

## Preamble

With the federal government declaring that the Affordable Care Act (ACA) has put health care consumers back in charge of their health care (U.S. Department of Health & Human Services, 2014), the United States is undergoing one of the most dramatic shifts in health care since the inception of Medicare. The ACA and changing demographics are expected to drive growth in health care spending from 2015 through 2022, with spending projected to represent nearly 20% of gross domestic product (GDP) by 2022 (Centers for Medicare & Medicaid Services, 2013). The very same drivers for this projected growth will also challenge providers and payers to increase quality and access while lowering costs.

## Navigant Healthcare Cymetrix Executive Advisory Board

Navigant Healthcare Cymetrix is pleased to announce the formation of an Executive Advisory Board that consists of healthcare and academic leaders who will meet on a periodic basis to explore the issues impacting the reform of our nation's delivery and financing of healthcare. The panelists include: Pat Fry, President and CEO, Sutter Health, Sacramento, CA; Jay Herron, Partner, Royer, Maddox & Herron (former CFO, CHRISTUS Health), Colleyville, TX; Paul Keckley, Ph.D., Managing Director, Healthcare, Navigant Healthcare, Nashville, TN; Michael Halberda, Managing Director and CEO, Navigant Healthcare Cymetrix, Irvine, CA; Dave Hampshire, Managing Director, Healthcare, Navigant Healthcare, Chicago, IL/Phoenix, AZ; Vince Schmitz, Health Care Consultant (retired CFO, MultiCare Health System), Gig Harbor, WA; Dan Zismer, Ph.D., MHA, Wegmiller Professor and Director, MHA and Executive Studies Programs, School of Public Health, University of Minnesota, Hopkins, MN; and Jayson Yardley, Managing Director and President, Navigant Healthcare Cymetrix, Irvine, CA. Donald Wegmiller and Jerry Nye of C-Suite Resources, Minneapolis, MN, provides facilitation for the advisory panel.

"As a revenue cycle management organization, Navigant Healthcare Cymetrix is focused on solutions. But we need to pause to look ahead to consider long-term strategies for a better health care system," says Michael Halberda, Chairman and CEO, Navigant Healthcare Cymetrix. "Tapping into the thought leadership of this distinguished group, we can consider the opportunities, risks, and changes that exist and continue moving forward confidently."

The Executive Advisory Board held its first meeting in May 2014 and the following report reflects the topics of discussion, insights considered, and key takeaways from the meeting.

## Introduction/Background

Health care providers are feeling the crunch as payment reform forces a shift from volume to value at the same time that consumers are playing a greater role in shaping how the industry delivers care. These major disruptions promise to transform health care, and organizations must innovate now in order to survive.

This consensus opinion from industry and academic experts emerged during the inaugural meeting of the Navigant Healthcare Cymetrix Executive Advisory Board. Convened to bring together diverse thought leaders to explore key issues, share insights, and contribute to the field, the round table discussion focused on The Interplay of Payment

Reform and Consumerism/Patient Activation. The wide-ranging dialogue touched on issues such as new approaches to clinical diagnoses and treatment, revenue cycle management, branding of health care organizations, ownership of health plans, leadership and management, sites of delivery, and use of technology. A key theme was that the Affordable Care Act (ACA) has lit the fuse that will alter health care, but that many other elements are driving change.

## A Time of Change

Cost versus quality has long dominated the dialogue about how to improve the American health care system, and implementation of the ACA in 2014 has moved value to the forefront. The influx of 8 million people who signed up for insurance through the ACA and concerns about whether employers may decide to simply offer their workers money to buy individual policies in the public marketplace promise to have an impact on all aspects of health care. Other factors that may produce further upheaval in the system include:

**Millennials** – The 80 million people in the U.S. between the ages of 18–34 want a health care system rather than the hodgepodge that currently exists (Keckley, 2014). The simple, coordinated, and accessible system that Millennials think should be in place includes incentives for healthiness, transparent pricing that covers everything, and health care as a basic right (Keckley, 2014).

**Patient Engagement** – Nearly 15 years after the Institute of Medicine declared that patient-centered care should be a core part of an improved health care system (Institute of Medicine, 2001), patient engagement is gaining traction. The ACA’s Accountable Care Organizations (ACOs) and patient-centered medical homes (PCMHs) make connections between patient engagement and quality. Making decisions based on patient needs and preferences, along with medical evidence and clinical judgment, also may lead to better outcomes and lower costs (James, 2013). Patient and family engagement in health care goes beyond the treatment decisions made as part of direct care and into organizational design/governance and policy making (Carman et al., 2013). Fully engaged patients, for example, might partner with a hospital to co-lead quality and safety committees or have equal representation when health care resources are allocated at the policy level (Carman et al., 2013). This is not to say that such a transition can occur rapidly; patients need understandable, actionable information in order to engage (Keckley, 2012).

**Retail Health Care** – Consumers can now seek health care at the same places that they shop. CVS, Walgreens, Target, Kroger, and other retailers have opened clinics featuring no appointments, seven-day-a-week services, and lower costs. Although one doctors’ association recently advised against using the clinics (AAAP, 2014), a poll suggested the retail sites are increasingly popular (US News, 2013). The clinics may also play a greater role as more Americans have health insurance through the ACA and are seeking bargains.

Combined, all of these factors could produce disruptive innovation in health care. Disruptive innovation occurs when a simple product or service is introduced and displaces established competitors (Christensen, 2014). Examples of disruptive innovation include cell phones that have replaced land lines, or the emergence of the Southwest Airlines and Jet Blue model of air travel. Rather than fighting disruption in health care, one approach is for industry stakeholders—providers, insurers, regulators—to facilitate change and embrace an opportunity for change that will lead to an improved health care system that meets surfacing needs (Christensen, Bohmer, & Kenagy, 2000).

## Cymetrix Executive Advisory Board

The following thoughts from the Navigant Healthcare Cymetrix Executive Advisory Board offer ideas about the challenges and opportunities that exist in the rapidly evolving health care system. The topics discussed during the May 2014 roundtable are synthesized in this summary and combined with additional background information in order to stimulate further thinking and discussion.

### Changing Environment and Consumerism

One of the biggest unknowns about health care reform is how consumers will behave. Will the public begin acting like shoppers when it comes to health care if they have to pay higher out-of-pocket costs? Or, will they accept increased costs and continue to behave as they have in the past? One reason these questions remain unanswered may be that the ACA represents a major policy shift that does not yet resonate at the personal level. At mid-year 2014, a majority (53%) of Americans said the ACA has not had any impact on their families (Hamel, Firth, & Brody, 2014).

Anticipating that payment reform will soon affect consumers in a noticeable way, roundtable participants predict:

- ❖ Details about costs and outcomes is currently difficult for consumers to obtain, but is likely to become accessible as consumers seek to make more informed treatment decisions.
- ❖ Consumers will demand and expect easy-to-use electronic applications to make appointments, access health records, view lab/test results, and email with a doctor.
- ❖ Freestanding facilities that are open 24-hours a day and can handle both urgent and non-urgent will become the norm.
- ❖ Connections between patients with similar illnesses or conditions will grow. Patients want to learn from and share with others who are in the same situation. Social media will be prominent.

### Employer Activation

Is consumerism a subplot of employer activation? The ACA mandates will soon expand from individuals to employers. Employers with 50 or more full-time workers or full-time equivalents must offer health coverage that is “affordable” and provides minimum value (i.e., pays at least 60% of the allowed cost of services) to full-time employees and their children up to age 26. The employer mandate will be phased in during 2015 and 2016.

These new requirements may spur dramatic change in how employers view the health and wellness needs of their workers. The ACA creates new incentives to promote employer wellness programs and expand existing programs (U.S. Department of Labor, n.d.). The rules do not specify the types of programs employers can offer. Examples of participatory wellness programs to encourage healthy behaviors include reimbursement for a health club membership, employee rewards for taking part in a free, monthly health education session, or employee rewards completing a health risk assessment (U.S. Department of Labor, n.d.). Employers may also offer health-contingent wellness programs that require workers to meet a certain health goal or status in order to earn a financial reward. Such programs may, for example, reward employees who do not use or reduce their use of tobacco, achieve a specified cholesterol level, or meet a certain weight goal (U.S. Department of Labor, n.d.). The rewards could include lower health insurance premiums. In 2013, 20% of large employers used outcomes-based incentives (Mercer, 2013). The idea is that healthier

employees will result in lower health care costs for the employer, as well as result in more productive employees (e.g., less absenteeism).

Although it is too soon to know if more employers will offer such programs in coming years, a recent poll suggests Americans are wary. A majority (62%) of the public believes it is not appropriate for employers to require their workers to pay higher insurance premiums if they do not participate in wellness programs (Hamel, Firth, & Brody, 2014). Nearly three-quarters (74%) do not believe employers should tie premiums to workers compliance with certain health goals (Hamel, Firth, & Brody, 2014).

Employers may also be “activated” as a result of the ACA to take greater control of health care in other ways and thus encourage their employees to be more consumer-oriented. For example, the California Public Employees’ Retirement System (CALPERS) has successfully used reference pricing to encourage enrollees to undergo joint replacement, outpatient colonoscopies, cataract surgeries, and arthroscopy at hospitals and freestanding facilities that provided the services below a certain price threshold (Lechner, Gourevitch, & Ginsburg, 2013). Another indication that employers may be seeking greater price transparency comes from Wall Street. The March 2014 initial public offering for Castlight Health, a company that offers software for employers who want to help workers hunt for health care bargains, saw stock prices jump from \$16 to \$40 a share. The thought is that employers will shift health care costs to employees through high-deductible plans, pushing workers to shop for lower priced care (Moukheiber, 2014).

Enrollment in consumer-directed health plans, which carry a higher deductible and a health savings account, accounted for 18% of covered employees in 2013 and is expected to rise (Mercer, 2013). Nearly two-thirds of large employers expect to offer a consumer-directed health plan within three years (Mercer, 2013). A key driver for the predicted growth of these low-cost plans is an excise tax that will take effect in 2018. Employers will be required to pay a 40% excise tax on health care coverage that costs more than \$10,200 per person or \$27,500 for a family. One estimate suggested that approximately one-third of employers will face the excise tax if no changes are made to their most costly plans by 2018 (Mercer, 2013).

These employer-driven strategies do not, however, guarantee that consumerism will take hold. Although out-of-pocket costs and convenience/access to care (e.g., retail clinics, urgent care, virtual care) may be driving some decisions, there are some significant barriers to full-fledged consumerism. One challenge is that the complexity of health care needs may diminish consumerism. For example, treatment for an ear infection may be possible with a single visit to a doctor’s office, urgent care center, retail clinic, or even through a virtual doctor’s visit. Treatment for Hepatitis C, though, may require six- to 12-months of expensive, complex drug therapies, with frequent blood tests and doctor visits to monitor efficacy. Beyond clinical considerations, another obstacle to consumerism is the lack of a push by policymakers or regulators. Business may believe or perceive that Americans are equipped to take control of their health care decisions, but government continues to seek protections for patients that limit their autonomy in many cases.

### **Scaling, Branding, and Other Tests**

Health care providers are under enormous pressure. Previously uninsured patients now insured thanks to ACA are now more attractive to other providers, and there may be increased competition for current Medicare patients. The increase in the number of newly insured patients at a time when reimbursement will likely be lowered is also a challenge. Add to that consumerism and the ACA’s emphasis on measuring quality, reporting outcomes, and managing costs.

Provider responses to the anticipated impact of the ACA are varied. Executive Advisory Board participants suggested:

- ❖ Some large integrated health systems with sizable market reach and strong balance sheets, may move aggressively toward the ownership of health plans in hopes of better controlling an expanded proportion of the “value chain” (i.e., ownership of the premium dollar as well as the health services reimbursement payments (reimbursements). The theory for this potentially risky strategy is to control as much of the universe of health care consumerism as possible. Ownership of health plans by provider organizations differs from similar initiatives in the 1980s and 1990s because plans must now meet quality metrics and demonstrate added value. This will require providers to have the necessary care management capabilities to assume downside risk
- ❖ ACOs face a tough road. ACOs are groups of doctors, hospitals, and other health care providers who agree to be held accountable for cost and quality of care for a defined population of patients . Many newly-formed ACOs lack experience in operating such complex, integrated organizations and do not have the capital to do so. Another possible challenge for these new organizations involves doctors, who have traditionally been paid on a fee-for-service basis and in some ACOs are paid a set amount. Will doctors in the future be willing to move away from procedure and volume-based payments and instead sign a contract with a guaranteed salary?
- ❖ Health systems are using brand strategies to position services and facilities. The hope is that customers will trust a brand name and develop loyalty to a particular system, believing that they will get same services across all of the system’s providers. The thought is that brands will attract consumers who may be taking greater control over their health care decisions in the future, either because of changes in insurance or in attitude. These consumers may be less tolerant of a fragmented system of care that causes the user (the patient) to interact inefficiently and, perhaps ineffectively, among and between multiple, disconnected provider systems and individual providers, each operating from their own, preferred business models and related incentive schemes. Thus, the challenge will be to implement standardized protocols to ensure that the patient experience is consistent among all settings. This approach to standardization goes beyond clinical protocols into organizational culture, or “the way things are done around here.” This includes customer service, quality, safety, access, and total costs of care.

## Revenue Cycle Management and Consumerism

Revenue cycle management and consumerism may not seem to be aligned at first glance, but roundtable participants identified numerous connections. Comprehensive revenue cycle management is focused on the entire patient experience rather than just the bottom line. For example, scheduling and pre-registration are first points of contact for patients and are included in the patient access services component of revenue cycle management. Insurance verification and eligibility/financial counseling are also important initial points of contact between providers and patients that span revenue cycle management. Providers who work with patients to communicate about access to care and payment for treatment establish a relationship based on collaboration. A focus on health information management in the revenue cycle also has a direct impact on the patient experience. Documentation integrity, chart preparation, transcription, and coding are all crucial in ensuring that patients receive the right services and that reimbursement will occur. For example, improper coding may lead to payment denial.

By considering all of these issues from perspective of the patient, organizations do more than simply standardize business practices. Rather, providers create an organizational culture that demonstrates respect for patients. This may

become increasingly important as patients become more consumer-oriented. Organizations that offer efficient patient interactions and clear information about costs (insurance coverage and out-of-pocket) may earn the loyalty of patients. The patient experience also will impact reimbursement from payers under health care reform.

**Clinical Innovation**

Beyond pharmaceutical and other treatment breakthroughs, clinical innovations may be possible through the use of technology and changing attitudes. This approach recognizes the fact that the current state of health care does not support unbridled consumerism in a purely retail market. Instead, opportunities exist now to provide guided self-care management. Consider, for example, that 20-30% of medications prescribed are never filled and that medication is not continued as prescribed in about 50% of cases (CDC, 2013). To improve medication adherence, a text could be sent to a patient. This strategy relies on standardizing rather than incentivizing behaviors. Other related ideas include using existing health information data to identify behavior patterns and establish predictive analytics that can be acted upon, and institutionalizing good habits rather than bad ones.

**Conclusion**

There is no standardized protocol for reforming the U.S. healthcare system, but there is no doubt that intense change will occur as a result of the ACA and the private initiatives that are emerging because of economic and societal forces to improve quality and safety, enhance the patient experience and reduce cost. This report on the insights of the Navigant Healthcare Cymetrix Advisory Board on payment reform and consumerism further the discussion and offer new topics for future consideration. Leadership, delivery system reform, care models, analytics, and technology all represent rich areas for continued conversation. Navigant Healthcare Cymetrix pledges to continue to foster this dialogue and encourages comments and questions ([info@cymetrix.com](mailto:info@cymetrix.com)) that will help shape the future of health care.

Navigant Healthcare Cymetrix is grateful to the members of its Executive Advisory Board for their willingness to use their combined expertise to consider the unknown that lies ahead.

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Navigant Healthcare Cymetrix Corporation (Cymetrix), a comprehensive revenue cycle management company, is a national leader in providing healthcare organizations and hospital-affiliated physician practices with end-to-end revenue cycle outsourcing solutions. We partner with these organizations to create custom solutions that deliver sustained improvement in performance and profitability while never losing sight of the patient experience. Since Cymetrix's inception in 2001 by a team of industry innovators, our objective has remained constant—unlock our customers' hidden financial opportunities while advancing them to the next level of performance.

Serving over 200 hospitals nationwide, we leverage technology and best-practice workflows with the operational expertise needed to optimize our customer's revenue cycle and help support their mission. Our solutions have the flexibility to accommodate the specific needs of each customer and are designed to achieve high revenue cycle performance with a seamless process integrating Patient Access Services, Health Information Management and Patient Financial Services. At Cymetrix, we measure ourselves by your achievement—that's why we work to build a partnership with our customers based on performance and delivering measurable results that ensure our shared growth.

### **About Navigant Healthcare**

Navigant Healthcare brings together a team of more than 1,300 seasoned consulting professionals and industry thought leaders. We assist health systems, physician practice groups, payers and life sciences companies in designing, developing, and implementing integrated, technology-enabled solutions that create high-performing healthcare organizations. With our unique interdisciplinary approach leveraging the depth and breadth of our experience as healthcare executives, clinicians, and physicians, we enable clients to build their capabilities and achieve sustainable peak performance around quality of care, cost, leadership, and culture in today's changing healthcare environment.