HEALTH CARE
Discussion
Jane Arnold: I think there are almost unlimited opportunities for integration and entrepreneurialism at this point. In an environment where the entire economy has to reinvent itself, those who are able to think outside the box have great opportunities. As the availability of funds changes direction, there’s an opportunity at the system level to steering, which should reduce costs overall. But those noninstitutional providers are often innovators and entrepreneurs.

Debbie Johnston: The work that we’re doing has been recognized by the American Hospital Association. They exclusively outline our workforce wellness program. One of strategies our hospital clients recognize is that an integrated wellness program can complement their efforts for post-discharge patients. As more employees leverage a wellness program that engages and educates an individual on a year-round basis, the improved health of their communities begins to diminish re-admittance occurrences.

Danielle Solomon: We obviously can’t continue to do things the way we’ve done them in the past. It’s not sustainable. So coming up with innovative ideas is essential right now in the marketplace.

Jane Arnold: There’s a unit within the Centers for Medicare and Medicaid Services which is the Center for Innovation that is sponsoring small pilot projects all over the country. The big ones were the pioneer Accountable Care Organizations.

Danielle Solomon: If a community in total was more “healthy”, you could find the cost to receive and provide care to be less expensive. By creating health care, you can be sure that they don’t come back into the hospital. They need to work with some of the provider companies that are very, very good at managing care post discharge. It’s a great opportunity for creating better systems, using data effectively, and providing the hands-on care that’s necessary outside of the institutional

Health care discussion

Debbie Johnston: Over the last 23 years we have been helping our clients solve this exact question. Organizations have tried ideas such as, changing plan providers, negotiating lower administrative fees, or restructuring plan design. However, the feedback we’ve received is that these techniques only impact medical spend a small amount. Having a wellness strategy in place creates health awareness so individuals understand their risks at the earliest possible stage. Prevention and year-round access to tools and resources creates a strategy for an individual to improve or maintain good health. Healthier employees result in lower costs and improved overall patient experience.

Danielle Solomon: With our expertise, we can help take your organization to the next level. We’re seeing that there are noninstitutional providers that are often innovators and entrepreneurs.

Danielle Solomon is a partner at BKD and a member of the BKD National Health Care Group with 10 years of experience working with large, not-for-profit health care systems. She provides services related to health care reform, operational ups and downs and follow clients on to their strong relationships that often begin with acquisitions of smaller organizations. She has a deep understanding of the health care industry and is experienced in making private equity transactions, advising small companies that are very, very good at what they are very good at, they can be sure that they don’t come back into the hospital. They need to work with some of the provider companies that are very, very good at managing care post discharge. It’s a great opportunity for creating better systems, using data effectively, and providing the hands-on care that’s necessary outside of the institutional

Jane Arnold’s 20 years of experience allow clients to meet with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly. When you work with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly. When you work with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly. When you work with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly. When you work with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly. When you work with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly. When you work with BKD National Health Care Group, expect attention from partners and managers you’ll see and hear from regularly.
name their physician. 58% have an undiagnosed or untreated chronic condition, and 6% have not seen a doctor in 5 years. There is so much opportunity to bring that patient back into the health system. By assisting an individual on where they can receive care, reduces the amount of time they spend researching all the complexities of where to go. Our ACO clients collaborate with us on integration opportunities as they continue to innovate their strategic approach.

Danielle Solomon: This isn’t the first time the industry has tried pilot programs or tried to change payment models. So what’s different now in the environment than we had in the 80s or 90s?

Jane Arnold: There are two major factors. I think, that predict success here in a way that were unavailable to us in the 80s. Data and desperation. The system is so profoundly broken at this point, there’s such an incredibly disproportionate amount of our U.S. economy directed toward health care that something has to give. And in the 80s, we couldn’t access data like we can now. The technology simply wasn’t available.

Danielle Solomon: And the laws and rules are loosening. Before, facilities were limited in their ability to gain share with physicians and provide financial incentives to work together to control costs. Now that the laws are more favorable, there are more opportunities for the new models to be successful.

Debbie Johnston: I agree that the data obtained by employers enable them to make educated decisions around their health care spend, particularly pharmacy utilization. Our health coaches often hear, “I can’t afford my medication.” Often these members aren’t aware of the resources available to them and in a lot of cases, they didn’t know how much their plan would cover for some of these medications. I would encourage an employer to see their data to personalize their messaging and communication when describing their health care benefits. For example, pharmacy utilization has become more and more disconnected from the gatekeepers physicians who are providing that primary care, wellness care as opposed to treatment for illness.

• Why is pricing for health care services so different and so difficult to either explain or understand?

Danielle Solomon: Without getting too technical, revenue recognition is extremely complicated in the U.S. Currently, there are more than 210 different generally accepted accounting principles for recognizing revenue. It’s crazy. And I think when you call a hospital and inquire about your out-of-pocket cost, they don’t know how to answer your question until you’ve come in, had the service performed and they’ve done all the coding. In reality, all the consumer really wants to know is, “What is my out-of-pocket cost going to be for this, so I can plan my budget?” The industry recognizes this problem and is moving to five principles on revenue recognition; however, it’s such a monumental task it will not happen until 2018. So it’s shifting that mind set. All hospitals have a charge master. So you can call and they can tell you what your charge is for a certain procedure, but it’s nowhere close to what they’re ultimately going to receive. If that’s the information they provide to the consumer, there’s going to be sticker shock—it’s not valuable information to help you make a decision. I was at a CFO forum last week, and there were six local CFOs on the panel. They all said, “If there’s a software system out there that would allow us to enter this information and get an estimate when a consumer calls, we would all line up to buy it. We understand with price transparency, all the new rules and regulations and all the scrum around not-for-profit status, we have to figure out a way to provide pricing information to the consumer.”

Jane Arnold: It’s a terrible challenge. And I think it originates from the premise of managed care, which is discounted care. And now you have to have a price from which to discount, and that price has become

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Debbie Johnston, Interactive Health Inc. (866) 279-1636 www.interactivehealthinc.com
to understand and then build upon the requirements year over year. Don’t let the program become stale. Get executive leadership to drive the strategy so employees can understand the message directly from top down. This approach will align organizational goals with how the wellness program benefits the individual. Think of the, “what’s in in for me” question to create high levels of participation, thus creating more awareness, which leads to high levels of engagement, and ultimately measurable results.

I can’t express enough that the communication is very, very vital. I can’t express enough that the delivery of it is extremely important. Employees could think, ‘This is just a way for the company to save money; they don’t really care about my health. They could be saying, ‘You can have your procedure performed here for this price and you can go there for this price.’ They can provide other elements we talked about earlier, such as patient satisfaction, quality statistics, physician experience and ratings. When comparing a radiology test, I want to understand the quality of the scan–are the two prices for the same quality of service, or does one have more advanced innovation? What’s the experience of the radiologist who’s going to be looking at this scan? Is he or she experienced in this specific area? It’s not necessarily just looking at cost, but offering that full transparency so we understand it’s about making the best health decision. When it comes to our health, cost isn’t and shouldn’t be the only factor.

Jane Arnold: And I think employers are in a good position to provide that just because it’s more cost effective to provide healthier, more productive employees. In that same philosophy transitions into the retiree population, which is a huge drag on the health care expenditures of the country, then I think primarily health systems will take the lead, because they are in the best position to work with Center for Medicare and Medicaid Services to develop programs that will create similar motivations for older people to take good care and management of their own health. It’s important to remember that Medicare is the biggest health care program in the country. And, so it tends to be a driver of a lot of program design because it has the size to be able to take those innovative steps.}

Debbie Johnston: Wellness programs can provide great information to guide benefit plan design. Our clients use aggregate data from their wellness program to make changes to their medical plans. Often, wellness aggregate information can provide information on where an employer population is trending, to identify future risks before they become claims. As I mentioned earlier, pharmacy data and knowledge can also help identify the most prevalent conditions to assist in plan design strategy. But, the most effective way an employer can be strategic about using wellness and other benefits is to take a strategic and personalized approach by integrating all your health resources, whether through your health plan, wellness provider, internal and community resources.

This type of approach will impact not only the health of the individual but also the health of the employer. This is what we are experiencing with our 1,500 clients.

**1,500 CLIENTS REPRESENTING HOW MANY PEOPLE?**

Debbie Johnston: We will serve a million lives this year in all 50 states.

**HOW DO THESE DIFFERENT APPROACHES TO PAYMENT IMPACT THE WAY PROVIDERS WORK TOGETHER?**

Jane Arnold: The providers have to work much more closely with one another, and one of the things that we’ve seen in this community and nationally is the acquisition by health systems of so many physician practices.

Danielle commented, there has been significant challenge over the last 30 years, as participants in the health care system have tried to contract with each other because they run afoul of the antitrust laws. We will need to be mindful of the antitrust laws, we still need to be mindful of the anti-kickback laws that so often are the hangovers of fraud and abuse but ultimately these sort of innovative partnerships are driven by the changes in payment systems.

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Jane Arnold: But that should be a good thing if the system’s working. It’s a terrible thing if the system’s not. It’s tragic if the system’s not, but hospitals are kind of scary places. I mean, you’re much more likely to get an infection in the hospital than you are in your own house. If you’re getting adequate care in your house, that should be a wonderful result. But it only works if you’re getting the high quality care that you need at home. It’s cheaper and better, but only if you’re actually getting the care. And those are the sorts of things that are real cost savings and real patient benefits that these programs should permit and encourage. But it only works if the infrastructure is in place to assure that the discharged patient is getting that care.

SO HEALTH CARE ORGANIZATIONS ARE UNDER SCRUTINY WITH NEW REGULATIONS AROUND THAT

Danielle Solomon: As far as providers are concerned, the new regulations were issued at the end of 2014, and they take effect in 2016. We’re working with organizations and providers to build compliance teams covering all areas of hospital operation. We’re helping these teams evaluate their current policies and procedures against the new regulations and laws to determine where the gaps are and then develop a timeline for compliance. In the same respect, they also need to look at state laws and different reimbursement considerations to make sure they have tools in place to monitor their actual performance against these new regulations, because their not-for-profit status is extremely beneficial and critical—both to the communities they serve and to the organization’s success. The government is also trying to provide more transparency for the consumer. Basically there are three focus areas: They want folks to know if they’re eligible for financial aid and how they can apply for that, what measures a facility can take to try to collect payment and what a hospital generally can bill for care.