ACOs Must Create Learning Environment for Physicians to Be Partners in Change

written by Thomas Dent, M.D. | April 12, 2018

The idea behind ACOs sounds simple enough: Build a network of primary care physicians, specialists, hospitals and other health care organizations that share risk and responsibility to provide coordinated care for each patient. Medicare or private insurers offer financial incentives to ensure that ACOs provide quality treatment while limiting unnecessary spending. Primary care physicians serve as key liaisons for each patient's care.

But ACO reality is much more complex and daunting. Shared savings have proven to be elusive. Quality benchmarks do not always accurately measure what's medically relevant. Patient attribution to specialists, rather than primary care physicians, skews costs. Nonetheless, as MIPS collapses and pressure mounts for adoption of Advanced Alternate Payment Models, ACOs are ascendant as the preferred option under CMS's Quality Payment Program.

In this intensely competitive, rapidly evolving environment, where health care organizations must learn to manage risk or perish, experience is the best teacher—with physicians as full partners in the process of managing change. The following four key strategies will help to create an ACO culture that encourages learning from successes as well as mistakes to improve performance, meet quality targets and achieve savings:

1. Foster Learning and Innovation through Dialogue with Physicians and Other Providers

Collaborative learning in an environment that stresses education over dictum is essential for the ACO's long-term success. Several different approaches can be built into projects that review outcomes and costs. For example, in reviewing patient outcomes, clinicians who treat the same patient could share perspectives on causes of outcome variance. Clinicians learn from peers about treatment outcomes and, in turn, provide information about their own patient experiences.

This kind of peer feedback does more than simply foster learning from others' experience. If conducted within a culture that supports mutual trust and cooperative problem-solving, such exchanges can promote not only improvement efforts, but also deep collaborative relationships that help the organization move forward from the bottom up. They establish a mechanism for dialogue among physicians, practices and other clinicians, nurturing organizational nimbleness.

Data sharing is essential to this feedback loop and should be used to build teams within the organization to review patient outcomes and costs collaboratively and within performance improvement or population health projects.

None of this will happen quickly. Everyone in the ACO will be learning new processes and routines. Patience and persistence are essential, with physicians leading the development of the timeline and the process of change.

2. Pilot and Test Interventions for Cost and Quality Improvements

ACO cost and quality interventions should be a collaborative effort of all involved providers. The key here is to pilot and test changes, seeking physician as well as patient feedback, before launching interventions throughout the ACO.

The pilot-testing tactic also may be used to engage physicians in patient learning. Podcasts and, particularly, videos featuring clinicians can be an effective way to communicate with patients about common concerns. These tools can amplify the clinician’s voice without requiring significant effort by physicians. A podcast and video library could be used to give patients 24/7 access to information curated by a trusted provider answering key questions. Patients who have experienced success in self-management may also be recruited to provide messages on life-style and medication use.

3. Distribute Aggregate Cost and Quality Analytics to Physicians, Along with Individualized Data

For cost and quality data review to be both meaningful and effective, practices and individual physicians must receive data through a transparent process on a regular basis. This marks a major leap from the status quo, where most ACO physicians only receive their own data, are unaware of what

else is going on throughout the ACO, and typically receive no aggregate analytics that make them feel part of a group with a shared set of goals.

Note the Hawthorne effect, whereby behaviors change just from being observed. If physicians have no access to data or ignore it, there is little likelihood for change. If, on the other hand, sharing data is framed as an opportunity to learn and grow, rather than as a performance task, there is a greater chance that clinicians will be interested in engaging in dry runs and pilot tests. Reviewing cost data across multiple years is a critical piece of this process, to identify and highlight improvement in costs—what will drive financial success for the ACO.

Remember that some critical results may need to be reported anonymously to encourage participation. Reporting on favorable or best practices, in turn, requires less need to mask feedback.

4. Develop Rewards for Physicians for Beneficial Input on Cost Initiatives and Inquiries

Encouraging and rewarding innovative thinking must be a central theme for organizations seeking to move to a risk model. ACO members that inspire others should be prized. It is exceptionally important for primary care physicians to maintain continuity of patient populations in order for the ACO to survive. But this must be accomplished through engendering loyalty, not scare or pressure tactics.

The physician reimbursement model will ultimately need to change in ACOs. The requirement for significant financial risk for the ACO must filter down to the clinicians in some fashion. The ACO must implement changes carefully to avoid unintended consequences of incentives, seeking input from stakeholders and testing effects of incentives on access to care, quality outcomes and cost.

Clinicians could be reimbursed for the additional time devoted to analysis, dialogue and cost data review required by the ACO. They also may be rewarded, not penalized, for giving necessary time to patients, engaging in a thorough discussion of benefits and harms of clinical alternatives. As patients become more informed, they may choose not to pursue certain diagnostic or therapeutic options—and this, indeed, will assist the ACO in meeting spending targets. The time taken by clinicians to work with the patient's support system might also be compensated.

Physicians Can Become Partners Through Long-Term Collaboration

The unfortunate consequence of many performance measurement programs and quality reporting requirements is that they have led to demoralized physicians and estrangement between physicians and organizational leadership. Rewards and penalties based on short-term results such as performance measures serve to undercut the organization's goals as well as physician morale.

The future of the ACO will depend on building both patient loyalty and innovative approaches to cost and quality, through partnership with physicians. After the typical processes such as coordination of care, reduction of readmissions, and

alignment of referral sources are performed, the ACO will need to dig deeper to achieve the savings targets. ACOs must invent methods to better recognize at-risk patients to avoid incidence or progression of disease and its associated costs, and develop creative methods of improving outcomes and costs associated with highest risk groups. The trust and positive attitude and involvement of physicians will be essential.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Fabrizio Verrecchia

ACO Economics 101: Optimize the Physician Network For Patient Choice

written by Dave Halpert | April 12, 2018

The inaugural MIPS 2017 submission period closed in a fog of

uncertainty. The demise of MIPS looms on the horizon, with little discussion of opportunities for improvement. Heath and Human Services Secretary Azar has advocated for removing the quality reporting component of MIPS, while the Medicare Payment Advisory Committee (MedPAC) recommended scrapping MIPS altogether and pushed for a transition to Alternate Payment Models .

Note that neither of these recommendations advocate a return to a simple Fee for Service model—it is not sustainable financially. Value-Based Health Care is here to stay, but Advanced Alternate Payment Models (AAPMs) with financial risk are the favored path, rather than a transitional program like MIPS. The Quality Payment Program already incentivizes providers participating in Alternative Payment Models, with ACOs being the most popular option. Since the first approvals in 2012, the number of ACOs has increased each year; there are now 561 Medicare Shared Savings Programs and Next Generation ACOs, with 10.5 million attributed beneficiaries.

The big question for providers: How to increase confidence in Return on Investment for ACO development? With millions of dollars in potential losses at stake, creating an ACO with two-sided risk requires understanding the details of Medicare's economic model. Drawing on the experience of ACOs with the best performance track records, providers are most likely to succeed by focusing on five key areas that will influence outcomes:

- Optimize ACO physician network for patient choice;
- Improve cost performance through specialty referrals and post-acute care;
- Manage participating providers' risk and reward;

Reengineer processes for chronic conditions;
Facilitate patient Medical Decision-Making.

Although there are other opportunities for achieving health care savings, concentrating on these five areas will reap the most gains. Let's take a closer look at how to optimize two fluid components of the ACO to build a solid economic foundation: the physician network and the patient population.

How Medicare Attributes Patients Can Affect ACO Savings

Medicare attributes patients to an ACO through a formula based on which provider most recently provided services to that patient—either a primary care physician or a specialist. If the patient is assigned to the ACO based on a primary care relationship, odds are the patient will stay within the ACO network and its referral arrangements to receive care. However, if the assignment is to a specialty physician because the patient only received care during prior years for a particular condition or procedure, patient care is less likely to be coordinated successfully.

A Strong Primary Care Network Better Positions ACOs for Success

Since all patients have free choice to see any Medicare provider, the first job of the ACO is to optimize the possibility that the patient will stay within the ACO network and referral arrangements to receive care. This is the keystone to managing costs. Developing a strong primary care ACO network lays the foundation.

To avoid being tied to patients who are not truly managed by an ACO primary care provider, ACOs should be wary of certain pitfalls in the attribution methodology. For example, patients may be attributed based on an encounter with a Nurse Practitioner or Physician Assistant, regardless of setting. So, a patient who sees a Nurse Practitioner in a specialist setting may tip that patient's attribution to the specialist, particularly if there are multiple visits with that NP. In cases where the NP is in a high cost setting (e.g. an oncology center), an ACO will be challenged to manage these patients' healthcare expenditures.

Attribution Formula Can Result in More ACO Specialists and Higher Cost Patients

How the ACO incorporates primary care and specialists in the physician network is essential to maximize patient connection and decrease cost. There is a particular risk, especially common in health systems with many employed physicians, of including large multi-specialty and single-specialty groups. In large systems, a network dominated by specialists participating under a single legal practice entity is a reality. Since Medicare defines participating practices by the ACO's designated Tax Identification Number, an ACO with specialty volume risks the higher likelihood of patients being attributed to those specialists for receiving specialty, but not primary, care.

Specialist-dominated patient attribution results will skew the ACO patient population toward higher costs. Even when risk-adjusted, the ACO has less likelihood of reducing higher costs, especially in the short term. Because the medical home of the

patient is not well established, there is less opportunity to avoid emergency room visits, services of other specialists outside the system for different conditions, and coordination of care, in general. A handful of larger systems or multi-specialty groups with a strong primary care core may have the resources and experience to overcome specialist attribution issues. But for most, it will take years to recognize and correct the issue.

Three Ways ACOs Can Better Align Attribution of Patients

ACOs can adjust attribution with three key strategies:

1. Incorporate a Strong Primary Care Core, Strengthened by Physician Leadership.

An ACO sponsor must have a core network of primary care physicians that accounts for the vast majority of patient attributions to its ACO. If this network does not exist, or if the population attributed to primary physicians is less than the minimum population of the ACO, it may be wise to consider delay until this goal is achieved.

Attribution is one of the strongest predictors of ACO success. The ideal attribution is based on primary care attachment—*not* because this will eliminate patients who may already be challenged with high-cost conditions but, rather, because it will be harder to coordinate best care for the patient *without* the primary care team. Conversely, the ACO's goal is also *not* to target only patients who are in control of their complex conditions. The ACO must develop its foundation on a medical home and neighborhood model to respond to patients' conditions,

risks and barriers to care in a coordinated way that deals with the whole patient. There are many reasons why patients are appropriately seeing specialists and not primaries for their care—but they may also not be the best initial patient population for the ACO to begin its work. Success will require staging of ACO development, and the network will change over time.

Information about existing ACOs is compelling enough to proffer a "smaller and lighter" option with a carve-out of physicians from a larger health system into a dedicated ACO network. As hospitals, physician practices and extended services have consolidated, large enterprises have formed—often with demonstrably higher costs. Those consolidations were intended to gain market share and patients under Value-Based Health Care. But larger size does not guarantee savings. Also, bureaucracy and politics of large organizations can impede innovation. Businesses seeking market disruption often develop new subsidiaries that are more nimble and unencumbered to create change. An ACO may be well served to consider a similar approach.

2. Use Appropriate Selection Criteria for ACO Providers

How ACOs select providers requires a different approach than under Fee-for-Service. Basic ACO economics penalize, rather than reward volume. Thus, the traditional physician selection criteria– number of physician admissions, volume of services, and high-end services—hurt and do not help ACO efforts. Instead, ACOs should consider their providers' previous cost profiles, requesting copies of Medicare QRURs. These cost

reports, in addition to expense profiles, will also flag attribution issues for specialty physicians who are providing the plurality of primary care services.

Other data on providers will also be of value. These include patient surveys, quality rankings from health plans, referral arrangements and preferences, and review of financial and quality data. Physicians participating in an at-risk ACO are, in essence, going into business together and tying their future revenues to the success of the enterprise. These physicians should be willing to share data to strengthen that enterprise.

3. Use Mechanisms That Encourage Primary Care Attribution

Some mechanisms exist to facilitate primary care attribution. The idea is to create a stronger bond between the patient and the primary care provider and avoid un-referred care.

Primary care providers can use Annual Wellness Visits (AWVs) to ensure that patients are seen and evaluated. Patients attributed to specialists can be offered AWVs to begin the process of engaging the patient with a primary care physician. While these visits require extra time (and are not pro bono) they provide a forum for preventive care, screening and chronic disease management—as well as a proactive mechanism to calculate real patient risk for population health initiatives. The primary care connection and preventive care are among entry requirements that some administrators and physicians with ACO experience consider important.

Annual Wellness Visits can also benefit the ACO by adjusting attribution. An AWV each year will ensure that the patients

being cared for (and kept healthy) continue to be attributed to that ACO. Since spending targets are based on patients seen during the prior performance period, ACOs should also ensure that those who had an AWV the previous year return during the current year.

Primary care providers can also help to curb the myth that a visit to a specialist (along with another round of diagnostics) means better care. A Shared Decision-Making process that promotes patient activism will help patients to weigh benefits and harms of services and make better medical decisions. For example, home based palliative care at the end of life for patients within an ACO led to cost savings, as hospice utilization increased, while hospitalizations decreased. In short, patient choice can effectively align with the ACO's strategic objectives if both the physician and patient are provided the time and support to set goals and make decisions.

Lessons on Economics from Past Financial Risk Models

An ACO differs from an HMO—the predominant model of financial risk in past decades—by two main features. First, the ACO is a provider entity and drives the organization of its physician network. Second, the patient is free to choose providers from the entire Medicare physician panel, without penalty.

These two aspects must be in balance for the ACO to achieve efficiencies as well as improved patient outcomes. Patients must be satisfied to stay in the network. Their satisfaction stems from a more trusted relationship with their main physicians, a greater sense of involvement and control, and more information, in keeping with their goals.

Let’s not sugarcoat it—having a lot of primaries in the network and patients attributed to primaries isn’t enough for an ACO to make it. There is much more required for success. Good communication methods, enough time to ask questions and make choices, and cost transparency will all affect patient loyalty and action. But without sound selection of an ACO network or physicians who are willing to lead and innovate, an ACO can’t even get off the ground.

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Image Credit: Patrick Tomasso

Reluctant Providers Can Benefit from Fresh Approach to ACOs

written by Theresa Hush | April 12, 2018

It’s no secret that CMS wants to move providers away from MIPS

and the Fee-for-Service payment system, toward an Alternative Payment Model (APM) like an Accountable Care Organization (ACO). This past January's announcement of an additional 124 new ACOs implies that we have reached a tipping point, with ACOs becoming more prevalent than standard Fee-for-Service payments.

But that optimism overstates the status of ACOs, both in terms of numbers and success. Despite a steady increase of new ACO approvals and ACO provider participation—including an attractive 5 percent bonus for providers who participate in an Advanced APM (AAPM) with financial risk—the pace of growth is moderate. Only 2 million more Medicare patients were attached by CMS to ACOs from 2017 to 2018. Just over half of ACOs have successfully come in under expenditure and savings targets, with a much smaller share receiving bonuses.

In addition, in the six years since the first ACOs were approved, only around a third of Medicare beneficiaries in the regular Medicare program have been attributed to an ACO for services overall. That's significantly below the 50 percent target set by CMS for 2018, and a long stretch to reach Advanced APM status, or ACOs with financial risk. For providers under the risk-based Next Generation ACO model, several ACOs actually terminated their programs in the end of 2017 because they feared failure under risk.

Majority of Providers Are Still Unprepared for the ACO Model

Clearly, the majority of providers have not been ready to make the change to an ACO. Why? Only a small number of the 562 ACOs have succeeded in achieving any savings at all, and some now

risk repayments to Medicare. The majority lack the confidence that they can organize efforts that will pay off in savings, loyal and satisfied patients, and contented physicians.

Non-ACO providers have legitimate organizational and market issues that raise barriers for ACO participation or development. One is a network cost structure based on hospital or large group ownership of facilities, technology and high-end specialty services. Once cash cows, these investments are now costly to an ACO organization.

Some current ACOs are in concentrated urban areas and have more mature networks, market penetration or dominance, and experience in value-based commercial insurance participation. But for providers who have yet to develop or participate in ACOs, there are legitimate reasons to be reluctant, including current higher costs coupled with lack of physician network cohesion or engagement.

Physicians Are the Front Line of ACOs, But Not Always in the Inner Circle

Technically, the ACO model is physician-focused, because patients are assigned to physicians who are delivering the majority of their primary care services. Based on that attribution, all other costs are assigned to the ACO—regardless of whether the attributed physician ordered the care.

Most physicians are now employed by hospitals and health systems or large multi-specialty groups. Even in geographic areas with the largest percentages of independent practices, a minority of physicians are on their own. Of those primary care physicians making up the core of ACO attributed patients, even

more are employed by hospitals.

Nonetheless, physicians remain both skeptical and uninformed about health care reform, with a declining number believing that ACOs are likely to increase quality or decrease cost. Physicians also strongly mourn the loss of their clinical autonomy and time for patients—who strongly agree that time with their physicians is too limited.

For an ACO to successfully provide cohesive, coordinated and cost effective care, the front line physicians must believe that they have the assistance of their ACO organizations to provide this kind of care. They will need information and support, but they also must be part of the enterprise's design and thought leadership.

ACOs Should Embrace Health Care Consumerism To Win Loyalty

When an ACO is formed, parent organization and provider attitudes toward and treatment of patients often die hard. ACO application and review of attributed patients are geared to viewing them as assets, rather than as individuals. Techniques on how to "manage" patients and avoid network "bleeding" are frequently discussed. This prevailing view of patients as a monolithic group, distinguished mainly by risk level, is—to say the least—troublesome.

Patient concerns about providers are well-documented, and all these issues will be carried over to an ACO unless leadership reengineers attitudes, processes and patient communication. Why bother? Because informed consumers are critical to the ACO's success. Unless patients are guided with facts and cost

information about their options, they will not trust ACO providers.

A recent patient survey revealed some noteworthy data for providers forming ACOs:

- Patients not only agree with physicians that visit time is inadequate; even more patients than physicians believe this to be true.
- 90 percent of patients believe that their providers should look beyond results and evaluate obstacles to improvement in their health.
- Most patients are very concerned about their ability to pay for medical care.
- Most believe that the system is too complicated and don't understand reforms.

Business has understood for a long time that consumer loyalty derives from addressing consumers' expressed needs, not by telling them what they should do. For an ACO to achieve a more successful care model, patient trust is essential. That trust must be earned by a concerted effort to achieve what Fee-for-Service health care could not—providing reliable, accessible information for health care consumer decisions.

Would-Be ACOs Increase Chances of Success with Innovative Development

The challenge for ACOs rests on their ability to achieve cost savings, for two reasons: First, most ACOs score similarly on quality reporting, regardless of size or organizational structure. Second, saving money is the hard part and the highest concern for organizations at financial risk.

Several factors seem to predict ACO cost savings. On the quality front, ACOs that have been in the program longer tend to do better. Predictably, more physician-led ACOs achieve shared savings than hospital-led ACOs. And surprisingly, smaller ACOs seem to do better than larger organizations.

Note that ACO success appears to dovetail with physician appreciation and prompt attention to patient concerns. This suggests that size may not be as much a determinant of success; rather, ACOs should work toward better physician communication and stronger leadership. Furthermore, hospital-based ACOs should rethink how they are constructing their ACOs to be more successful, a significant challenge to the model.

Lay a Solid Foundation with a Creative ACO Development Agenda

Many organizations naturally assume that they can achieve success based on historical prowess of market share and size in the Fee-for-Service world. But it appears that successful ACOs are trending toward leaner, more physician- and patient-focused organizations as a model that can work, if—a Big If—there is enough cash for the initial and ongoing investment.

Providers envisioning how to construct a successful ACO should consider this development agenda:

> Create an ACO primary care nucleus. A nucleus of primary care physicians is the core of an ACO. Cost information is available from Medicare, with permission by the practice, that can be used to evaluate the group based on past quality reporting and cost history, in order to identify potentially successful groups.

Develop an ACO plan around 5,000-10,000 patients of those primary physician practices targeted as likely successful and willing. A multi-specialty group may need to consider separating business units of participating primary care physicians and other professional staff, to align their economics with the ACO.

Create degrees of separation from existing organizations, if needed. Regardless of whether a hospital organization or physician group is leading the charge on ACO development, physicians are so central to the services that they should be leaders of the organization. Referral patterns built on stoking volume to specialists and technology-driven services will require reevaluation of specialty services (and fees) by the ACO. Politically challenging to accomplish in one organization, this effort could benefit by creating a separate entity, at least on a pilot basis. This would help remove those participants from the organization who do not believe in the ACO or are averse to financial risk.

Appoint a patient advisory board that participates in development and ongoing initiatives. To address the health care consumer issues identified previously, the ACO's leadership must be in dialogue with patients, including patients who will not be attributed to the ACO.

Choose technology for population health, analytics, quality reporting and guidance of the ACO. Begin assessment of the proposed practices and patient population to establish the key initial areas of focus.

Establish patient communication preferences and mechanisms. ACO approval is too late to begin the process of securing communication channels, which should be drafted in concert with the patient advisory board and modified as needed later. If there are external vendors who will play a role in

patient communications, they can be pre-selected during this phase.
Establish materials for patients on cost and key initiatives that will help them understand what the ACO is, how they may benefit, and how to provide input as patients and participants.

All of the above are pre-application activities that can be done by groups currently involved in the MIPS program. In fact, using the four components of MIPS can help organizations do the spadework: reviewing comparative costs, establishing population health and performance improvement, and creating quality registries for Medicare-specific populations along with all MIPS-eligible patients.

The success of ACOs may lie in the ability of the principals to side-step current culture and obstacles to create a new design for care, powered by physicians and patients. For organizations still holding out on development, the promising track is to start small and grow, using current data and infrastructure under MIPS as an ACO start-up.

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Image Credit: Israel Egío

Five Ways Medicare's Patient Data-Sharing Will Rock Health Care

written by Theresa Hush | April 12, 2018

Medicare came closer to fulfilling its promise of patient data-sharing last week with the announcement of bundled initiatives to connect health care consumers with their health care data.

First, the Trump administration announced the launch of myHealthEData, a government-wide initiative designed to permit patients to control their healthcare data and determine how it can be used. Several federal agencies will be involved: CMS, Veterans Affairs, ONC and the National Institutes of Health, all under the direction of the White House Office for American Innovation. The effort is designed to break down barriers that limit or block patients' access to their data, to ensure that they can securely direct their data to desired applications, and to require providers to permit access.

The next step is Medicare's Blue Button 2.0, an access program to make Medicare Parts A, B and D claims data available to beneficiaries in a secure and universal format. CMS has recruited more than 100 organizations to develop applications that would enable Medicare beneficiaries to view and share their claims data. Currently, Medicare beneficiaries may be able to obtain a non-interactive PDF of some claims data. CMS urged private health plans to initiate similar programs, implying that it may leverage Medicare Advantage plans to do so.

Along with increased access to claims data, CMS announced that it will require providers to update systems to provide patients with secure electronic data for sharing via applications. The requirements will include those with 2015 Edition certified technology (CEHRT), beginning in 2019. CMS stated that it would require data sharing upon discharge and would mandate certain

types of data.

The American Medical Association (AMA) applauded the CMS effort. The American Hospital Association (AHA), while supporting the myHealthEData initiative and patient data-sharing, did not support changes in the certification requirements for 2019 because of concerns over variability in applications and issues with standards.

Health Data "from the Patient's Perspective" Is a Misnomer

It will take time for patient data-sharing to come to fruition. But this will happen. The drive toward patient engagement—often a euphemism for patient payment—will continue. This is why it's essential for patients to have full access to their data and to understand their costs, a topic we have addressed along with other reforms like price transparency.

But there is a problematic element to some of the thinking around this issue. The myHealthEData initiative's stated objective is to approach data-sharing "from the patient's perspective." Yet, the data is not created by the patient; rather, it is created by the provider. That introduces a data perspective that is definitely not the patient's—with some significant consequences that will require resolution. Here are just a few:

1. Erroneous claims data will surface in patient records.

Because claims data originates in codes provided for insurance and processing, errors may be introduced into patient history.

The objective of getting reimbursement has governed selection of diagnosis codes, use of modifiers and pre-requisites for procedures. Once “rule out” diagnoses were prohibited for laboratory orders, physicians or their staffs often listed the possible chronic disease for the diagnosis, anyway, making it part of the patient’s record.

Electronic records don’t necessarily improve the quality of the data; they just make it easier to obtain. Given the return to “thin” coverage and restricted coverage for pre-existing conditions, the inclusion of codes for possible diseases raises rates and makes it hard for patients to secure their own insurance, should they lose group coverage. Patients will soon understand the significance of such errors.

Once patients can access their records and view conditions recorded as diagnoses that they don’t have, they will want a way to correct the record and disseminate those corrections. They will fight erroneous data; providers and insurers should be prepared to address these demands.

As patients review their own records, they will undoubtedly also discover diagnoses and procedures that are truthful, but which they object to being in the record or provided to others. Elimination of this data would certainly be a serious problem, since an accurate record of the patient is the goal of data sharing with other providers. All the more reason for providers to anticipate this issue and proactively address ways to deal with it .

2. Recording of provider actions and procedures is error-prone.

Templates that speed physician use of an EMR can create a "click the box" mentality, whereby clinicians quickly tick off elements that did *not* occur, such as noting there was *no* physical exam when physician and patient had just a conversation, or marking *no* full reconciliation of medicines when they had an abbreviated discussion of prescriptions. Time is short. Patient and physician process a lot of information during a visit, increasing potential for incorrect data entry or automatic ticking of boxes.

The risk of error is compounded by the need for physicians and staff also to address quality measures during a patient's visit. Additional coded data of varying degrees of accuracy come from many sources, be it the patient, the check-in nurse or the physician. Incorrect responses could even be hard wired into the EMR system. Yes, all of these happen.

Just as for claims data, we will need a validation mechanism for patients to review and provide corrections or register disputes of recorded data. These records document services between provider and patient. They are not merely a record of what the provider did or advised; they are legal documentation of what happened.

3. EMR records will also show evidence of what was *not* done.

Patients expect their providers to meet a certain standard of health care. While "measure results" may or may not be included in patient records as a discrete category, it probably should

be. Patients should be aware of what quality measures they and/or their physicians are expected to meet, so they can be part of the process of achieving appropriate measures.

But that heightened awareness will also bring to light any lack of attention to conditions or poor processes governing care. As a result, patients may demand more accountability for quality as well as cost. Providers must prepare to address astute patients' desires for documentation of measures, quality results and comparisons with other patients.

4. Data will reveal provider biases.

Most patient complaints arise from a belief that physicians don't take their complaints seriously or treat them with respect. Studies of physician-patient conversations reveal that physicians universally tend to cut off patients and not fully hear their concerns. Like all people, physicians also have attitudes that shape their practices and influence how they deal with certain patient groups. Research has substantiated that both women and patients of color face challenges in being taken seriously. Patients who harbor concerns about their care will search their data to identify these biases and may hold organizations accountable for discrimination.

Health care systems should proactively address biases in care by seeking patient feedback and working through issues with providers. Sharing data will reveal the problem's scope and necessitate coaching and cultural sensitivity training as part of ongoing efforts.

5. EMR data will create demand for medical literacy and Shared Decision-Making.

Patients who do capture their data, store it and want to take charge of their health are in the vanguard of a consumer force that health care organizations must take seriously. While a minority of patients may initially take full advantage of shared data, those who do will know that they are pioneering a consumer health movement. They will be motivated by what they see (or don't) in their own data to demand reform in health care and a seat at the medical decision-making table. Having their data is only the first step in consumer-driven health care reforms.

Providers need to ready methods for responding to consumers' needs for engagement with information, programs and processes such as Shared Decision-Making.

Patient Feedback and Involvement Will Make Data-Sharing Work

Providing electronic data to patients is an important and essential step toward helping patients fully participate in health care decisions. But stakeholders cannot afford to be pollyannaish about the effects. As with quality data on physicians, the real value of health care data owned by patients is to begin the conversation of what is possible to improve their health status. That includes a close examination of current data for validity and gaps.

Providers should recognize the opportunity to win trust among new and existing patients. By providing data along with avenues for patients to validate, correct and provide input or

concerns, providers enlist their patients in the first part of a mutually trustful relationship. That trust will create the foundation for real Value-Based Health Care.

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Image Credit: Cliff Johnson

Can Provider-Led ACOs and AAPMs Deliver Health Care Transformation?

written by Theresa Hush | April 12, 2018

“In times of rapid change, experience could be your worst enemy,” said J. Paul Getty. He might have been giving us advice on how to transform health care.

We have reached the tipping point for broader adoption of ACOs and other Advanced Alternative Payment Models (AAPMs) to organize health care and payment under both Medicare and commercial insurance. But our recent experience cannot tell us whether these approaches will work.

This, despite the fact that an estimated 10 percent of insured individuals—32 million people—were already covered by private and public ACO services in mid-2017. And we reached that point even before Medicare approved 124 new ACOs for 2018, for a total of 10.5 million Medicare beneficiaries. Note that the private sector covers more ACO patients than Medicare, although the model originated as a Medicare solution.

CMS is pushing Medicare away from the current payment program into AAPMs, including ACOs. The agency is clearly supportive of MedPAC recommendations to overhaul MIPS, the alternative Medicare Value-Based Reimbursement program, and escalating AAPM participation.

So, now that we're here, can ACOs and other AAPMs actually deliver on the goals of cost control and quality? As the AAPM model of ACOs moves toward greater risk, effective actions to control costs will be essential—and disruptive to their providers, their array of services and, potentially, to their patients. Here are some critical questions:

- How can providers steward a system that depends on voluntary patient loyalty to keep services within the ACO?
- How can ACOs—especially facility- and technology-heavy ACOs—sustain controlled costs below a benchmark with annual reductions?
- Will providers be willing to trim specialists and technology to keep within budget?
- Can providers really deliver on better outcomes for patients, including those with high risk and difficult social needs, and still lower costs?

This is where ACO economics and patient needs come into conflict. ACO analytics will identify which patients have higher risk and which patients have problematic utilization. The expenditure thresholds, lowering each year, create risk for providers as they begin to launch programs to address solutions for these patients, such as better service coordination and necessary interventions.

ACO Success Is Erratic, but Belief Runs High (Not Always Among Physicians)

Success among ACOs has been spotty, at best, and difficult to achieve for most organizations. The difficulties arise across all types of ACO structures: physician-led, hospital-led, jointly led, and so on, although at least one analysis confirms much better results from ACOs led by independent physicians. Additionally, while first year activities can yield easier savings with lower readmissions, sustained effort is difficult and uncertain. Indeed, ACOs can go from success one year to missed targets the next, making it hard to keep providers when financial risk is imposed.

The fact is, no one has discovered the tried-and-true recipe for ACO success, despite the various success criteria optimistically listed by ACO vendors. And, to be sure, specific systems have achieved big payback. Belief in the model runs high within the industry. Many provider organizations maintain an opportunistic belief in the ability to capture market share and grow. Health plans and other financial watchdogs hold the current Fee-for-Service system in such disdain that they view a more organized alternative with better intentions as a good step. Health plans have found a way of partnering with providers, ensuring ongoing business services and contracts that keep the bottom line healthy.

For private physicians, ACOs appear to offer a chance to acquire infrastructure that might otherwise be unaffordable and, possibly, a path to maintain independence. However, physicians who actually participate in ACOs are not uniformly convinced that the model can be successful, and many do not

even understand the particulars of their own ACOs. In addition, many physicians do not believe that the ACO actually contributes to savings and do not feel benefited.

Continued ACO Savings Require More Than the Basics

Anecdotes from the ACO frontlines show that many tend to pursue the same initiatives. Among them:

- Efforts to reduce re-admissions, such as post-discharge contact or arrangements for aftercare;
- Population health initiatives to fill gaps in care (such as those defined by quality measures);
- Analytics to identify high risk individuals or those with high emergency room use and steer them into various interventions, if possible, such as case management;
- Annual Wellness Visits, which may be combined with other efforts to elicit patient-reported outcomes, gather quality data, establish risk levels, or segue into Chronic Care Management, as well as other reimbursed continuity of care programs;
- Physician data sharing and goal setting, including embedded compensation plan incentives to meet targets;
- Patient outreach where the patient is attributed to specialists but appears to have no primary care provider;
- Various disease-based management programs, often beginning with diabetes;
- Identifying variations in care.

Nothing is wrong with these initiatives. They are solid ways to take responsibility for a panel of patients and move away from episodic, acute care. They are also not easy to orchestrate,

because they demand additional workload from practices, changes in workflow, data gathering and physician engagement.

Even if these programs are perfectly implemented and successful—most organizations only have bandwidth for a few—they won't be enough to produce ongoing savings. Why? In addition to the fact that the expenditures benchmark demands more savings every year, these initiatives do not address the key areas where high costs may reside.

To achieve substantial savings, ACOs will need to target lower utilization of services beyond just hospitalization and emergency room use. They must look to the drivers of such costs and facilitate resolution of patient needs.

Four Ways ACOs Can Achieve Breakthroughs in Quality and Cost

The cost drain of an aging population, coupled with obesity and chronic disease, must push providers to adopt mechanisms that are well beyond the scope of most current health care providers. ACOs will need to create bridges to community organizations as well as connect directly to the patient, going well beyond traditional roles and services. It's a tall order for organizations that are transitioning from simply providing services to embracing accountability for patient health. However, there is no surer way for ACOs to achieve required savings than to address the rising prevalence of risk, disease progression and inequity of care.

1. Reduce health disparity among patients.

The ACO agenda usually tends to focus on "reducing variation"

in care as a cost problem. If patient populations were truly homogenous, this would make sense. But not all groups of people have received the same type of care in the past, due to inequities tied to race, ethnicity or gender.

Reducing variation is a process-oriented task to fill gaps in care; improving outcomes requires that services be individualized to patient needs. ACOs have had a difficult time addressing costs and quality effectively for groups such as minorities and women, as revealed by their performance.

Why does health equity matter to the ACO goal? Because minority groups and women represent, in the aggregate, a substantial number of patients who generally have a higher incidence and severity of chronic conditions that will have a large effect on the ACO's results, but who also have legitimate concerns or trust issues with providers who have stereotyped them or failed to communicate effectively. Addressing disparity will affect two key factors in ACO savings: patient loyalty and focused interventions, both of which will impact total costs.

Reducing health disparity can have a profound effect on outcomes and affordability of care for patients, according to a Road Map suggested by the National Quality Foundation. This should also help distinguish provider-led ACOs from payer initiatives, like HMOs of the past. The provider-led ACO should have a mission to deliver compassionate and respectful care with the intent of improving patient health; it will take more diligent efforts to test and implement health care interventions, along with improved communication.

2. Implement Shared Decision-Making.

As we've discussed in a series of articles on medical decision-making, one key to achieving better results—both clinically and financially—is to clarify the benefits, potential harms and costs of treatments for patients. Shared Decision-Making provides a path for patients to rationally choose services, facilitated by their physicians' information and guidance .

Shared Decision-Making requires time for conversations between physician and patient, which in the past have been marked by interruptions and failure to recognize the patient as a rational decision-maker.

To achieve positive results on savings, the ACO must work to re-calibrate physician attitudes, encouraging a better understanding and appreciation of the patient as decision-maker. Only through true physician-patient partnerships will patients maintain loyalty and follow through on plans made with their providers.

3. Partner with community organizations or seek support to provide necessary social services to patients.

Many patients face hardship in managing both health care and health care expenses because of unmet social needs. Some AAPM models have recognized this by incorporating social support, such as CPC Plus. ACOs, however, have no stipulated requirement to facilitate social services to patients.

As more providers recognize patients' need for social support, community models are emerging to develop investor-owned social

impact bonds, medical-legal partnerships and other social support vehicles. ACOs that are targeting long-term outcome improvement should consider social support interventions among their tools to meet this goal, as well as to garner patient loyalty.

4. Develop measures and payment structures for specialists, especially episodic payment contracts.

One downside of most ACO models is the ambivalent relationship between the ACO and its participating specialists. Under Fee-for-Service, specialty costs are an expensive, often uncontrollable item for the ACO. There is consternation about the participation—or not—of specialists, with some ACOs choosing a "contractual" model for referral physicians.

A better approach is to organize payment episodes for participating specialists, coupled with measured Shared Decision-Making. Under this model, specialty physicians can guide patients through a process of making treatment decisions, and any resulting decision to undergo procedures or treatment could be part of an episodic care agreement. That would cap payments to the specialty, while ensuring that Fee-for-Service incentives to perform treatments and procedures are absent or reduced.

Can Providers Lead the Transformation of the Industry?

So far, ACO savings are lukewarm. While some argue that performance to date recognizes that neither provider nor patient is compelled to join an ACO, this is not the sole

factor. The existing ACO program has simply not demanded participation. The requirements will change substantially going forward, stimulating ACOs to be more innovative and demanding.

But can they lead the transformation? That remains to be seen. If ACOs are able to reengineer a path that promotes patient loyalty, better medical decisions and patient-centric programs, they can legitimately claim such leadership. That will require more attention to and discrimination among patient groups, less "bucketing" of patients into populations based on broad criteria that is primarily clinical, and replacing patient "management" or engagement with solutions to identify and meet their needs.

ACOs can choose an alternate path, selecting healthy populations and attempting to redline their services for only affluent or well people. Or, they can try to maintain peace by avoiding change and focusing on easy savings. Neither of these two routes is likely to succeed in the long run. Redlining sick individuals will backfire as patients are unable to find providers and must resort to flooding emergency rooms. Low hanging fruit is quickly harvested, leaving ACOs no alternative but to make changes to stay below expenditure thresholds or, under financial risk, pay money back to the government.

Experience may, indeed, be the drag on rapid change in health care. But commitment and innovation to improve patient health can be the gas that propels us there.

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their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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Who Wins and Loses If CMS Kills MIPS?

written by Theresa Hush | April 12, 2018

Last month, the new Health and Human Services (HHS) Administrator, Alex Azar, tolled the death knell on MACRA MIPS quality reporting. Even as the MIPS program just began its second year, Azar reinforced what MedPAC (Medicare Payment Advisory Commission) has been suggesting since June 2017: trash MIPS quality reporting and speed up provider transition to APMs (Alternative Payment Models). MedPAC is so eager to engineer this that it recently suggested even more incentives to help physicians make the switch.

If you believe the hype, both providers and patients will win if MIPS is eliminated or vastly rewritten. Certainly, the notion that reduced MIPS paperwork will enable providers to spend more time with patients sounds appealing. But providers are not naïve. They know that generating more APM participation

is a major undertaking with significant risk. CMS is quite clear that "Regular" participation in Medicare—with or without MIPS quality reporting—will essentially disappear. As a result, Medicare's Value-Based Health Care program will focus on capping costs; that will only happen through provider participation in Medicare Advantage and APM financial risk arrangements.

We'll save that part of the Kill MIPS message for another post, as it deserves its own quality time.

MIPS Is an Easy Target for Regulatory Reform

By now it's quite evident that the MIPS regulatory approach is inconsistent with the anti-regulatory philosophy of the current administration. There is no question that the measures are overly complex, do not incorporate enough patient outcomes, and fail to provide a foundation for good comparisons between providers. There are valid questions about what benefit such measures provide to the Medicare program or to its beneficiaries.

Indeed, we predicted the program's demise more than a year ago. MIPS was always intended as a transitional stop on the way to providers' participation in Alternative Payment Programs. In addition, the complex infrastructure needed by both providers and Medicare to calculate results across hundreds of measures is, arguably, unsustainable.

But those arguments have always been about improving how we measure Value and Quality—not eliminating measurement altogether—to more closely align with medical effectiveness and patient outcomes. By killing MIPS, CMS risks minimizing "Value"

to equate only with “Savings” as the primary criteria for APM success. By using claims alone and eliminating the reporting of clinical data, CMS suggests that it is no longer concerned with patient outcomes, nor with improvement.

Whether and when CMS will kill MIPS has not yet been determined, but there’s good reason to believe that a massive overhaul or elimination is in the works. Would the death of MIPS quality reporting be a boon for providers? What will it mean for Medicare patients, if anything? Let’s take a closer look at who might benefit and lose from a derailment of MIPS. The answers may surprise you.

Does MIPS Actually Burden Providers?

CMS accuses MIPS of increasing the burden on providers and asserts that eliminating MIPS in lieu of claims-based reporting will help physicians by “leaving more time for clinicians to focus on patient care.” Indeed, the “provider burden” associated with quality reporting has become a flashpoint for the new CMS administration, which casts its top priority as “patients over paperwork.”

It is doubtful, however, that physicians will truly have more time for patient care because of changes in MIPS or elimination of the program altogether. Most data for quality reporting is harvested from Electronic Medical Records (EMRs) or billing data, not provided by physicians. In fact, the vast majority of physicians are not at all involved in collecting data for reporting or in the reporting itself, unless this functionality is built into patient EMR templates. Most EMRs are now designed to facilitate a standard of care and include many prompts for providers.

Office staff can be heavily involved in the quality process, completing data for patients and organizing workflows that ensure collection of data to meet quality reporting. But clinician time with patients is not significantly affected by the quality reporting process because doing so would negatively affect their productivity and patients—plus, most physicians would not tolerate it.

It's important to remember that Medicare is not the only program requiring quality reporting. Many Blue Cross plans provide incentives based on quality, and some organizations have sought certification of quality or medical home status, requiring adherence and reporting of quality data.

Quality Measures Are Deeply Embedded in Physician Compensation

Consolidated health systems were quick to incorporate quality and performance measures into physician compensation schemes. In fact, on average, around 10 percent of physician pay is based on quality incentives; in more mature, value-focused markets, that figure is around 20-30 percent.

But less than half of physicians subject to such compensation plans are earning most of their incentive dollars. As a result, these incentives can't be undone without vastly increasing the organization's physician compensation budget. While incentives are not always tied one-to-one to MIPS measures, sometimes they are. Incentives are also often connected to equivalent indicators or other CMS-provided cost measures, such as readmissions.

The poor implementation of quality measures by health care

systems and organizations has been one of the downsides of Value-Based Health Care. With problematic data and programs that all-too-often focus on finding the bad apples among providers, physicians have become sensitized and demoralized by scores and rankings. But eliminating MIPS won't provide them any relief. The real solution requires a shift to a more participatory and investigative approach to both quality and cost data. It also requires a reorientation to measuring improvements in patient health status and outcomes over time—the real test of value.

Indeed, the use of incentive-based physician compensation is likely to increase, not decrease, as physicians participate in APMs. Risk of excessive costs will be passed on to providers generating the services for patients and will likely further reduce physician compensation in organizations that are unable to generate savings.

Does MIPS Quality Data Have Any Value for Medicare or Consumers?

To claim that consumers have directly benefited from quality measurement efforts such as MIPS would be difficult to prove. Nor have consumers gained more accessible information about patient outcomes or quality that they could use in making medical decisions. Consumers, including Medicare beneficiaries, are still totally reliant on word-of-mouth and Yelp reviews to choose providers.

But it would also be foolish to claim that PQRS and MIPS had no beneficial effect, even if the statement cannot be proven. Prior to quality reporting requirements, most physician organizations did not even track patients in populations and

calculate gaps in care. There were no templates to integrate quality measures; in fact, quality measures didn't exist. Whatever services a patient received were solely up to the provider.

PQRS changed the culture for examining patient care and helped instigate a transition to population health. This didn't move health care far enough to the goal, but it was an important step in the right direction. It happened because organizations needed to measure and report quality to meet Medicare and commercial payer requirements. That's a lot of change in ten years.

To make informed decisions about who delivers their care, consumers will need real data that provides a window on provider quality and how their patients fare. If consumers must bear the costs and choices that Medicare, health plans and their employers intend, they must have the tools to manage.

MIPS is too fragmented, too complicated and too measurement-period-fixed to serve consumers effectively. But whatever results from the next iteration of MIPS, consumers will still need information that the MIPS support infrastructure currently provides. This includes:

- Use of clinical data to support quality measurement;
- All-provider and all-patient data, not only for providers who don't participate in APMs, but also for making APM choices
- Simplified quality measure sets for patients that reflect outcomes over time for chronic conditions, as well as cost per condition;

Specific episodic procedure sets for patients that show functional outcomes and cost.

MedPAC has correctly targeted MIPS as overly complex and not delivering on its goals. Consumers and Medicare beneficiaries, however, should be able to use quality assessments of providers just as we use financial audits, to verify both that providers have the internal quality controls required to deliver good care, and that they are measuring their results. Indeed, the measurement is the point.

So, Who Wins and Who Loses if CMS Kills MIPS?

1. Physicians are unlikely to win under any MIPS death scenario.

Physicians won't see a sudden increase in time available for their patients. Some non-patient care staff resources could be eased. Small-to-midsized practices could, in the short term, spend fewer resources on data collection and reporting for Medicare.

Physicians won't see quality-related incentives disappear from compensation plans. It is unlikely that health systems will unwind the incentives that have become embedded, because that would require additional resources.

2. Provider Organizations may actually lose if the infrastructure to capture quality information unravels.

If CMS uses claims data to evaluate quality, as opposed to the current capture of clinical data, physicians go back to the method of relying on CMS for their scoring and lose the

ability to improve their performance before the measurement period ends. That would be a real loss for large groups that have been successful.
Killing MIPS will not eliminate similar efforts required by physician contracting networks, by large institutional or health system efforts, or by compensation plans.

3. Consumers and Medicare beneficiaries lose if Value is solely defined by cost versus quality of patient care or improvement in health status.

Replacing quality reporting entirely with claims is a step backwards for both providers and consumers.

Ironically, by streamlining the predecessor programs and making MIPS more comprehensive as well as detailed, CMS highlighted the complexity and flaws of the individual programs. The paradox is that MIPS is a step forward in beginning to focus on improvement, properly assess the cost of care, and take advantage of the wealth of clinical data now available. But it is a step back in its complicated design, the sheer volume of quality measures across all providers, and its continued reliance on procedural measures and limited clinical values.

Both providers and consumers would benefit from a major redo of quality measurement, analogous to a framework used by the financial industry. We need validation of an organization's efforts to measure provider and patient performance, regardless of APM or other participation, and assurance of ongoing efforts to investigate quality gaps.

Most of all, we need to take the time to appropriately evaluate MIPS, provider burdens and potential harms to beneficiaries before rushing to solutions that could affect patients. Who among us does not remember the flight from HMOs caused by denials of care and selective enrollment? Provider-owned entities that must assume financial risk for patient care are not without danger. Like everything in health care, even the best solution has both potential benefits and harms.

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Shared Decision-Making May Be the Next Consumer Health Movement

written by Theresa Hush | April 12, 2018

Consumers are rapidly mobilizing around all aspects of health care—affordability, access to the system and choices about their care. As changes in health insurance shift more and more cost onto consumers, patients want to be involved in decisions that will affect their finances as well as their health.

Yet they face a dilemma: The only way to really affect their costs is to be involved in decisions about how much and what kind of health care they use. That means being involved in medical decisions. But when prices are hidden and consumers don't know the facts about alternative—and uncertain—outcomes, they need their providers to partner with them get the best health care they can afford. That's what Shared Decision-Making is about: the patient and physician working together to meet the patient's health care goals.

The culture of clinician-patient relationships is heavily biased toward patients relying on physicians' recommendations for appropriate treatments, without asking about alternatives or evidence to back up those recommendations. But as consumers bear a greater cost burden for their health care, they are pressing to play a more active role in medical decision-making.

Shared Decision-Making Puts Patients in Charge of Their Health Care

To that end, Shared Decision-Making is an approach that places patients at the helm of their own health care. It requires access to evidence-based treatment outcomes combined with a shift in the clinician-patient dynamic. Physician and patient work together as a team to review options; but it is the patient who makes the ultimate decisions about treatment.

This model has benefits not only for consumers who want more control over their health care, but also for providers who are committed to improved performance and better patient outcomes. We've been writing a lot about Shared Decision-Making recently. Here is a collection of those posts that explore the nuts and bolts of implementing the process for long-term benefits to both provider and patient:

Is Shared Decision-Making the Path to Improved Provider Performance?

Nine steps to improved health system performance via Shared Decision-Making

The Crux of Shared Decision-Making: Who is Actually Deciding?

Six essential elements to ensure appropriate review of data, information and the patient's own circumstances

Time Out! How Strategic Pauses Can Enhance Medical Decision-Making to Improve Outcomes

A closer look at how strategic pauses, an established medical practice, can help improve treatment for hypertension, as an example of Shared Decision-Making, plus six steps to ensure success of strategic pause performance improvement activity

Don't Just Check the Box: Capture the Patient's Story to Define Meaningful Goals of Care

A close, personal look by an experienced primary care physician at how taking the time to understand the patient's true

circumstances can improve care as part of a Shared Decision-Making process.

Redesigning Health Care for the New Consumer

Roji Health Intelligence's free 65-page eBook that examines in-depth how consumers can retain access to health care amidst dramatically rising costs.

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How Safe is Medicare? What To Know About White House Budget Proposals

written by Theresa Hush | April 12, 2018

Health care providers may be lulled into believing that

Medicare budget cuts proposed by the White House last week won't happen. Media reports have repeatedly emphasized that the budget is simply a policy proposal. Congress alone has the authority to determine spending limits and allocate funds.

But labeling this budget—and the Medicare proposals in it—as "dead on arrival" is a mistake. For one, the proposal includes efforts aimed at reducing drug prices and fighting the opioid epidemic. But these are minor political enticements, compared to the proposed Medicare cuts labeled as "Reducing Wasteful Federal Spending." Those are the most significant ideas in the document, which have real potential for passage:

> Politically, these proposals align with other efforts to trim federal spending. Passing them could be seen as an important victory in an otherwise contentious budget process.
> Cutting $266 billion is worth the effort to risk Medicare reductions, especially if the cuts are not perceived as eliminating beneficiary services.
> Those who would like to breach the wall protecting entitlements—and not just Medicaid—will likely support Medicare cuts.

White House Budget Proposals Predominantly Affect Provider Reimbursements—and Probably Also Reduce Access

The impact of these programs, if adopted, would be significant for providers. Notably, the proposals are said to reduce costs "without harming beneficiaries' access to care or altering covered items and services." However, changing reimbursements

will cause long-term effects that, together with other proposed measures—such as capping Medicaid expenditures and turning the program over to the states—will affect beneficiaries as well as providers.

These effects will not fall evenly across all health care. The largest impact will likely be felt by inpatient rehabilitation facilities and long term care hospitals, as well as by large health networks and academic systems—especially those in urban areas that serve lower income patients. Here are the top five proposed changes with aggregate savings of $266 billion over 10 years, in order of estimated cost reductions:

1. Establish Uniform Payment System for Post-Acute Services (Fiscal 2019, $0.8 Billion; 10-Year Projected Savings, $80.2 Billion)

The White House Budget proposes to construct a uniform payment schedule for nursing homes, home health agencies, rehab institutions and other post-acute providers, as recommended by the Medicare Payment Advisory Commission (MedPAC) in 2016. Just as for past reimbursement changes for hospitals and outpatient facilities, this intends to correct the incentives of reimbursement systems that pay by type of service and do not always correlate with patients' clinical needs. Note that in unifying rates, the plan is also to lower the average payment for care, resulting in the savings estimate. MedPAC additionally recommended a patient share for such costs, which may also be an unspecified element in the projected savings.

There is support for a uniform post-acute payment program on a relatively short timetable, but it is controversial in the

hospital industry. Nevertheless, given significant MedPAC spadework in research and testing on a uniform post-acute payment system, plus the search for budget cuts, this proposal may well go forward.

2. Modify Payments to Hospitals for Uncompensated or Charity Care (Fiscal 2019, $0; 10-Year Savings Projection, $69.5 Billion)

Medicare is one vehicle for supporting the health care system to serve patients who cannot afford care. Although it does not directly pay the bills of charity care patients, there are payments, such as Medicaid's Disproportionate Share Hospital payments, that are included in the Medicare budget. The White House Budget proposes to remove this from the Medicare budget altogether and create a separate program.

There is no doubt that "calling out" the program separately will make it vulnerable to cuts and perhaps elimination, much like other distinct programs on the list of proposed cuts. And while it may appear to be an accounting shift, with zero cuts in Fiscal 2019, there is little question that such a shift would affect access to care by threatening vulnerable facilities.

There are legitimate policy questions here: how to support the medical infrastructure for the poor, and whether it should be part of an insurance program. But since there is no entitlement for health care through any other means, arguments for making the Medicare system totally aligned with payments for Medicare services has larger implications. It means that the federal

government woud no longer play a role to support the health care system accessed by lower income Medicare and dual-eligible Medicare-Medicaid beneficiaries (as well as low income ineligibles, like the working poor).

3. Reduce and Redirect Funds to Providers for Graduate Medical Education (Fiscal 2019, $.4 billion; 10-year savings, $48 billion)

A less-understood part of Medicare payments is support for Graduate Medical Education (GME), or payment for residents. Many also do not realize that this is included in most Medicaid programs.

The payments are substantial and meant to support the patient care delivered by residency programs, many of which operate clinics or provide care for Medicare beneficiaries. But as pointed out by the budget, there is no accounting for the relationship between payment levels and how much care is actually rendered to Medicare or Medicaid beneficiaries.

It is not an easy formula to fix, and any adjustments will have ripple effects throughout areas where academic centers are concentrated. Many hospitals dedicated to serving inner city populations have affiliated with institutions having residency programs. They view it as vital to providing care at lower cost by extending their workforce, as well as offering specialized services that these patients cannot access elsewhere.

The proposal also raises questions about residency program size and placement. Will institutions with large residency programs get credit if they rotate those residents to community

providers?

But the larger issue is how Medicare or any other insurance program should support the physician supply. This is a valid policy question: How should we support the education and training of physicians, and how does the supply of physicians drive costs? However, it is less a question of wasteful federal spending than of public policy, encompassing the role of government support for education and training for our workforce, in general, and for physicians, in particular.

Again, cuts to providers may have significant impacts on beneficiaries. Since Medicare support for GME is so interwoven with care to lower income populations, there is little question that cuts could, indeed, affect access to care for individuals who cannot afford the prices charged by many academic institutions.

4. Reduce Medicare Coverage for Bad Debts (Fiscal 2019, $0.4 Billion; 10-year savings, $37 Billion)

This proposed cut would reduce Medicare's contribution to unpaid deductibles and copayments owed by beneficiaries, from 65 percent to 25 percent over time. The budget says this is in keeping with private sector levels of reimbursements.

According to a report sponsored by the American Hospital Association, hospitals must make diligent efforts to collect debt owed by beneficiaries, a substantial number of whom are dual Medicare-Medicaid beneficiaries with Medicaid copayments that fail to cover the full amount of care. Hospitals may

indeed be diligent in collections, but the fact that health care costs are too high for fixed income or impoverished patients to bear is illuminated by the projected savings figure of $37 billion. And that situation is not only unlikely to change; if cuts in Medicaid also take place, bad debts will only get worse.

It could well be inappropriate for Medicare to pay a higher level than the private sector for failure of some patients to pay their bills. That is a public policy—not budget—determination to make with regards to the overall affects of the Medicare reimbursement system. Hospitals, on the other hand, argue that lower Medicare payments shift costs to private sector payers now, so that coverage of more beneficiary charity care is reasonable. In any case, however, this proposal would result in a flat-out payment reduction for hospitals, most affecting those hospitals with the highest volume of lower-income Medicare patients and dual-eligibles. In particularly vulnerable hospitals, it could tip the balance of survival and affect beneficiaries' access to services.

5. Pay Hospital-employed Physicians Practicing Off-site the Same Scale as Non-employed Physicians (Fiscal 2019, $1.2 billion; 10-year savings, $34 billion)

It's no secret that hospitals have been acquiring and expanding physician practices and outpatient facilities. By expanding their networks to communities, they have also enjoyed higher hospital-related reimbursement for those physicians. The Bipartisan Budget Act of 2015, however, changed that rate prospectively, while allowing existing physicians in off-site

facilities to continue at higher fee levels. The White House proposal removes the grandfathering provision and effectively creates a uniform fee schedule for physicians, regardless of practice location.

This appears to be a parity maneuver. On its surface, the proposal seems not only fair, but also an effort to equalize physicians across the system. As usual, however, health care is more complex. Like the charity care proposal, there are historical reasons for the higher payments, involving community infrastructure for care.

Some "off-site" facilities—not all, certainly—were created before hospital acquisition of practices peaked, and represented community investments that provided necessary off-site care and services to populations that could not otherwise access them. While we can debate whether higher fees are the right or wrong vehicle, we still may need another method to improve beneficiary access to services in their communities—or risk the demise of these facilities and the health of those who need them for treatment.

The Medicare Budget Is Not Simple Because Medicare Is More than a Payment System

These are just five of the major provisions in the proposed White House budget. There are other provisions that don't affect provider rates, but, if adopted, could affect the speed and scope of Medicare's transition to a financial risk program.

I have focused on these five cuts to show how Medicare has never been just a "payment system." Proposals to correct imbalance, shift sources of payment, create uniformity,

eliminate higher costs—all have a ripple effect throughout the system. Some may be appropriate and overdue. Some may affect vulnerable providers and will therefore change access to services.

Medicare is not the same as an insurance program, although the current policy debate tends to characterize it that way. The Medicare payment system, along with Medicaid, has always been, in part, a placeholder for supporting access to health care as a larger initiative. That's why we have support for the infrastructure of health care in community facilities, for providers who serve poorer and uncompensated patients, and for the physician supply. These functions are not one-to-one benefit-to-cost for Medicare beneficiaries, and if we viewed Medicare only as an insurance program, the proposed cuts seem appropriate. But the effect on access to care is an entirely different story.

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Image Credit: Dimitar Belchev

Don’t Just Check the Box: Capture the Patient’s Story to Define Meaningful Goals of Care

written by Thomas Dent, M.D. | April 12, 2018

What does Shared Decision-Making between doctor and patient really look like? I spent four decades as a primary care physician, as well as 27 years teaching medical students and residents. Looking back on my treatment of patients, I now question whether my management was driven by what the patient wanted—or by what I wanted for the patient.

Certainly, I wanted to do what was in the best interest of the patient, and I sincerely hope that our interests were often well aligned. In certain specific cases, I acted against the stated desires of the patient, a necessary call (discussed below). Most often, however, I could have better elucidated the desires and capabilities of my patients. They were often passive participants in goal-setting.

Why do I now believe that patients must be the primary authors of their goals? Because patients bear the bulk of

responsibility for acting on these goals. They are the only ones who can make necessary lifestyle changes as well as follow any therapeutic plan that I formulate.

In my practice, I believed patients would do most of what I defined as their therapy; where I was unsure, I would try to identify barriers. But I did not start the conversation with questions about the patients' desires or goals. Rather, I would ask how the patient was doing with a problem from a previous visit. This would immediately limit responses. The patient's life occurred outside of the examination room, and there were multiple factors affecting the patient that I didn't always know.

As a result, I realize now that I was in the dark about meeting the patient's expectations. Diagnostic testing or referrals to find answers for poor outcomes was potentially wasteful and even misleading, absent an understanding of what the patient wanted and was willing to accept.

I share these reflections because the time has come for a shift in priorities in the exam room.

Defining Patient Goals Is Messy but Essential

The process of defining goals is more complex than we clinicians may want to admit. I would often not state a goal as mine, but defer to guidelines. Let's say a patient asked if a blood pressure reading was okay. I would explain if it was above or below a guideline. If high, I would then place this in context of associated risks. What's tricky here is the fact that high blood pressure is often asymptomatic; so it's unlikely that a patient would arrive at the necessary goal of

lowering blood pressure unless he or she had experiences with prior therapy.

When a symptom or outcome was more obvious, however, a patient might ask to discover the cause. “Just knowing” is important and often a point of agreement between patient and physician. But this type of goal setting didn’t work when the patient had mental health issues that were the source of the symptoms, and she or he would not accept the diagnosis, as a result.

Over time, my and my patients’ expressed goals would change. New conditions arose and, sometimes, old ones resolved. Treatment side effects would affect priorities, as would marginal improvement in outcomes. When patients stopped smoking, lost weight or stopped drinking, I felt I was at least partially responsible. However, when patients reverted to these behaviors (as very often happened), I also felt responsible. I owned the goals and outcomes because I had created and pushed them. But in reality, for new behaviors to become long lasting, healthy habits, the patient must own the goal and steps to reach it. I could help with medications or referrals, but the patient’s home or social life trumped my efforts.

Some of the most important input I received for creating and meeting goals for the patient came from individuals close to him or her. They often revealed goals that the patient had but could not or had not articulated.

Even with the best of intentions, however, I didn’t always have time to address goal-setting, The ability to meet goals during a single office visit was limited. Persistence over long periods of time worked best, but wasn’t always easy to

accomplish. There was no well-organized process to capture goals and measure success in follow-ups. Visits would often be consumed by urgent concerns. And, because I was the one who created the goals, the work was on me—when it should have been a shared responsibility.

So, what were some of the goals I set, and were they actually meaningful to the patient? Some goals involved intermediate outcomes (BP, weight, HgbA1C). These goals are often quality measures for primary care physicians, more physician-centric than patient-centric. Therefore, patients had little investment in meeting them.

Other cases necessitated that I be directive in establishing goals: protecting vulnerable children, working with patients acting under the influence of alcohol or other mind-altering medications, or treating people who were otherwise incompetent. These instances require physicians to create interventions with family members or other people important to the patient, and who might provide insight and leverage to help the patient.

Achieve Better Results by Engaging Patients in Goal-Setting

All this experience has taught me that the patient—and physician—will achieve better results if the patient sets the goals. So why are physicians still not likely to ask patients about their goals at the outset of treatment?

At a very basic level, patient-set goals may differ dramatically from physician-set goals. The underlying reasons for a patient's goal may well be complex and require a nuanced discovery process by the physician—one that is time consuming

and difficult to pursue within the constraints of office caseload and revenue requirements.

This is not to argue against a shift in the exam room dynamic, however. A discussion that reveals a patient's personal circumstances, such as poverty or loneliness, may have a profound impact on how the care team might act, with dramatic benefit for the patient. After years of taking hypertensive medications, for example, a patient might put "lower my blood pressure" on a list of goals, but the true desire is to avoid a stroke or other vascular event in order to maintain independence—mobility, cognition and self-care.

Likewise, without probing more deeply into a patient's circumstances, the physician could miss subtle changes to cognition that the patient chooses not to mention because of hopelessness or fear and denial. Patients may set goals that don't make sense unless the care team understands personal deadlines, such as attending a son's wedding. Physicians may err on the side of setting low-bar goals based on patients' age, and miss their true ability or passion for running or other sports.

Ask Key Questions to Help Identify Patient Goals

To help patients articulate these goals, we need a different approach to the discovery process. It starts with asking broad questions to draw out the patient's opinions, preferences and beliefs. The patient and/or family need information about the patient's health status and options to create an appropriate context for making decisions. Questions like the following can elicit the patient's overall goals for health and treatment:

- What do you want to be able to do or achieve, related to your health?
- What is the most important and meaningful goal for you as a person, which will make life better (more enjoyable or more fulfilling) physically, emotionally or spiritually?
- What do you think is needed to meet these goals?
- What is the most effective treatment you have experienced or step you have taken to improve your health in the past?

This is, admittedly, a tall order. Physicians are disinclined to ask such questions because patient-set goals require action beyond the competence and comfort level of many physicians, such as delving into social and family dynamics. In addition, physicians may have to create clinical interventions to achieve the patient's goals, and that requires time that exceeds most primary care office visits.

Meaningful goals are often messy and time consuming to develop. Walking carefully through potential adverse outcomes for any given intervention is necessary for patients to understand and watch for inherent risks. Interventions to meet goals should also utilize the patient's social support system as much as possible (with the patient's permission) as a means of identifying barriers and understanding the patient's motivation. Ultimately, patients must be engaged and motivated in order to create meaningful goals that they will actually strive to meet.

How Organizations Can Help Physicians Facilitate Better Outcomes Through Patient Goal-Setting

Given limits on physician time and resources, their organizations must play a key role in helping them elicit patient goals and introduce Shared Decision-Making. The organization has five essential tasks:

1. Create a method to allow documentation and tracking of patient goals.

Physicians need an easy method of documenting and tracking patient goals for further discussions and goal modification. This documentation and tracking should be discussed and implemented as part of the organization's support structure for physicians.

In documenting meaningful goals, organizations should consider how much input the patient should have in memorializing his or her healthcare wishes. Desires, fears and prioritization of health choices must be accurately reflected, time stamped and tracked. This includes the trade-offs that the patient is willing to make.

While "documentation" is usually structured and boxed, it is important for Shared Decision-Making to obtain unstructured responses to the above questions. We can't put words in the patient's mouth or limit responses. This is in keeping with the goal of having patient-centered Shared Decision-Making and reflects the goal of creating a unique story for each patient.

2. Help physicians develop the motivational and guidance skills they need to elicit patient goals.

The AMA has recently promoted a process of asking patients "What Matters to You?" This is an admirable program to uncover the social determinants of health. As healthcare professionals begin to use this approach, the entire goal-setting process will need restructuring. It is my belief that the more detailed approach I delineated above will capture a richer and more nuanced picture of what matters most to a patient—a more complete story.

Motivational skills grow from empathy and understanding the patient as a person. Identifying approaches and techniques that have resulted in observable improvements in goal results will enable clinicians to recognize the factors used in their practice or organization that contributed to success.

3. Measure results of patient outcomes related to goals, including capture of patient-reported results.

We often assume that measurement of results must fall upon physicians and data harvested from their input. But there is a strong case to be made for asking patients how they did. First, it provides a touch point to reconnect on goals and assess progress. It also provides an opportunity to give physicians useful feedback, via measurements such as the following, using descriptors for each response on a scale.

Patient obtained feedback:

Whether they are able to meet or work toward their goals;
How effective the health care team has been in helping them reach their goals.

Data from visit analytics:

Visit and contact adherence for chronic condition management (frequency and regularity of contact between office and patient, including visit and telehealth contacts);
Change in attribution for Medicare patients (i.e. whether or not the patient was assigned to the clinician based on the amount of primary care services).

4. Facilitate needed time for goal-setting and further discussion through appointments focused on Shared Decision-Making.

To create this environment requires substantial time and physician training. Organizations that seek to implement true Shared Decision-Making—in which the patient, not the physician, really sets the goals—must restructure productivity goals and expectations for office visits.

The pay-off for the patient and organization promise to be significant. By capturing patients' desires, fears and aspirations to formulate goals, the patient and physician form an important bond. Paying attention to the unique patient story will uncover factors leading to poor health or, at least, lack of improvement. Creating a loyal cadre of patients who value clinicians who ask detailed questions and take time to listen will distinguish these institutions.

5. Utilize care teams with diverse skills, such as including community health workers.

A health care team comprised of a range of providers augments the physician's ability to understand the patient's goals. More providers will ultimately spend more time with the patient; other skills and insights can illuminate the patient's circumstances. Team knowledge of the family, community and available resources can help to refine goals and support the patient's efforts to achieve them.

Patients may be more open to sharing deeper concerns with some health care workers than they are with physicians because patients view them as more accessible. Home care workers can provide dramatic insights into the patient's life outside the office. This is also true for physicians who provide home visits. Community health workers are often an underutilized resource for clinicians to enhance their understanding of the patient's community and his or her role in it.

The Patient's Real Story Is More Than a Medical Record

The patient's story is so much more than what gets captured in a medical record. It is fluid and requires the patient's oversight and tending. At the same time, the patient may not have considered all of her or his goals, and the physician can help identify the appropriate path. The patient should expect responsiveness, encouragement and kind understanding from the health care team. Clinicians must begin to look where they haven't always looked to fully address their patients' desires and needs. This includes asking what transcendent goals the patient might have. Helping others has a therapeutic value that

should not be ignored.

I wish I could go back and ask my patients more about their personal goals. I believe this would have improved their wellbeing. I encourage clinicians to learn from my experience and invest the time and effort needed to fully understand patients' goals as a critical step toward real Shared Decision-Making.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Simon Migaj

Five Lessons from Big Business on Value-Based Health Care

written by Theresa Hush | April 12, 2018

Last year we predicted that CMS would step back from the

complex requirements of its Value-Based Health Care initiative, in favor of reducing provider burdens for quality reporting and reducing regulation, in general. While MACRA MIPS and the move toward financial risk still remain, we correctly anticipated that Medicare would focus its efforts on its own beneficiaries—and less on leading the charge for cost control in health care.

We hoped that providers would seize the opportunity to take ownership of making health care work better, rather than respond to external requirements. Instead, despite several organizations that have pushed the agenda for change in their systems, most provider-based health initiatives have been too small, too slow and too focused on gaining leverage against the competition—all in anticipation of "managing" patients under VBHC.

That window of opportunity to take the lead in health care reform may have closed, now. Some new leaders have entered the picture who have the motivation and resources to demand change.

Big Business Has Stepped Up in Health Care

In the past two months, Big Business has made announcements that promise to shake up and change the course of health care. Three announcements, in particular, represent the strongest statements of intent that the health care fortress is about to be breached:

- CVS-Aetna Merger
- Apple Health Records app for iPhones
- Amazon, Berkshire Hathaway and JP Morgan Chase creation of new health care company for their employees

Judging from the industry's quiet response—marked by a "many have tried and failed" attitude toward the supposed naïveté of business entering the fray of health care costs—it appears that providers may think Big Business efforts are tangential. But do health systems leadership teams really believe that Big Business has no expertise to offer? That would be a risky miscalculation for providers.

Health Care Organizations' Response to VBHC—Get Bigger

Provider health systems have been caught in a feverish pace of acquisition and mergers. These transactions assume that providers can take the lead in shaping the future course of services and care under Value-Based Health Care. Indeed, health care has been growing so much that it's hard to keep track of who is purchasing or merging with whom. But these mergers don't seem to be helping to keep costs under control, as measured by prices paid by employers, consumers and patients.

Despite evidence pointing to even higher costs coming from the merged enterprises, there has been an unrelenting march toward ever-bigger provider health systems. There is so much consolidation occurring that there is an uptick in both anti-trust activity and refusals of mergers.

Yet, already many communities face concentrations of health systems that threaten competition and therefore keep health care prices high, as well as endanger consumers by holding them captive.

Providers say that the investment in technology and other infrastructure needed to size up for Value-Based Health Care

warrants the expansion. They point to the need to manage population outcomes and cost through a continuum of services, from primary care through specialty hospital services, and beyond.

The effect on the industry has been staggering, prompting a sharp decline of independent physicians. Attracted by both compensation and practice support for dealing with VBHC demands, plus the need to buffer their futures against financial risk, less than half of the country's physicians now remain independent.

At the same time, as health care systems have gained size and resources such as technology, their failure to produce savings—even when they have created their own ACOs—leads to loss of credibility in both the VBHC model as well as provider systems. This failure to produce savings should not be a surprise; the system still supports fee-for-service reimbursement, has low risk for health care systems, and does not envelope patients in methods to increase value in health care decision-making. It's a tiptoe transition to accountability that assumes ample time to evolve.

CVS-Aetna Merger Is An Appeal to Consumers

The CVS purchase of Aetna has many interesting possibilities for disrupting the health care system. Industry watchers have focused on the use of the CVS pharmacy benefit plan for Aetna-covered patients, or the potential for aggregating data for use by consumers. These are important features that may help whittle down costs.

But these are not the most significant features for this

transaction. What is? The growing community-based clinic operations that provide more and more primary care. By linking coverage, data and real community providers, consumers have an alternative way to get fast, efficient, convenient and quality-driven primary care. They also have a path to trust more in their insurance company, because that insurance company is now focused on giving them better data and more value.

The CVS-Aetna merger is *at least* as much focused on consumers as it is on administration of benefits and costs, and likely much more. Case in point: Where did you get your flu shot? My doctor gave me a choice last year. "You can get your flu shot here and it will cost you $85," she told me. "Or, you can go to CVS and it will cost you $15." This year, I didn't pay anything when I went to a retail pharmacy.

And this: My daughter flew in from New York for Christmas with a terrible cough and congestion. We didn't even discuss the possibilities of calling her previous physician or going to an emergency room. She went to a Walgreens Minute Clinic, was seen the same day and received great service.

What should providers take away from these transactions? First, there are some significant consumer-facing businesses that believe affordable pricing, convenience and customer service are the way to build a patient base. Second, they have demonstrated that consumers are voting with their wallets for price transparency and other mechanisms to lower their costs.

Providers' response to the CVS-Aetna threat of movement into their more distinct provider space? You guessed it: Just get bigger.

Can Apple's Health Record Impact Health Care Decisions by Patients?

The two-decade effort to digitize patient health care information has benefited hospital analytics. But it didn't do much for patients. Stripped of critical information that would have allowed them to consult with others and obstructed by layers of bureaucracy and cost, consumers have not had full access or ownership of their own data.

Apple's data integration is built on a platform of EMR data contributed by health care systems, placed in consumers's palms via their phones. This may be a real game changer in the movement to help patients monitor their health status and make health choices. As the data and interpretive tools improve, it may become commonplace to evaluate our diets, exercise and other activities through this window. It may also be a method to convey our own data to practitioners, facilitate specialized care or create data for precision medicine.

The Apple initiative is all the more important because some very prestigious health care systems will participate in the initial round. After years of protective data generation, these forward thinkers have stepped up, along with their EMR vendors, to slay the interconnectivity dragon. Broad industry support of the fledgling effort is refreshing as well as cost-effective for providers, who would otherwise face exorbitant costs to redesign systems to meet the full consumer needs and collect patient-provided data. The Apple Health Record creates a DMZ between provider and patient data that still must be navigated for its value and use.

Equally important, Apple has given providers a very good lesson

by demonstrating that access to health care data is something consumers want and are willing to use to improve their health status. The tech giant may have learned this from their Apple Watch, a lesson that defies providers' complaints that they can't get patients to change their behavior. The real question for consumer involvement in their health care: not If, but How.

Amazon, JP Morgan Chase and Berkshire Hathaway—Strong Consumer Focus and Consumer-Infrastructure

The details are murky on the three giants' objectives in creating a health care company for their employees. Many health care provider systems think it naïve for the trio to expect to curtail costs. Beyond these organizations, there is more exuberance for Big Business initiatives to disrupt health care and excitement about the possibilities of on-demand care, better avenues for consumers to get information, and support for cost-effective choices.

Regardless of what will eventually grow out of this enterprise, it is likely to have significant impact simply because of the players involved. Providers should be taking home some lessons on why this is happening and what to do next. And what are those lessons? Let's start with how Big Business will take charge of reforming health care, if they lose faith that health care systems themselves will do it. And then we should consider whether three very consumer-directed organizations, who have focused on convenience and price, will be creating innovative alternatives for their employees. Finally, do we really think they will stop there?

Five Lessons For Providers From Big Business

Taken together, the central themes of these initiatives involve two important concepts. First, Big Business is done waiting. If providers do not act to address costs now, business is prepared to take matters into its own hands. Regulating providers into cost control is a tricky path, but competition is what these folks know how to do.

Second, these businesses respect the consumer as the decision maker and value customer service in a way that differs from most health care enterprises. For providers, the “customer” is often the physician, their participating health plans and employers. Their patients are the recipients of care, but that doesn’t necessarily translate into “customers” to which they are accountable. As a result, they struggle with developing customer-service-friendly practices, shared data, encouraging patients to consider options, shared decision-making and price transparency.

Health care systems should carefully consider what Big Business is making clear through these initiatives:

- The time is up for minimum effort and pilots to improve health care cost performance.
- Price, convenience and customer service are still the way to get patients.
- Patient decisions will be the future of cost control, because providers have not been able to get there (yet).
- Price transparency, quality data and decision support for patients are viable services used to lower costs.
- Consumers want access to their health care data and are willing to engage with that data to improve their choices.

> Streamlined, on-demand health care services and support for health care decisions will be the most important tools for providers to develop.

The health care system must change, and the only question is who will be on the leadership team. It could be business, or health care providers, or a combination of the two. How fast providers can develop their own businesses to be customer-focused—toward the patient and prospective patient, that is—will determine their place in the industry.

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