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Metro NY HFMA Newscast Schedule

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As we draw a close to the summer days and await autumn’s arrival, our healthcare finance professionals are hard at work, balancing budgets and preparing for independent financial audits, among other things too numerous to count. Many are planning their future strategy for the upcoming changes in Healthcare that challenge us - now, soon and later: Population Health Management, Delivery System Reform Incentive Payments (DSRIPs), and the continuing turmoil of the Patient Protection and Affordable Care Act (ACA).

In our quest to continue to lead the change, our talented committee members presented some great Education sessions this summer. Finance presented a very well received 101 (basics) seminar in July. The Corporate Compliance Committee followed suit, providing valuable compliance information in July, as well. Our Patient Financial Services Committee presented an outstanding “free to members” seminar on Medicaid in August. Attendees to all sessions were pleased with the variety of education offered, during the usual quiet summer months.

In September, we offered our staple Mid-Year Reimbursement seminar on the 8th. Our Fall Academy will be held on October 15th at the Uniondale Marriott. This Academy will feature keynote speaker, Paul Keckely, discussing the Health Care Exchanges - observations and data points for consideration. The day will continue our previous format, with a myriad of breakout sessions from our Committees; it will conclude with a general session about the ACA’s impact on Self Pay collections. Please remember to check the website for further details and registration information.

Our Corporate Sponsor Webinars will continue again, this year, along with our Regional webinars - all free to members. Please mark your calendars, the Joseph A. Levi 56th Annual Institute will be held March 12 and 13, 2015, at the LaGuardia Marriott.

Our social committee hosted A Day at the Races at Belmont Racetrack on Friday, October 3. It is always a great day to come out and have some fun at the track.

The Region 2: Fall Institute will be held at Turning Stone Resort on October 22-24, 2014. Registration is currently open. This year (again), we are coordinating a study group with other chapters in our Region to
assist you in taking the certification exam. It is a series of study meetings presented via webinar to review the material. The chapter will pay for your study guide (one time) and the exam, provided that you take the exam before April 2015.

Each year, HFMA National conducts a Member Satisfaction Survey in late October. Please take the time to complete the survey when you receive it. I would appreciate that you give our Chapter high marks in all applicable categories. If you have issues or concerns please contact me at wendyl@tritechhcm.com. I will be take your input seriously; I will address any and all concerns directly. Our Committee members work hard to ensure that the Chapter performs at the highest level possible, so that we may meet your needs.

I would like to sincerely thank all of you Corporate Sponsors and dedicated volunteers who make the Metro NY Chapter so successful. I look forward to seeing each one of you at an upcoming event.

Wendy Leo
Fall means certain things for healthcare finance professionals. Among these are: the leaves changing, next year’s budget (including whatever changes it was prepared with), implementation of the inpatient prospective payment system changes, etc. I think you know what I mean. We have seen many changes in healthcare in the past few years. We all realize that the pace and tempo of change is increasing, too.

One of the ways that I keep up (or try to) with the increasing tempo is by taking advantage of my HFMA membership. Among the sections found on our Chapter website’s main page (http://www.hfametrony.org/) are: Educational Seminars and Institutes, Corporate Sponsor link, Wendy Leo’s President’s message, Job Opportunities and the Marvin Ruskhoff Scholarship application and eligibility requirements link.

For Educational Seminars and Institutes, among the sessions are free webinars: Creating a Concierge Patient Experience; and Using Measure, Apply & Perform to Achieve Excellence in Revenue Cycle Operations. Those are free to members. We also have seminars/updates: Managed Care; and Accounting and Audit (seminar / webinar). Peeking ahead to the New Year, our committees already have scheduled: Patient Financial Services; and Compliance Update. Of course, it’s not too early to think about volunteering or presenting at The Joseph A. Levi Annual Institute.

I understand that education budgets have come under increasing pressure in the past few years. Adding to the Chapter education opportunities are the On-Demand and Live webinars on our National website (www.hfma.org). There are more than 30 on demand offerings; most On-Demand webinars are free to members. As I write this, there are more than 10 live webinars listed there, also; likewise, most live webinars are free to members.

Whether you are looking for advancement, are unemployed or have a friend who is unemployed, the Job Opportunities section of our Chapter website has many levels of openings: from Admitting Clerk to Vice President of Operations. There is also a link to the National HFMA Job Bank website. It contains a searchable bank of jobs, the ability to anonymously post your resume, create job alerts and a job seeker account.

The last section I’ll cover is the Marvin Ruskhoff Scholarship. Marvin was a former CFO of The Mount Sinai Hospital. I met him when I was a staff auditor for Ernst & Whinney (now Ernst & Young). Marvin had a great deal of influence on our corner of the industry and our Chapter leadership. Richard J. Henley was his administrative intern back then. Rich went on to become our Chapter President and National President. The Chapter leadership decided to recognize Marvin’s contributions in the form of two $1,000 scholarships. The application deadline is April 1 (no kidding). Members of the Metropolitan NY Chapter of HFMA, spouse and dependents of the Metro NY HFMA member are eligible.

While the pace of change is ever increasing, HFMA provides opportunities for each of us to stay current, excel and move forward. I hope to see you at an educational event soon. Please feel free to reach out to me at HFMA.Marty@GMail.com about whatever is on your mind.
### 2014/15 IMPORTANT DATES

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<tr>
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**FREE Webinars**

(Check [www.hfmametrony.org](http://www.hfmametrony.org) and [www hfma.org](http://www.hfma.org) for more)

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HFMA Seminars provide timely, in-depth strategies and metrics to help you keep pace with the healthcare finance topics you care about the most. View all upcoming HFMA Seminars and register at [www.hfma.org/seminars](http://www.hfma.org/seminars).
MetroNY HFMA is pleased to welcome the following new members to our Chapter. We ask our current membership to roll out the red carpet to these new members and help them see for themselves the benefits of HFMA membership. Encourage them to attend seminars and other Chapter events. We ask these new members to consider joining a Committee to not only help the Chapter accomplish its work, but to expand their networks of top notch personal and professional relationships. See the list of MetroNY HFMA Committee Chairs, along with their contact information, listed in this eNewsletter.

**JULY 2014**

- Barrington Burke-Green  
  Visiting Nurse Services of Staten Island
- Nicholas Pillarella  
  Weill Cornell Medical College
- Andrew Montaruli  
  MediSys Management
- Asmait Yohannes  
  Mount Sinai Medical Center
- Nataliya Averyanova  
  VillageCareMax
- Joshua Kalenderian  
  Deutsche Bank
- Michael Dolacky  
  Senzar
- Jessica E Stack  
  DGA Partners
- Rey D David  
  Connex Group
- Juliet Montague  
  Mount Sinai Health System
- Cecilia Lap Man Yu  
  Consultant
- Joan F De La Prida  
  Island Medical Management
- Michael P Rapps Esq.  
  Eternity Wealth Advisors, Inc.
- Joshua Kurtzig  
  Unity Family Healthcare
- Sandra M Johnson  
  Interfaith Medical Center

- Kevin Wood  
  MUFG Union Bank, N.A.
- Terri Butler  
  Brookdale Hospital
- Eli Dinerman  

**AUGUST 2014**

- Diane Johnson  
  Bronx Lebanon Hospital Center
- John Carino  
  ServiceSpan
- Alison L Shipley  
  PwC
- Blaise R Heid  
  CB Private & Commercial Banking
- Rira Wandel  
  Queens Medical Associates
- Brian D Holiday  
  HCE LLC
- Margarita Krasnopolsky  
  Atlantic Dialysis Management Services, LLC
- David Sans  
  Mount Sinai Health System
- Kirstie Toussaint  
  NSLIJ Lenox Hill Hospital

**SEPTEMBER 2014**

- Omar A Doyley  
  TransUnion
- Meredyth Lacombe  
  NYU Langone Medical Center
- James T Conklin  
  Modern Medical Systems Co.
- Kelsie Kleiber  
  Deloitte
- Ron W Deems, III  
  Deloitte
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- Deidre Steel  
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- Anita Menon  
  KPMG
- Gloria Tutt-King  
  St Barnabas Hospital
- Toni Allen  
  Rutgers New Jersey Medical School
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“For too long, finance professionals and nurses haven’t been working in collaboration as well as they could, and now I think the time is right for change,” said ANI speaker Pamela Austin Thompson, CEO, American Organization of Nurse Executives and senior vice president of nursing, American Hospital Association.

The need for healthcare finance leaders and nurses to better leverage each other’s skill sets is growing, as providers look to manage for value, better coordinate care across the continuum, drive decisions around population health, and better understand resource needs associated with shifts in care to less intensive settings, Thompson said during her session, “Catalyzing Change: Aligning Nurses and Finance Professionals to Drive Value.”

“I don’t think we can do the work we need to do in the environment of reform without improving this relationship,” she said.

Core areas where alignment will be particularly important are in understanding cost and quality outcomes, improving patient safety and quality, planning for workforce change, and advancing education.

“Quality discussions often benefit from recognizing that the value of nursing is beyond the task performed,” Thompson said. She noted that a better indicator of value is health outcomes achieved per dollar spent. Quality outcomes can be disease-specific or focus on safety, avoidance of error, patient satisfaction with the process of care, access, and convenience.

Nurses working in tandem with finance executives will play a key role in not only identifying opportunities to achieve these quality outcomes but also in examining processes and resources that will allow systems to be more effective and efficient in the delivery of care, she said.

Among efforts Thompson is seeing that contribute to improved collaboration:

- Rounding together
- Creating mutual liaisons for each other’s work units
- Aligning around shared goals (e.g., readmission reduction) and identifying those interfaces where coordination is essential

Thompson also pointed to the success of programs that provide clinical leaders with knowledge of finance fundamentals, such as the certificate program in healthcare finance that AONE co-sponsors with HFMA. Clinical leaders who have gone through the training have instituted many practical changes at their organizations that are aiding collaboration. Projects cited include the creation of daily productivity worksheets, participation on the organization’s capital committee, participation in service-line selection, development of task forces around managing care and costs for at-risk patient populations, and the pursuit of performance-improvement projects around bed availability and access.

“Steps are being taken” she said. “It’s happening. We’re already working together better than before. We just need more people doing it.”
HFMA Metro NY
Past President’s Dinner Dance

Photos selected by Marty Abschutz

www.hfametrony.org
You and Your 340B Program: Are You Compliant or Confused?

By: Venson Wallin and Bill Bithoney, MD, The BDO Center for Healthcare Excellence and Innovation

What is the 340B program?
The 340B program is a means through which providers, known as “covered entities,” can offer pharmaceuticals to a greater amount of eligible patients than they could at traditional manufacturer pricing. This is because the program requires that manufacturers sell the drugs to the eligible providers at a discount, thereby enabling a larger number of those in need to get the assistance they need with purchasing their prescriptions. The 340B program is very popular for this very reason; covered entities are able to purchase drug supplies at the 340B discounted price, and then bill the patient's insurance company the traditional rate. This “margin” generates much needed profit for some of the more income-challenged providers, while having minimal impact on the Medicare and Medicaid program costs. The patient wins, the provider wins, and the government programs win. Providers understand the upside, and annual 340B drug spending by covered entities exceeds six billion dollars and approximately one-third of U.S. hospitals participate in the program. The spending and number of participating providers is forecast to increase significantly during the coming years.

In 1992, Congress created the 340B program via Public Law 102-585, the Veterans Health Care Act of 1992, which is otherwise known as Section 340B of the Public Health Service Act. The law requires drug manufacturers that participate in the Medicaid program to agree to provide discounts on covered outpatient drugs purchased by government-supported facilities, or “covered entities.” Examples of “covered entities” include disproportionate share hospitals, sole community hospitals, rural referral centers, critical access hospitals, and children's hospitals and cancer hospitals exempt from the Medicare prospective payment system. Enrollment periods for those providers seeking to participate in the program are open on a quarterly basis. Administration of the 340B program is performed by the Office of Pharmacy Affairs (OPA) of the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.

Achieving Compliance with 340B Program Guidelines
Compliance pertaining to a 340B program is relative. A provider may consider themselves in compliance with the guidelines of the program based on their understanding of these guidelines, whereas HRSA and the OPA may consider the provider to be noncompliant based on their interpretation of these same guidelines. These divergent opinions are a result of a set of rules that are written in a somewhat general manner, excluding the detailed implementation regulations that are common to other HHS programs. HRSA recognizes the need for more clarity on the part of the covered entities and is actively working to close the interpretation “gap” and to achieve more compliance within the program.

HRSA has heard the rumblings from the industry and Congress over the past several years regarding the 340B program and the need for more detailed directions to minimize both unintentional violations of the program as well as intentional efforts to take advantage of the interpretation “gap” to prosper to an extent not anticipated by the authors of the program. Audits in recent years by HRSA and the Office of the Inspector General (OIG) of HHS have confirmed the fact that covered entities are having challenges meeting full compliance with guidelines, particularly in the areas of diversion and duplicate discounts. Another key factor in meeting compliance requirements identified through the audits is the degree to which providers utilize contract pharmacies and their oversight of such. The use of contract pharmacies, while occurring in the minority of covered entities at this point, is growing and there is a wide disparity in their treatment and oversight. HRSA has strongly recommended the use of independent audits of contract pharmacies to address compliance.

Increased Focus on Integrity and Compliance
So where does one go from here? Good question and one that the HHS OIG and HRSA intend to address in the immediate future. They are both being very active in publishing clarifying documents and preparing to conduct more extensive audits of 340B programs. The HHS OIG 2014 Work Plan contains initiatives pertaining to the 340B program, including a focus on contract pharmacy compliance by covered entities. In February, 2014, the OPA issued a program update that addressed contract pharmacy compliance and the continued focus on the program’s integrity. In its June, 2014 program update, HRSA discussed
an additional six million dollars that Congress had set aside for the 340B program. The additional funding is being used to establish a new branch of HRSA – Program Performance and Quality – which is tasked with overseeing program integrity. HRSA stressed that program integrity has always been a focal point of their staff, but that the new branch will now enable them to devote even more emphasis on this topic. And in its July, 2014 program update, HRSA further clarified its audit process, reaffirming its focus on increased audits and the intent to no longer issue preliminary audit reports but to only issue final reports. The commitment to a renewed attention to compliance through increased audits is evident through these updates and publications and covered entities would be advised to prepare for the inevitability of an increase in 340B program audits and that they may soon fall within HRSA’s radar.

“Mega-Reg” to provide clarification Many facilities may be feeling somewhat alarmed by this enhanced focus on program integrity in that they believe they may need more guidance to ensure that their program is truly compliant. As discussed before, heretofore, detailed implementation guidance on the 340B program has been found to be somewhat lacking, and compliance became an “interpretation of the rules” exercise. Now, with more expected of them, the covered entities are in need of specific clarification of the rules and HRSA is preparing to provide such guidance. The much discussed “mega-reg” that HRSA is expecting to issue will provide specific guidance on issues such as the definition of an eligible patient, compliance requirements for contract pharmacy arrangements, hospital eligibility criteria, and the eligibility of off-site hospital facilities.

Throwing a potential curve into HRSA’s plans is the recent (May, 2014) decision by the United States District Court for the District of Columbia (USDCDC), which held that HRSA lacked the ability to issue the regulation regarding orphan drugs. HRSA had attempted to promulgate limitations on the use of orphan drugs by certain covered entities; however, the USDCDC found that the 340B regulation itself limited HRSA’s ability to promulgate regulations to only those areas dealing with the administrative dispute resolution process, calculation of ceiling prices, and civil monetary penalties. Furthermore, orphan drugs were not deemed to be included in the definition of any of these three areas, therefore, HRSA was found to not have the authority to issue any regulations pertaining to them. Covered entities may wonder why this is important if orphan drugs are not a large part of their 340B program. The importance lies in the ability of HRSA to issue and enforce the “mega-reg.” HRSA has so far chosen not to appeal the USDCDC finding, and it must decide, before proceeding, whether the issues covered by the “mega-reg” would survive a likely court challenge in light of the USDCDC decision, and whether a further “tweaking” of the regulation should occur prior to its actual issuance. At this point, HRSA has indicated that they continue to look to move forward with the “mega-reg.”

Conclusion
It is very clear that the history of the 340B program being loosely regulated and enforced is just that – history. HRSA, the OPA and the HHS OIG all have the 340B program high on their list of priorities and they are committed to ensuring a more consistent implementation of the program and to strengthening its integrity. Through audits and publication of clarifying guidance, they are working with covered entities to achieve those goals. Covered entities should be proactive in assessing the compliance of their 340B programs and taking steps to document compliance and/or perform corrective efforts to become compliant. Steps may include performing internal assessments of policies and procedures or partnering with external agents to assist with these assessments, performing audits of the program components, obtaining independent audits of contract pharmacy arrangements, and developing a routine process of monitoring new HRSA program updates and their impacts, including the new “mega-reg.” By taking these steps, covered entities can begin to move the gauge from “confusion” to “compliance.”
HFMA Metro NY
Past President’s Dinner Dance

Photos selected by Marty Abschutz
On July 18, 2014, a full-day course entitled, “Medicare 101: Charting Your Course through Hospital Medicare Cost Reporting” was sponsored by our Metro-NY HFMA chapter. The class instructors were Julie DiFrancesco, Director, McGladrey LLP and me, Tracey Roland, Principal Member, Reimbursement Alliance Group, LLC.

During the morning, the introduction and purpose of the Medicare cost report (“cost report”) was discussed. The cost report is a year-end financial report, similar to a tax return. It serves as a reconciliation of what a Hospital has been paid by the Medicare program during the year compared to what the Hospital is entitled to for that year. The Centers for Medicare and Medicaid Services (CMS) estimate that it takes 850 hours on average to complete a Medicare cost report. It was explained to the class participants why it takes so long to complete (e.g., there is an extensive amount of data that is accumulated and needs to be summarized on the cost report).

The history of the Medicare reimbursement system was also discussed, from the time when the program was established (1965) through today. It was explained how there was a transition from a cost-based reimbursement methodology to a prospective payment system (PPS). A walk-through of how Medicare severity diagnosis-related groups (MS-DRGs) are calculated was also covered. In addition, the topic of the wage index was discussed so that the class participants could obtain an understanding of how critical it (the wage index) is to a Hospital’s PPS reimbursement. For example, in the New York City (“NYC”) area, a one cent change to the NYC rate equates to approximately $1,000,000 in reimbursement to the Hospitals, up or down.

In the afternoon, the cost report settlement components were covered, with calculations showing how each settlement component is developed. Examples of the settlement components on the cost report are: teaching, disproportionate share (DSH), health information technology (HIT), sequestration, bad debts and various cost-based components (e.g., organ acquisitions). The “New DSH” methodology was also discussed, including why DSH changes were needed, from our government’s perspective. The remainder of the afternoon included a walk-through of a sample Medicare cost report. The purpose of each schedule and the source data needed for each schedule were highlighted.

When the Balanced Budget Act (BBA) was enacted in the 1990’s, many healthcare executives believed the cost report was going away because of the transition to the Medicare PPS reimbursement methodology. On the contrary, the Medicare cost report continues to be an important financial report for healthcare providers’ revenues.
HFMA Metro NY
Past President’s Dinner Dance

Photos selected by Marty Abschutz
Most healthcare leaders would agree that the industry is in the midst of one of the most transformational changes in its history. There is recognition from payors, providers, and government officials that the current system is based on a perverse incentive model that rewards the provision of “sick care” as opposed to “well care.” Tolerance for the current model is rapidly declining. Today, numerous healthcare organizations have started their transformational journeys, and promising models have emerged that are having early successes. While best practices will continue to evolve, the care delivery models and incentive structures that need to be developed for future success are becoming more defined. Networks of providers will be accountable for managing the health of defined populations, and provider reimbursement will be at risk for providing high value care. It is our belief that to have success in this new paradigm, organizations must remove significant amounts of excess utilization and lower the medical cost of their attributed lives. What is not clear is how much utilization will need to be removed and how quickly it must happen. While these two factors will certainly be market dependent, this report explores the expectations of healthcare executives on how healthcare utilization will change in the future and compares their expectations to where we believe healthcare organizations will need to drive utilization levels to be successful in the future.

Methodology

An electronic survey was distributed in March 2014 to executives and board members at hospitals and health systems around the country. The survey asked respondents to predict changes in utilization of various services. In each case, they were asked if, over the next five years, they expected to see an increase or decrease and the magnitude of the change.

123 surveys were completed. Over 80% of respondents were C-level officers, with the remainder consisting of Presidents, Senior VPs, and board members. Responses came from 38 states. There was broad representation from both small and large hospitals as well as respondents representing independent hospitals and hospitals part of health systems.

The survey responses were compared to the differences between Well Managed and Loosely Managed utilization benchmarks for healthcare delivery systems as defined by actuarial consulting firm Milliman, in its Health Cost Guidelines (HCGs). The HCGs are a set of benchmarks for healthcare utilization and cost, based on data from commercial insurance carriers and Medicare. The two sets of benchmarks make up a spectrum that ranges from organizations with limited medical management activities (Loosely Managed) to organizations that perform extensive medical management activities (Well Managed). The Well Managed benchmarks in aggregate represent a theoretically achievable model of care, but are not necessarily being achieved by any organization across all metrics in today’s environment.

Currently, the utilization for most health care delivery systems falls closer on the spectrum to the Loosely Managed benchmarks than the Well Managed benchmarks. The assumption used for our analysis is that health care delivery systems will be moving toward the Well Managed benchmarks over the course of the next five years (although it is our expectations that the majority of healthcare organizations will take longer than five years to achieve Well Managed utilization levels). Therefore, by measuring the gap between the Loosely Managed and Well Managed benchmarks of the HCGs, we can begin to estimate the potential change in utilization as organizations transition over time and compare this to the expectation of the healthcare executives from the survey.
Detailed Findings

Inpatient Comparison

When asked how the utilization of all inpatient services, measured by admissions per 1,000 population, would change over the next 5 years, 63% of our survey respondents expected a decrease, 16% expected an increase, and the remaining 21% expected no change. On average, the expected change was a 3% decrease. Among the executives predicting the largest decreases, 5 out of 12 executives specifically cited increased population health management as a primary contributor to the decline.

Based on the estimates built using the HCG data, a well-managed population should see a reduction of inpatient admissions per 1,000 population of 30% relative to loosely managed levels (which are already 10% lower than they were 5 years ago). This figure is based on real data observed from plans and providers that have more mature population health management in place. While it is unlikely that care will fully transition to Well Managed levels over the next five years the discrepancy between the survey estimate and these models (along with recent historical trends) suggests that executives are not preparing for demand changes of this scale.

To gain additional insight, we asked similar questions about the utilization of specific inpatient services. Surprisingly, when asked about Cardiovascular, Orthopedic, General Surgery, General Medicine, Oncology, and Neurosciences inpatient services, the average executive expected an increase in utilization for all of these other than General Medicine. Even among those executives who expected overall inpatient services to decrease by at least 5% (40 of the 123), almost two-thirds expected an increase for any particular non-General Medicine service line in the next 5 years. Based on our data-driven models, all of these should expect decreases of 25-35% from a transition to Well Managed population health.

A total of 8 executives referenced the aging population at least once in their responses, with the references spread around the various service areas. We recognize that while changing reimbursement models and population health management should result in decreasing utilization of many services, the steady aging of the US population is expected to counteract the impact somewhat. The percentage of US residents, older than 65, is projected to increase from 14.5% to 16.3% by 2019, which should result in a 4-5% increase in utilization of inpatient days based on current utilization patterns.

Another frequently-cited reason to expect fewer inpatient visits was a shift towards observation care. CMS’s changing definition of observation care makes it difficult to project using data, but 77% of survey respondents expect increased utilization, with 30% expecting an increase of at least 10%. This latter figure is by far the most extreme response of any question surveyed.

Emergency Services

Of the areas surveyed, there was the least consensus about the future utilization of Emergency Services. Over 40% of executives expect changes of at least 5%, but they are split on whether that will be an increase or decrease. On the whole, the respondents tended slightly towards increase, with 53% expecting some amount of growth. Of those predicting utilization increases that provided a rationale, the most common was lack of access to primary care. The executives predicting decreased utilization cited competition from urgent care centers, and better utilization of primary and specialty care.
The HCG data suggests a reduction of visits per person of around 35% between a loosely-managed population and a well-managed population. As with inpatient services, the discrepancy between the survey response and this calculated figure suggests executives are not expecting this level of dramatic change in the near future. However, unlike Inpatient Services where the overall trends were in the same direction, there was more disagreement among executives on the direction the use rate will shift in the future.

**Diagnostic and Treatment Services**

Roughly, 75% of survey respondents expected changes of less than 5% in utilization of both major imaging (CT, MRI, PET) services, and interventional labs (Cath, Electrophysiology, Interventional Radiology). A slight majority did expect some increase in Interventional Labs, resulting in an average projection of 2% growth. For major imaging the average was a small fractional percentage decrease. Here again we see a large discrepancy between the survey responses and the HCGs. In this case, the data suggests that most markets have significant over utilization of Major Imaging and decreases of over 50% utilization will be seen if markets fully transition from Loosely Managed to Well Managed care. Additionally, decreases in many markets could end up being around 30% for interventional procedures.

The executives expected more changes to surgical services. By asking about both inpatient and ambulatory surgery, it is clear they collectively anticipate a shift in utilization from the former to the latter. Nearly half the respondents expect inpatient surgery to decline, with most of the rest expecting no change. Almost 80% expect an increase in ambulatory surgery, giving an average projection of 4% growth. However, despite this near-unanimity, it is again in conflict with the HCG data, which anticipate declines of 24% in inpatient surgery admissions, and over 40% of facility-based ambulatory surgery visits. These ambulatory surgery figures represent the widest discrepancy between survey response and the data model.

We agree with the respondents, there will be a shift of inpatient to outpatient surgery over time. The HCG data is a current snapshot of benchmarks from Well Managed and Loosely Managed markets that does not take into account the potential for additional services to be performed in outpatient settings over time. That being said, after conducting comparative market utilization analysis for numerous markets we have seen significant difference in the utilization of ambulatory surgical services, where arthroscopic knee surgery may have a 60% higher use rate in one market than the national median or laparoscopic cholecystectomy occurring 120% more often in another market than the national median. To that end, it is our belief that even with the shifting of surgical settings as markets transition to Well Managed ambulatory surgery use rates will decline in the future.

**Ambulatory Clinics**

The closest we came to agreement between the executives and the data model was in terms of Ambulatory Clinic services. The model predicts very modest declines of 3% for primary care and 11% for specialty clinics, both of which would also be offset by approximately a 2% increase in utilization due to aging. In our survey data, less than 10% of executives projected declines in each of primary care and specialty care clinic utilization. While in both cases large majorities projected small changes, those changes were almost all positive. On average they project a 5% increase in primary care along with 3% in specialty care. It is important to note that the HCG data does not take into account the utilization of digital channels for providing ambulatory care in the future. While predicting the impact of technology on ambulatory clinic use rates is difficult; some healthcare technology experts are projecting 30-40% of visits could be conducted via telephone or through digital channels in the future.
Conclusions

The local aspect of healthcare mean the level of healthcare utilization decreases will happen at differing paces throughout the country; however, the results of the survey show that many healthcare organizations likely do not understand the potential magnitude for utilization reductions and/or believe that most healthcare organizations will not have the structures in place to make significant changes over the next five years. It is our opinion that most healthcare organizations will not achieve Well Managed benchmarks over the next five years (although some will surpass them on selected metrics), but organizations should be conducting long-term planning that takes into account these types of reductions. Provider organizations will also need to consider how their asset portfolios will evolve in the future and begin to think in terms of consolidation and delivering care in alternative lower cost settings instead of planning for growth as they have been historically accustomed.

Additionally, the scale of the opportunity to remove duplication and waste and to create value will have a significant impact on most healthcare market places. The first movers to value-based delivery will have a distinct market advantage over those that continue to live in the fee-for-service world if they are able to capture the value that they are creating. Most markets have significant opportunity to lower excess utilization and medical loss. The health systems that are able to do this well will be able to go to market at a substantially lower price point and shift considerable numbers of lives and market share to their delivery network. The impact of which will accelerate the pace of consolidation in the healthcare market.

SIDEBAR

Some of the key factors that will account for organizations removing excess utilization and the associated cost are:

- Programs that educate physicians on ways to provide care more efficiently
- Disease management programs that actively manage patients with chronic conditions and that are at risk
- Utilizing care teams with physician extenders to allow physicians to focus on caring for sicker, high-risk, and chronic patients
- Demand management programs that teach members when to seek medical assistance
- Changes in health plan design that incentivize patients to seek care in more appropriate settings and incentivizes healthy behaviors and preventative care
- Active use of case managers to facilitate treatment of acute and chronically ill patients, and coordinate their care
- Increased care management and changes to reimbursement models that require providers to first use less costly medical options prior to interventions
- Financial incentives that reward providers for efficient utilization and quality outcomes
- Integrated networks that coordinate the use of appropriate levels of care (e.g., post-acute, ambulatory care) and limit duplication
- Information systems that support the monitoring of utilization and compliance with evidence-based practices
- Clinical data warehouses and analytical tools that locate chronic populations and use predictive modeling to determine high-risk populations to be targeted for early intervention
- Digital channels that utilize algorithm for treatment of minor health issues and the use of telemedicine

About the authors

This report was produced in collaboration with the Health Care Group of Kurt Salmon, a global management and strategy consulting firm. For further information, visit: www.kurtsalmon.com/healthcare.

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Data and leadership by healthcare finance experts will have the biggest effects on improving quality and cost control in the U.S. healthcare system, according to a leading healthcare researcher and quality improvement expert.

Atul Gawande, MD, a surgeon at Brigham and Women's Hospital in Boston and researcher on cost and barriers to quality improvement, told attendees at ANI: the HFMA National Institute this past June that improving the care of and reducing costs for the most expensive patients show the way to improving the overall system.

“It’s still all about the sickest; what we do and whether our systems can care for the sickest in our society,” Gawande said about the 5 percent of patients who account for 50 percent of healthcare spending. “That’s how we fix health care.”

To improve clinical and financial outcomes for the sickest parts of the population, providers and payers have to change how the healthcare system interacts with those patients.

Initiatives, such as one focused on 100 of the highest healthcare users in Camden, N.J., found that teams of providers were needed instead of just one clinician. That initiative found problems were not identified by the many separate providers seeing a patient, such as the asthmatic patient who required repeated hospitalizations because no one ever taught him how to use his inhaler correctly. The same patient also benefited from nontraditional healthcare interventions, such as buying him a vacuum to help clean the air in his home.

“For these highest-cost patients we need entirely new systems and require entirely new investments,” Gawande said.

That is why new clinical teams focusing on the sickest will need the involvement, and sometimes the leadership, of healthcare finance leaders. Such professionals are in a position to push for financial incentives that reward providers for avoiding unnecessary care and pay for nontraditional interventions that are clinically effective.

Without motivation by hospital finance officials to change the incentives under which providers are paid so that they financially benefit when patients become healthier—and not from retreatment of patients whose care was poorly coordinated—“that discussion doesn’t even get started,” Gawande said.

**Perverse Financial Incentives**

That commitment by finance leaders may be complicated by factors that were identified in Gawande’s own research published last year. His study showed a hospital’s surgical profits increased 330 percent when there was a surgical complication because insurers pay hospitals to fix their own mistakes.

“It allowed them to go back to their insurers and say, ‘We need to make a different deal because we don’t want to be in this position; we want to profit when we make it go right, so we have to find a solution to be able to do that,’” Gawande said. Without the results of the study, “that discussion doesn’t even get started.”

The hospital in the study, Texas Health Resources, developed a deal with insurers according to which their payments would remain unchanged if they achieved a 10 percent reduction in errors. They ended up with a reduction of 15 percent.

“We’ll try to find out if we have made a system or an approach that has worked to solve this,” Gawande said, referring to final financial figures expected later this summer from the hospital’s new insurer arrangements.

Gawande emphasized that a crucial component in “flipping around” the financial incentives to reward high-quality care is a growth in such transparency.

Transparency in quality and cost outcomes can help drive the healthcare system toward improvement, with research having shown that often the best care is delivered at the lowest cost.

“When it turns out that the best care is possible by making it more like a system, more organized, avoiding complications, making more sense along the way, and that it ends up being among the lowest-costing, that is a tremendous opportunity,” Gawande said.
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To maximize the usefulness of healthcare data, hospitals need to begin infusing their IT infrastructure with “intelligence,” according to a leading health IT expert.

John Glaser, PhD, CEO of health services for Siemens Healthcare and a featured speaker at ANI: The HFMA National Institute this past June, told attendees that “most electronic health record [EHR] data is really crummy.” Inconsistencies, gaps, and other issues mean that as EHRs proliferate and the amount of data collected increases, the underlying quality problem with that data will be exacerbated. To bolster those systems, providers will need to implement a wide range of “intelligence,” or methods and software that guide a particular diagnostic or administrative decision.

“Increasingly what the intelligence is being asked to do is to look across the data to detect anomalies and fix them,” Glaser said. For example, when EHR data describes a patient as having both type 1 and type 2 diabetes, emerging systems can analyze other available information to conclude that there is a high probability that the patient in fact is one type or the other.

“It’s not just logic on guiding a clinical call or logic on a process, it is logic that deals with the reconciliation of data,” Glaser said.

Similarly, IT intelligence will need to “permeate” the revenue cycle process, Glaser said. The emergence of intelligence is one of the major forces shaping the design of the systems that healthcare providers will use over the next decade.

### Helping Processes

Another coming force is the introduction of a series of processes associated with holding providers accountable for care, specifically for care management or population management. The populations may include many more patients than those with chronic diseases.

In such cases, IT intelligence is needed for an information system to take essential steps, such as:

- identifying material deviations in a patient's health
- notifying the correct clinician based on the issue that arises
- assessing the risk that patients will not follow the care plan

Intelligent systems “can certainly use the analytics to detect anomalies between the data, and people will certainly be more effective,” Glaser said. “And the machine learns so after a while it doesn’t ask the doctor about the inconsistencies in the data; it just fixes it.”

Advanced functions of IT intelligence include:

- Extracting data and using it for quality measures or other purposes
- Looking for patterns within the data, which are not always obvious, to improve care
- Helping decision makers focus on the right data
- Predicting adverse health events that have a high risk of occurring.

“So if you increasingly need to get the right data to the right person at the right time, then what I will be able to do is leverage the intelligence built into these systems, leverage the changes coming as part of population management, and leverage the new technology to increase my ability to do that across the board,” Glaser said.
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