Payer-Provider Culture and Collaboration: Reshaping the Healthcare Industry

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Los Angeles, October, 2013
Health insurance exchanges: Let’s do them right
By Dennis Triplett
There Are No Certain Answers but Many Choices

The payer-provider relationship is, but has not always been, a fundamental element of healthcare culture.

- The Social Transformation of American Medicine, Paul Starr, 1982
- Demanding Medical Excellence: Doctors and Accountability in the Information Age, Michael Millenson, 2000
- Medicine in Denial, Lawrence L. Weed, Lincoln Weed, 2011
- The Philosophy of Medicine Reborn: A Pellegrino Reader, Edmund D. Pellegrino, 2011

“Right now I’m having amnesia and déjà vu at the same time. I think I’ve forgotten this before.”

- Steven W. Starr, 1982
Multiculturalism

....not a morality tale....
Culture eats strategy for lunch.'
Dick Clark (CEO, Merck), Mark Fields (COO, Ford), via Peter Drucker (Heaven, assmptn.)
Culture

Dominant shared behaviors
Stable, highly resistant to change; ‘commonly’ defines what is right or wrong, good or bad, correct or incorrect, as justified by moral standards, reasoning or tradition

Beliefs and language
Commonly understood roles, responsibilities, beliefs and customs, informed by cognitive, emotional and social conventions

‘It’s the way we do things around here’
Rose, et. al,
A Leadership Framework for Culture Change in Health Care, Joint Commission Journal on Quality and Patient Safety August, 2006
Goals

1. **Comprehend** the problems before us that require mutual ‘accountability’ to resolve

2. Review what the parties **care** about (morally, ethically and fiscally)

3. Emphasize the challenges in **collaboration** that we face

4. Examine core elements of information sharing essential to **coordinate** care and ‘quality’

5. Outline reasons for optimism as payers and providers **converge** to reshape our industry
Comprehension

“Facts do not cease to exist because they are ignored.”

Aldous Huxley, Proper Studies (1927)
Comprehension: The Current State

- Care costs more per person, unit, dose, condition, and in aggregate than in other industrialized country: unsustainable.
- Providers (caregivers and suppliers) make their living selling ‘pieces’ of care; payers assume fiscal risk and parcel payment in the same piecemeal way.
- Information regarding the effectiveness of interventions and outcomes of care across the continuum lags practices or is absent.
- Little clear evidence of what exactly comprises best quality as the model shifts to ‘fee-for-value’.
- Practices are very difficult to re-engineer without shared clinical and operational information across health industry segments.
- Works of ethical commitment that result in fewer billable events and less revenue, which presents caregiver with a perverse incentive.
  - There is no significant financial benefit to caregivers for improved quality or continuity of care, nor substantial objective penalty for poor quality.
  - Harm and error are prevalent and paradoxically profitable.
- Administrative costs in the system are excessive (14% of spend) and non-value add for payers, providers and patients.
- Economic models that threaten fees as revenue threaten all stakeholder’s livelihoods and perhaps even the US economy, given the amount of GDP that is accounted for by the industry.


Arnold Relman, Cost Control, Doctors’ Ethics, And Patient Care Issues in Science and Technology, 1985
“It is difficult to get a man to understand something when his salary depends upon his not understanding it.”

Upton Sinclair
Quality

Degree to which health services are likely to achieve desired health outcomes and are consistent with current professional knowledge.

IOM Roundtable on Health Care Quality JAMA 1998;280:1000-5

QUALITY (Right Care) = Safety (High Reliability) + Value (Outcome for Intensity) + Appropriateness

INAPPROPRIATE: health benefit to the patient is less than the potential harm.

EQUIVOCAL: harm and benefit are about equal.

APPROPRIATE: patient benefit exceeds potential harm.

NECESSARY: represents the only viable option, and produces a large health benefit.

R. Brook, JAMA, August 10, 2011

SAFETY

VALUE

PROPRIATENESS
High Reliability Science

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise
- Appropriate standardization of what we do
- Redundancy functions (rules/alerts)
- Process redesign: mindfulness, potential failure remediation and culture management
Marginal Returns:
Intensity of costly intervention trumps escalating resource costs

- Supply chain management:
- Contracting and cataloguing
- Revenue cycle management
- Standardization, technology and management
- Specific financial and operational strategies
- Pre-pension funding
- Net patient service revenue
- Bad debt and charity care
- Total operating revenue
- Diminishing returns, equivalent discharge increase operating income
- Increased net income
- Risk management

Anything not worth doing is worth NOT DOING well.
Self-reported Responsibility and Enthusiasm for Various Means of Reducing Health Care Costs Among 2556 US Physician Survey Respondents

What Do Providers Think?

Goals

2. Review what the parties *care* about (morally, ethically and fiscally)
Payers Care About

- Business success, profitability and judicious distribution of premium $s.
- Actuarial estimates and experiential data (specific and global cost controls/coverage limits) to inform and predict where and how premium dollars will be spent.
- Optimization of plan financial health in a complex business across ‘covered lives’.
- Accurate, efficient claims administration with fee-based monetary controls to maintain business viability (MLR).
- Management of administrative costs, member utilization and provider ‘performance’ in a fee-based episodic environment, based on ‘submitted’ aggregates of claim data.
- Support of new outcomes based remuneration, better health.
- Pre-authorized utilization by providers based on covered life benefits chosen before care delivery.
- Medical necessity rules (that may be incongruous with caregiver / consumer beliefs about quality practices or care excellence).
- Fund distribution and fiscal efficiency based on limited, predicted and budgeted post-service benefit reimbursements to providers/patients.
- Adverse business impacts of fraud, misuse or inappropriate utilization of funds for medical activities.
- Serving the interests of owners or stakeholders depending upon business structure.

“The payer community, especially the managed care payer community, has been on this gig for 30 years. They are the only ones with [information and] an economic incentive aligned for prevention and wellness.”

(D. Nash in, HealthLeaders, 2013)
Providers Care About

- Healing patients with compassion, using practices based on individual knowledge and expertise and professional capability.
- Treating disease/disorder occurrences successfully by instance, episode, specialty based on individual knowledge and experience.
- Professional autonomy, integrity of healing relationships to deliver best care.
- Treating every case individually with the 'imperative of rescue' as a driving ethical principle.
- New and innovative technology.
- Professional competence, collegial regard and reputation.
- Not making rationing decisions or care restrictions other than by virtue of individual ‘expert’ rationale.
- Earnings as a by-product of service for the individual but not requirement for the patient.

Medicine cannot be defined solely as knowledge-based, but as knowledge directed by an architectonic principle—healing or helping a sick person become whole again.

E. Pellegrino, Medicine Today, in The Philosophy of Medicine Reborn, 2011

- Minimizing medico-legal risk, community standards; secondary focus on societal impacts of individual actions.
- Access to patient information and current references in the workflow of practice.
What Interferes with Payer Cares

- Limited information about care effectiveness and outcomes.
  - Lack of knowledge about the impact of reimbursement constraints on individual and aggregate health status.
  - Incomplete, ambiguous, arbitrary and sometimes false information gathered from billing code data-sets.
  - Counterproductive caregiver behavior if workflow or professional judgment are adversely perceived.
  - Blowback from caregivers who are trying to ‘do the right thing’.

- Patients who know what they want.
  - Unrealistic expectations for reimbursement by members despite existing agreements for coverage.
  - Inadequate methods to ‘manage’ cases and fairly reimburse specific condition diagnoses and treatments.

- Clinician and member misunderstandings of reimbursement guidelines at the time of treatment or intervention.

- Authority is now diffused and partitioned among members of ever larger teams of health workers, administrators and other functionaries.

- Administrator large teams of health workers, administrators and other functionaries.

  - Administrative inefficiency of internal and external systems.
    - Member complaints, inquiries, dissatisfaction with coverage, and non-compliance with established benefits.

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Edmund Pellegrino, The Philosophy of Medicine Reborn, 2011
What Interferes with Provider Cares

- Limited time for thoughtful and compassionate healing relationships (43 minutes per physician/day administrative) as reimbursement per ‘piece’ has declined and EHRs have arrived.
- Lack of information about individual patient outcomes and aggregate health status across the care continuum.
- Data overload, redundancy and anxiety about the risk of same.
- Payment rules not agreeably aligned with clinical evidence, complete case knowledge and often with opinion or experience.
- Burgeoning redundant or non-contextual data or disparately accessed tools outside of normal work-flow.
- Conditions addressed at a visit vary from doctor to doctor, based on perceived topic value, per US primary care visit time of 16 minutes on average.
- Patient expectations and compliance.
- Inaccessible, variable, rules-out of care limitations from friction.
- Inability to comprehend and align with the complexity and driven by billing and Revenue Cycle Management (RCM) requirements.
- Costs of interacting with multiple payers clearing houses, TPAs and others—requiring employment of more coding, billing and posting clerks than any other US industry.
- Payment rule non-compliance leading to degraded relationships with patients and diminished reimbursement.
- E&M Code reimbursement distractions and questionable documentation.
‘Revenue Cycle Management’
(Administrative and clinical functions that relate to the capture, management and collection of service revenue.)

- Providers negotiate with insurers on contracting and credentialing then:
  - Eligibility, visit intensity (diagnosis treatment), bill submission, claim status and cleansing, inquiries and collections, remittance, payment posting, denials, overpayments and underpayments, take-backs, appeals, reporting, audits.

- Providers spend 14% of revenue to be reimbursed
  - Of every $11.00 claim, $2.30 is lost to administrative costs; higher deductible plans are making costs of collection and patient default numbers go up significantly
  - Waste on average diminishes doctor pay by $16,420 per year; total annual cost of interaction with health plans per practice per year including costs per FTE per hour (MD, nursing, Sr. Admin, clerical, legal): $68,274*

- Patient payments, if not collected at time of visit, are not ever received between 40-70% of the time, collection costs exceed recovery, higher deductible plans and sparser services exaggerate the problem.
  - Payments can cost three to five times more to collect than expected payment amounts ...further escalated by rising patient bad debt and higher deductibles, estimated to have been more than $65 billion in 2010.

*AMA, 2013, and McKinsey 2010
## Administrative Burden

<table>
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<tr>
<th>Payer</th>
<th>% Claims Requiring Rework</th>
<th>Overall Rework Cost / Claim</th>
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<tr>
<td>Aetna</td>
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<tr>
<td>UnitedHealthcare</td>
<td>5.36</td>
<td>$2.13</td>
</tr>
</tbody>
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Delayed Remittance  
Inaccuracy of Payment Expectations  
Identification and Performance of Prior Authorization  
Payer Specific Claim Edits  
Undisclosed Claim Edits  
Claim Denials

2013 NHIRC Report Card, AMA; www.ama-assn.org/go/reportcard
Clinical medicine is the activity that defines clinicians and sets them apart from other persons who may have medical knowledge but do not use it specifically in clinical encounters with individual patients.

Moreover, clinical medicine is the final pathway through which public policies ultimately come to effect the lives of sick persons.

No matter how broad or socially oriented we make medicine, illness remains a universal human experience, and it’s impact on individual human persons remains the reason why medicine and physicians exist in the first place.
Consumers

“Assumed best and equal quality without spared expense: Patients for the most part did not want cost to play any role in decision-making.”

*Focus Groups Highlight That Many Patients Object To Clinicians’ Focusing On Costs*

*R Sommers, et.al., Health Affairs, Feb 2013*

“Few patients understand how many decisions are a toss up, and how bleak and forbidding the landscape of disease can look…doctors, scientists, and journalists have given us all, including themselves, such a hard sell about advances in medicine that only the most sophisticated ever go to a physician any more without overestimating what the physician can do.”

*M Konner, Medicine at the Crossroads, 1994*

“The Internet is like a herd of performing elephants with diarrhea—massive, difficult to redirect, awe-inspiring, entertaining and a source of mind-boggling amounts of excrement when you least expect it.”

*Gene Spafford, 1992*
Goals

3 Emphasize the challenges in *collaboration* that we face
I don't believe there's any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can't completely ignore.

George Carlin, American Philosopher
MORE OF WHAT WE CARE ABOUT

AND WHAT INTERFERES WITH WHAT WE CARE ABOUT

IS THE SAME, NOT DIFFERENT.

ELIMINATION VERSUS COLLABORATION
Collaboration

Significantly higher level than ‘cooperation.’ Shared understanding, open communication, mutual trust, tolerance of differing points of view the essential part of any high-reliability organization (HRO) or process.

**Mindfulness:** consistently watch out for others and remain open to input, then readily adopt behavior in the interest of the goal.
Opportunities for Collaboration

- Standardize, simplify, embrace, measure, share and reward activities demonstrated via accepted metrics to be of high quality.
- Coordinate and share broader health related information (claim based or clinical) for analysis, intervention and cohort management purposes.
  - ‘Provider-run ACOs are finding they need to double-check claims data from insurers with an eagle eye, and also must develop new procedures — such as universal consent forms for data-sharing —to make certain they obtain the information they need’.  
  
  ABN, May 2013

- Integrate complete, timely and transparent (actionable) administrative and clinical information among payers, providers and consumers.
  - Adopt simpler administrative standard operations, provide mutual real-time transparency of costs of care at the unit level and in the aggregate across episodes of illness, as well as across populations.
  - Simplify and standardize coding and reporting capabilities to assure accuracy, improve workflow with focus on outcomes.
Only Through Collaboration

- Transform ‘case management’ (via payer-centric fiscal drivers and levers) into quality driven practice behavior changes.
- Provide appropriate administrative, and clinical information /decision support changes ‘from within’ in a timely, workflow friendly fashion.
- Improve value and effectiveness transparency and simplify administrative burdens (eligibility, member fiscal responsibilities, preferential pricing options, authorization requirements).
- Induce changes in the interest of cost efficacy through influence of clinical discretionary judgment working with caregivers.
- Enhance professional satisfaction, financial success, health and profitability by removing costs of poor quality and reducing administrative distractions from healing interactions.
Examine core elements of information sharing essential to coordinate care and ‘quality’
COORDINATION
The Greatest Barrier to progress:

Inadequate accurate actionable information
**Big Data:**
- Multiple types of data across a population, potentially from multiple sources
- Structured or unstructured nature, and of heterogeneous objects (text, numbers, images, documents)

**Small Data**
- Streams of data from increasingly pervasive individual tracking devices

‘At the heart of many current attempts at data driven health is a powerfully seductive but inherently flawed model of the relationship for the data to knowledge, interpretation and action.’

G. Neff, Why Big Data Won’t Cure Us, U. of Washington, Sept, 2013

**BIG DATA:** Not new or novel, the pollution of the information age, a byproduct produced by virtually every technological process, and something that is more costly to manage than its value.

Bruce Schneier, Privacy Guru

The Cloud(s).....
Extreme weight loss and thinness due to a loss of subcutaneous fat (the fatty, or adipose tissue beneath the skin) and muscle throughout the body. It affects human beings and animals, is often described as "wasting", and is caused by severe malnourishment and starvation.

The malnourishment associated with emaciation has been referred to as "inanition".

In philosophy, inanition is spiritual emptiness or lack of purpose or will to live.
‘In(form)anition’

- Inadequate individual patient/cohort health status information and access to current clinical knowledge in context and work-flow to nourish quality based diagnostic and treatment choices.
- More data does not equal more information (data toxicity)

“Medical knowledge is scattered to the wind---little bits of it in lots of individuals. There is no product---you and I are the product Medicine consumes us.”

A. Kessler, The End of Medicine, 2006
Semantic Incongruity

- Health data even using standard code sets is non-comparable and incomplete.
- Health systems (Payer and Provider) cannot interchange data at a meaningful level.
- Secondary data analysis (Research, QA) is not possible; collection of data into data models is ambiguous, redundant or non-specific.
- Linkage to Decision Support Resources NOT possible because launch base is undependable.
- Cross-community collaboration dependent on information availability is almost impossible.

“If you cannot name it you cannot teach it, research it, practice it, finance it, or put it into public policy.”

Norma Lang, 1992,
Dean of Nursing
University of Pennsylvania
Data and Clinical Effectiveness

- Claims data: significantly erroneous and disparate from clinical reality in paper and electronic health records, with errors being introduced by anyone involved in the coding process for a host of reasons.
  - There are inherent problems in the conceptual meaning and semantic consistency of claims coding systems, and insufficient completeness and granularity to allow for comparative studies or to align with clinical documentation.
  - Significant disparities between claims and EHR data have been documented for surgical conditions, childhood pharyngitis, pediatric emergency visits, patients with diabetes mellitus and hospital complications.

- Quality measure disparities between claims data and EHR data have been shown for quality linked measures (cholesterol screening, influenza vaccinations, diabetic nephropathy and HA1).

- EHR data may be erroneous as well, depending upon the system and the documenters of care with elements of data that are incomparable, missing, erroneous, uninterpretable, inconsistent or hidden in narrative text.

Hersh, WR, et.al, Caveats for the Use of Operational Electronic Health Record Data in Comparative Effectiveness Research. Medical Care, Aug. 2013
Data and Clinical Effectiveness

- Neither claims data nor EHR data tell a complete story; patients get care in different institutions or reimbursements from different insurers, and even data in a patient’s record at a single institution may be incomplete.
- The timing of clinical diagnoses may lead to false conclusions; even death may not be recorded in an EHR if it occurs outside an institution of record.
- Data may be locked in narrative text.
  - NLP developing for the last decades must still link text to coded concepts, and is not yet accurate or reliable enough for clinical research, quality measurement and other purposes.
- Data provenance (from whence did the data come) may skew conclusions—order, pharmacy, patient history.
- **Most critical element of success for collection and conclusions made from EHR or other data sources is universally adopted, standards based, interoperable health care information captured seamlessly across diverse sites where patients receive care.**

Hersh, WR, et.al, Caveats for the Use of Operational Electronic Health Record Data in Comparative Effectiveness Research. Medical Care, Aug. 2013
ICD-10: Poster Child for Collaboration

- Major change in systems that currently leverage ICD-9
  - EMR, Practice management software and other upstream and downstream systems
- Superbill becomes obsolete
  - Too many codes to put on one page (17K-144K codes)
- Lack of awareness, tools, trained staff, thought and documentation practices, and
- Dangerous ‘isolated’ focus on Payer vs. Clearinghouse, vs. Provider systems without continuity
- Upstream and downstream consequences of the change (impact on other analytic systems, ratings and performance indicators)

- Risks
  - Increased rejected claims queries from payers, edits and payment delay, administrative time and confusion
  - Staffing and overhead expenses
    - England 2008 transition:
      - $83,000 small group;
      - $2.7M large group
    - Education, business/contract process-analysis, billing revisions, cash flow disruption, it costs and increased documentation time
    - Canada Hospital transition (2001-2005) chart coding drop in productivity by 50% 1Q, 12% long term
    - Disruption of cash flow
    - Hospital queries require documentation to the specificity of ICD-10-PC (surgeon and OP still bills with CPT-4)
    - Transition complexity in October
    - Documentation, fraud/abuse audits

Phil Smith, MD MedMorph
2004 IFHRO Congress & AHIMA Convention Proceedings, October 2004
Nachimson Advisors, LLC, 2008
ICD-10: Poster Child for Collaboration

- It will take several years (5) of data collection before ICD-10 data will prove its worth in secondary uses for quality improvement and comparative effectiveness research (Chute).
- There are uncertainties about how the coding system shift will affect reimbursement, though most experts say the overall result is likely to be revenue-neutral.
- While ICD-10 is intended to make payment more precise, many hospitals and physicians will strive to more fully and accurately document their services, resulting in higher costs to payers and patients.
- Providers that aren’t as skilled and rigorous in documenting services under ICD-10 could receive lower payments.

- According to the economic impact statement accompanying the first federal rule proposing the change, the transition is expected to cost $1.64 billion over 15 years, with more than 43% of that coming from the cost of upgrading IT systems.
  - That cost is spread across multiple participants—government ($315 million), payers ($164 million), providers ($137 million) and software developers ($96 million).
- Providers will be the hardest hit for much of the remaining 57% of costs, with $356 million to be spent on training, and $571 million in costs resulting from expected productivity losses.
- The upfront transition costs before benefits begin to show were pegged at $1.5 billion.
ICD-10: Poster Child for Collaboration

- Surveys show most hospital care providers are fairly confident they will be able to make the new deadline, but three-fourths of respondents expressed concern that Medicare won’t be ready to test their ICD-10 submissions.
- Similar surveys show outpatient awareness and readiness is less than 40%.
- One of the CMS' Medicare administrative contractors, National Government Services, recommended in June that the CMS perform external, “end-to-end” ICD-10 testing of all participants in the healthcare claim stream—providers, claims clearinghouses and payers.

- HHS warned that “Should healthcare entities' infrastructure not be ready or thoroughly tested, providers may experience returned claims and delayed payment for the healthcare services.” Let’s read that again, shall we?
- Supporters say ICD-10 will allow providers to keep better track of patient care and aggregate data to perform quality-improvement analysis, give hospital and physician leaders sharper tools for analyzing the impact of new procedures and managing population health.
- They’ll also be better able to track individual practices and identify inappropriate practice variation.

Hell is paved with good intentions.

Saint Bernard of Clairvaux (1091-1153)
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<td>V9549XS</td>
<td>Other spacecraft accident injuring occupant, sequela</td>
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‘When individuals in leadership roles create anaclitic depression in themselves, in potential followers, or both, they weaken or eliminate the emotional linkages that are required for them to be effective leaders. At best their capacity to lead is weakened, at worst, destroyed.’

The term, ‘resistance to change’ is generally employed by those who do not expect to suffer from the change they want to introduce, a change that will probably cause anaclitic depression in others.’

Jerry Harvey
Outline reasons for optimism as payers and providers *converge* to reshape our industry.
Convergence

• Perverse incentives reconsidered, new payment models emerging, volume to value shifts (blended payments, PCMH panel revenue sharing, ACO, etc.).
• Integration activities and partnerships upstream and downstream from acute care developing.
• M&A activities, payer-provider collaboration, provider plans and payer clinical interest on rise.
• Tools to support collaboration, coordination and analytics are more prevalent.

• Increased focus on efficiency/outcomes
  More efficient technology and management of clinical and revenue cycle
  Financially regulated and rewarded safety and outcome process programs
  via CMS payment withholding (Never-events, readmissions, quality metrics).
• Wise standardization, meaningful measurement, and respectful reporting emerging
  Guidelines, business and clinical decision support tools and content developed, socialized, tended, and they work*!
  Advancing knowledge and administrative support is increasingly available in workflow (order-sets, references, alerts, RCM).

*Kawamoto K, Houlihan CA, Balas EA, Lobash DF. Improving clinical practice using clinical decision support systems: a systematic review of trials to identify features critical to success. BMJ. 2006 Apr 2;332(7494)
Provider Needs to Advance Value

Core Technology Infrastructure Demand

Today
- Growing core tool deployment
- Focus on optimizing EHR use
- Demand for value-based care solutions limited to select set of innovative providers

Tomorrow
- Clinical data sharing and exchange
- Next generation workflow tools
- Widely established data sharing / info exchange
- Tailored set of workflow tools in place for entire care team

Future
- EHRs fully commoditized
- Providers focused on intelligent analytics / insights
- Growing need for business optimization services

Oliver Wyman, 2013
Convergence

- Healthcare information and operations (caregivers) and consumers are becoming better automated.
  - Use of EHRs has increased significantly
  - Ability to move, normalize, and analyze data exists in a more robust fashion than 20 years ago.
- Recognition of the pivotal role that data / 'analytics' plays in the success of accountable care.
  - Investments in infrastructure and business applications for analytics have been embraced (highest priority).
- The Chief Medical Information Officer is not only a an accepted vital role in C-Suites, it is now a Board Certified Medical Specialty.
- Cultural barriers to data ownership and stewardship remain significant, perhaps greater than technical barriers.
"You can get much farther with a kind word and a gun than you can with a kind word alone."

Al Capone
2014 Issues

• Medicare Physician Payment (SGR)
  • Unlikely (although possible) that a long term fix will be implemented in 2014, so likely that this issue drives a significant amount of attention next year.

• Technology Issues
  • ICD-10
  • Meaningful Use Stage II
  • FDA/FCC regulation of apps/devices within the provider environment

• Medicare Reimbursement Issues
  • Sequestration
  • Provider payments
  • Exchange cost-sharing subsidies
  • Site-neutral payments (Evaluation & Management)

IF "CON" IS THE OPPOSITE OF "PRO", WHAT IS THE OPPOSITE OF PROGRESS?

Jack Handy, Deep Thoughts
**Convergence Volunteers**

- April 12, 2013, Partnership for Sustainable Health Care America's Health Insurance Plans (Payers), Ascension Health (Providers), Families USA (consumer advocates), The National Coalition on Health Care (not-for-profit research), and The Pacific Business Group on Health (employers coalition)

- Five "consensus recommendations":
  - Transitioning from a traditional fee-for-service system to one that rewards high-quality patient care.
  - Offering patients incentives for choosing providers who deliver high-quality care under a value-based insurance plan.
  - Implementing a tiered reimbursement strategy that provides higher payments for services that are proven to be more effective.
  - Reducing reimbursements for services considered less effective and that have a lower value compared with other treatments.
  - Creating state-level incentives to improve care.

*Block, Modern Healthcare, 4/11/13*
Convergence Businesses

- CommonWell Health Alliance: A group of competing electronic health record vendors have agreed to work together to promote data exchange standards across their systems. *HIMSS, 2013*

- eClinicalWorks and Epic Work Collaboratively to Make EHRs Interoperable *9-24-2013*

- MCG (Milliman Care Guidelines) Exploring Product Integrations with Zynx Health, FDB (First Databank), and Map of Medicine.

  ‘I know I'm not the first one to do this, and hopefully will not be the last, but I wanted to share with everyone a list of our most important and often used clinical decision support rules. We're a Children's hospital using Cerner, and are willing to share the CCL code to any of these rules with anyone who is interested.’ *AMDIS, 2013*

- *Choosing Wisely® | ABIM Foundation* [www.abimfoundation.org/Initiatives](http://www.abimfoundation.org/Initiatives) aims to promote discussions between physicians and patients about health care costs. Credibility
Real Time Payer-Provider Collaboration

Operating Burdens

- Reduce calls and manual inquiries from providers & members
  - Detailed member eligibility/liability
  - Provider/plan network status
  - Authorization requirements
- Eliminate manual rework
  - Paper claims
  - Pended claims
  - Rejected claims
  - Staff time and costs
  - Provider Appeals/Grievances
- Manage trading partners
  - Efficient many-to-many connections
  - Seamless regulatory updates
  - Shared services model

Care Collaboration

- Enable new payment models (fee-for-service ➤ fee-for-value)
  - Pay-for-Performance
  - Patient Centered Medical Homes (PCMH)
  - Risk sharing (e.g. Accountable Care Organization)
  - Bundled payments
  - Help providers deliver more efficient/effective care
- Share clinically-relevant data with care givers
  - Value (cost-efficacy & waste reduction)
  - Safety, Appropriateness, gaps in care
  - Rx Adherence
- Integrate payer patient health record (PHR)
- Provide analytics-based decision support
- Encourage health maintenance

TRIZETTO
Provider Solutions®
### Care Models in Today’s Market

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<th>Patient Centered Medical Homes (PCMH)</th>
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#### Patient Centered Medical Homes (PCMH)
- **Best aligned with optimal quality (value), focused on patients with specific health needs, aligning payment with outcomes care team can control, across care venues.**
- **Rewards less spending but not necessarily improved value or outcomes.**
- **Fee for service gives providers control, autonomy and sovereignty but rewards increased intensity and volume; not quality (value).**

#### Benefits Administration
- Full administrative capability for capitation and employer direct programs
- Benefits design, value-based benefits and member incentives
- Claim/encounter processing

#### Network & Contract Management
- Build, direct, and manage “direct to employer” contracts
- Aligned physician incentives and engagement models
- Claims modeling and analysis for contract negotiations

#### Care Management
- Care team can control, across care venues

#### Healthcare Analytics
- Business intelligence and data analytics
- Population based clinical analytics
- Improve clinical care, operational efficiencies and revenue
- Big Data mining

- **Case, disease and utilization management for all “performance based” contracts**
- **Quality, performance and compliance tracking**
- **Patient engagement/outreach strategy encouraging patients to improve health**
- **Information interoperability and semantic consistency**
- **Business intelligence and data analytics**
- **Population based clinical analytics**
- **Improve clinical care, operational efficiencies and revenue**
- **Big Data mining**
Transitioning to Accountable Care

**Care/Service Management**

**Enabling Technologies**
- Payer based CM/DM/UM, (claims data)
  - Analytics: Patient & Population specific
  - Provider Portal
  - Patient engagement tools

**Key Services Supported**
- Call Center CM/DM/UM
  - Nurse and Care Coordinator outreach
  - Wellness Programs and Benefits
  - Cost Containment

**Accountable Care and PHM**

**Enabling Technologies**
- Cross continuum information and decision support capabilities in context of provider workflow
  - Analytics: Person, Population, administrative
  - Real-time Multipayer-Provider Portal/EHR integration
  - Patient engagement tools
  - Normalized/standardized Health Information Exchange

**Key Integrated Service Support: Accountable Care**
- Physician office based population management AND Health coordination
- Wellness support and ancillary care provider enablement; are QUALITY emphasis/ shared revenue
- Care Coordination regardless of institution or payer
- Home care and related services/ Consumer choice

**Current State Characteristics**
- Call center management workflow
- Primarily claims based analytics and workflow
- Single “payer”- single core system integration
- Scalable to millions of members, applicability and effectiveness limited

**Future State Characteristics**
- Becomes Distributed workflow/office based
- Becomes clinically based in real-time flow
- Multi-payer, multiple core systems
- Still scalable to millions, add Big Data
WHAT DOESN’T WORK IN ISOLATION

- Regulation: fraud and self-dealing
  Does not address root cause of low value care

- Consumer-driven care
  Shifts costs to individuals who also lack information about care value and outcomes

- Evidence based medicine/guideline compliance
  Does not intrinsically lead to improved outcomes or efficiency, or acknowledge individuality

- Convenience based care
  Does not address costs of low value care

- Reduction of error
  Essential in HRO but does not address the larger problem of intensity and higher value of care

- Global capitation
  May reduce spending without improving value or outcomes and does little for alignment around outcomes based global patient needs

- Care coordination
  Does not address fragmented or dysfunctional service/fee modeled care (as opposed to integrated condition practice model)

- Electronic Health Records
  Do not intrinsically improve interoperability, outcome determination and management, clinical decision support or information unification

Porter and Lee, HBR, Oct. 2014
Convergence: of Culture Toward Ideal State
Coordination: “System” and Process
Collaboration: (Teaming)
Caring: Commitment, What We ‘Care’ About
Comprehension: the Problem
THE FOUR STAGES OF ACCEPTANCE

This is worthless nonsense;
This is an interesting but perverse, point of view;

This is true, but quite unimportant;
I always said so.

J.B.S. Haldane, British evolutionary geneticist, enzymologist
Jnl. of Genetics, 1963