MD, president and CEO of NQF.

NQF also is examining the number and type of its 650 endorsed measures.

“We will be doing this and constantly renewing this understanding that we can get to a better measure set,” Agrawal says. “Frankly, the 650 might be too high a number.”

NQF has also worked with CMS through the Measure Applications Partnership to improve alignment between quality measures that are used in various federal healthcare programs. Through that process, NQF recommended a 20 percent reduction in the measures used by CMS, specifically targeting measures that either no longer were technically the best measure or “had been topped out,” Agrawal says.

NQF also is rolling out a provider portal to receive feedback on its measures.

“We will see there are a lot of issues around data collection, data integration, and integration with the clinical workflow,” Agrawal says.



### PRIORITIZE MEASURES AND GAPS

FIG. 5

Source: Presentation by Shantanu Agrawal, MD, National Quality Forum

*“We will see there are a lot of [measurement] issues around data collection, data integration, and integration with the clinical workflow. Those are all expected, and I hope we’ll be a rich source of information, so we can start to make improvements on it together—clinicians and these other stakeholders.”*

—Shantanu Agrawal, MD, president and CEO, National Quality Forum

“Those are all expected, and I hope we’ll be a rich source of information, so we can start to make improvements on it together—clinicians and these other stakeholders.”

“tremendous burden” that they place on physicians and other clinicians, which contributes to staff turnover.

Greg Jolissaint, MD, vice president for military and veterans health at Trinity Health, finds fault with the measure set.

It is important to mitigate the cost of implementing measures, Marco says, by focusing on measures that will improve patients’ health.

“I can tell you that measures have not been used as something to incentivize anybody,” Jolissaint says. “They are used as a stick to get people to perform.”

Health systems need to improve their translations of federal priorities for frontline staff by interpreting how to implement various mandates. For instance, the federal push to reduce unnecessary readmissions should lead health systems to install a performance management system that tells clinicians about opportunities to reduce readmissions, which patients are likely to be readmitted, and alternatives to admitting them.

Instead, quality measures need to be relevant and demonstrate high-quality care at both the individual-patient and population health levels, Jolissaint says.

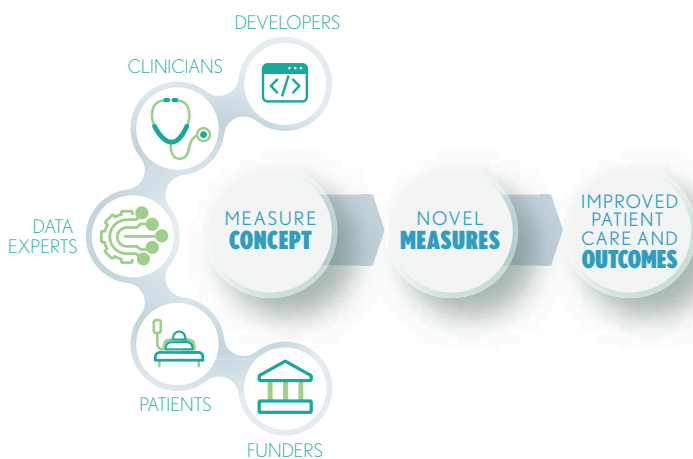
Jolissaint says organizations need to ask physicians what they want to measure and provide them with the support staff to do so.

Alan Marco, MD, president and CEO of Wright State Physicians, praises the science behind NQF’s measures but recognizes the

Agrawal warns that the opportunity for individual medical-specialty societies to create measures under MACRA has led to a “vast measure proliferation.”

“Now we have taken measurement that could have been all about integration and working across specialties and actually said, ‘No, we want five, 10, 15 measures per specialty,’ which is a lot,” Agrawal says.

On the key issue of aligning measures among different payers, Agrawal says there is “not a great way at a national level to lead measure alignment.” Although a willingness of payers and employers to align with other organizations on quality measures is lacking on a national basis, some alignment experiments have emerged in Minnesota and California.



**MEASURE INNOVATION: NQF MEASURE INCUBATOR**

FIG. 6

Source: Presentation by Shantanu Agrawal, MD, National Quality Forum

## Presentations at the 2017 HFMA Thought Leadership Retreat

### Understanding Payment Models: How Healthcare Systems Can Address Social Determinants of Health

**Enrique Martinez-Vidal**, vice president, State Policy and Technical Assistance, AcademyHealth

**Brad McMonigle**, vice president, Behavioral Health, Talbert House

**Angela Sherwin**, vice president, Medicaid Accountable Care, Steward Health Care

### The Future of Value at CMS

**Amy Bassano**, acting director, Center for Medicare & Medicaid Innovation

### Finance and Clinical Collaborations for the Future

**Michael J. Grossman**, senior director, Revenue Cycle Optimization, Virginia Hospital Center

**Patricia Mook**, MSN, RN, NEA-BC, CAHMS, chief nursing information officer, Inova Health System

### Driving Measurement That Sustains Safety and Performance

**Shantanu Agrawal**, MD, president and CEO, National Quality Forum

### Panel Response and Discussion

**Peter B. Angood**, MD, FRCS, FACS, MCCM, president and CEO, American Association for Physician Leadership

**Byron Scott**, MD, MBA, FAAPL, deputy chief health officer, Simpler Consulting, IBM Watson Health

**Alan Marco**, MD, MMM, FAAPL, president and CEO, Wright State Physicians

**Greg Jolissaint**, MD, MS, CPE, FAAPL, formerly chief of staff/ chief medical officer, Martinsburg VA Medical Center, and now vice president, Military and Veterans Health, Trinity Health

### Digital Health Solutions: Health System Savior or Disruptor?

**Anna Marie Butrie**, vice president, Innovation, Trinity Health

**Jason C. Lineen**, vice president, Strategy, AVIA

### Imagining the Future of Medicare Advantage

**Gordon Edwards**, CPA, CFO, Marshfield Clinic Health System

**Krista Hoglund**, director, Actuarial and Risk Adjustment Services, Security Health Plan

**Mary Anne Jones**, senior vice president and CFO, Priority Health

**Puneet Budhiraja**, vice president and chief actuary, Capital District Physicians' Health Plan

**Elizabeth Monsrud**, CFO, UCare Minnesota

### Where We Go From Here: The Future of Value

**Joseph J. Fifer**, FHFMA, CPA, president and CEO, HFMA

"Measurement has always been a part of our work," says Carol Friesen, vice president of Health Systems Services for Bryan Health in Lincoln, Neb., and 2017-18 Chair of HFMA. "Somehow, we need to figure out in our organizations how we translate our national priorities into learning performance systems for the future. That's why it will help us to work with our social determinants of health."

Beyond measurement, NQF has started to provide practical tools and resources that leverage the best scientific evidence and expert guidance on how providers can implement quality improvement in specific areas, such as antibiotic stewardship.

"There were a lot of acute care hospitals that told us that they were looking for this kind of thing," Agrawal says.

## OUR SPONSORS

HFMA would like to thank Navigant, Humana, and Xtend Healthcare for supporting the 11th Annual Thought Leadership Retreat.

The two-day event brought together a diverse group of industry leaders to discuss challenges and solutions to improve healthcare delivery.

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With more than 38,000 members, the Healthcare Financial Management Association (HFMA) is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. It helps healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. HFMA's mission is to lead the financial management of health care.

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