

CLIENT ADVISORY:

IS HEALTH CARE REFORM WORKING?

The Patient Protection and Affordable Care Act (“ACA”) was promoted as legislation that would improve health, coordinate care and reduce overall costs. We are now several years down the path of reform, and many

report that health care costs in the United States continue to be on an upward trajectory, while many of the goals of the ACA remain as potential rather than a reality.

To further complicate matters, insurance companies are continuing to compete for healthy subscribers rather than reward performance, which falls short of the goal of improving health.

The experts assert that if insurers were competing for results rather than a laser focus on premium cost, a successful system would be based upon measuring outcomes and improvement in health rather than the actuarial risk.

Since the passage of the ACA, providers are consolidating, merging, acquiring and restructuring. Although the dialogue touches upon improved outcomes, the cost trends are not consistent with this mantra.

Anyone who experiences a hospitalization will witness the challenges that exist regarding the coordination of care. During a recent stay in the hospital, I had the pleasure of witnessing an overwhelmed hard-working staff, inefficiencies in the system and the challenges

that continue to exist for nurses, technicians and staff. My experience made it clear to me that we have a long road to travel, and although everyone within the system is working hard to provide quality care, inefficiencies and a lack of coordination continue to exist. This means the costs will remain high until the dynamic changes. (This experience is an incentive for me to stay out of the hospital!)

We are being told that what will change the system will require a coordinated effort to: 1) measuring and reporting outcomes for patients; 2) insisting upon consumer engagement; 3) offering plans on the basis of measured outcomes; and 4) discouraging insurers from avoiding value services such as preventive care, which would be more effective in producing quality results and reducing costs.

As an employer, I have become more engaged in the process of assisting our employees to be healthy rather than simply providing insurance coverage. In our firm we have stressed a culture of wellness within the work setting which actually improves morale and health. The goal is to place an emphasis on prevention, screening, directing employees to high-value providers, and ultimately lowering costs.

The authors of the ACA have asserted that once a value-based insurance market has been established, and everyone is required to purchase health insurance, the younger and healthier population revenue being driven into the system will increase while premiums for everyone will be reduced and health will be improved. Coverage is important; however, it would appear that restructuring the delivery system and changing financial incentives to performance will be what reduces costs.



Our system continues to focus on minimizing the cost of each intervention and limiting services rather than on maximizing value over the entire care cycle. What appears to be more effective is concentrating on the metrics for comprehensive outcome measurement so that we actually know what improves value and what does not.

If the measurement and dissemination of outcomes were mandatory for providers, which are now the trend, improving individual health and assisting patients in choosing a better health plan should begin to reduce the embedded costs in the system. Measuring outcomes over the full cycle of care for a medical condition seems to make more sense than focusing on the cost for each intervention. The primary care provider is being asked to deliver multiple services with limited staff to a very broad patient population, which results in inefficiencies and less than coordinated care.

One author in the *New England Medical Journal* states that the following steps are necessary to truly improve the system:

1. Move toward integrated practice units that encompass all the skills and services required over the full cycle of care for each medical condition, including common coexisting conditions and complications.
2. Include outpatient and inpatient care, testing, education and coaching, and rehabilitation within the same actual or virtual organization. This structure, organized around the patient's needs, will result in care with much higher value and a far better experience for patients.
3. Modify or eliminate government policies that create artificial obstacles to integrated, multidisciplinary care (e.g., the Stark laws). In a value-based system, the abuses that gave rise to such legislation will decline substantially.

4. Develop a reimbursement system that aligns everyone's interests around improving value for patients. Reimbursement must move to single bundled payments covering the entire cycle of care for a medical condition, including all providers and services. Bundled payments will shift the focus to restoring and maintaining health, providing a mix of services that optimizes outcomes and reorganizing care into integrated practice structures. For chronic conditions, bundled payments should cover extended periods of care and include responsibility for evaluating and addressing complications.

5. Require providers to compete for patients, based on value at the medical-condition level, both within and across state borders. This will allow excellent providers to grow and serve more patients while reducing hyper-fragmentation and duplication of services. In order to achieve high value, providers need a sufficient volume of cases of a given medical condition to allow for the development of deep expertise, integrated teams and tailored facilities. We may need to institute minimum-volume thresholds for complex medical conditions in order to jump-start consolidation and spur geographic expansion of qualified providers. At the same time, strict antitrust scrutiny must be applied to avoid excessive concentration among a small number of providers or health plans in a region.

6. Improve electronic medical records to enable value improvement but only if they support integrated care and outcome measurement. Simply automating current delivery practices will be a hugely expensive exercise in futility. Among our highest near-term priorities is to finalize and then continuously update health information technology (HIT) standards that include precise data definitions (for diagnoses and treatments, for example), an architecture for aggregating data for each patient over time and across providers and protocols for seamless communication among systems.

In the end, consumers must become much more involved in their health and health care. Unless patients truly take responsibility for their health, even the best doctor or team will fail. Simply forcing consumers to pay more for their care is not the answer. New integrated care delivery structures, together with bundled reimbursement for full care cycles, will enable vast improvements in patient engagement as will the availability of good outcome data.¹

The author further states that outcome measurement will improve insurance-market competition and will drive the restructuring of care delivery. Delivery restructuring will be accelerated by bundled reimbursement and electronic medical records will facilitate both delivery restructuring and outcome measurement. Aligning the stakeholder's interest with value should be the strategy.²

¹ *New England Medical Journal*, Investing in Health Care Reform, Karen Davis, Ph.D., February 2009

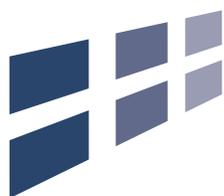
² *New England Medical Journal*, From Rhetoric to Reality – Community Health Workers in Post-Reform U.S. Health Care, Shreya Kangovi, M.D., David Grande, M.D., M.P.A., and Chau Trinh-Shevrin, Dr.P.H., June 2015



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