Proskauer Health Care

Checking Up on the Quest for the Triple Aim

1___Reducing health care costs
2___Improving the patient experience
3___Improving the health of populations

In the near decade since the passage of the Affordable Care Act, there has been continuous debate about its impact. Has it made care more accessible? Has it reined in costs as much as anticipated? Have outcomes really improved?

The Affordable Care Act initiated a new journey for most health care organizations, one that would move them from a volume to a value-based care model.

While every organization across the care continuum is taking its own path to value-based care, the end goal remains the same—achieve the Triple Aim.
As developed by the Institute for Health Care Improvement, this framework rests on three core pillars:

- reducing health care costs;
- improving the patient experience; and
- improving the health of populations.

True value-based care will be achieved when all pillars are accounted for.

To grasp how close health care organizations are to reaching this goal, and in order to understand remaining hurdles, Proskauer commissioned a study of 100 health care C-suite executives from across the care continuum. The survey, fielded in February 2019, asked executives to examine how they are faring on their individual value-based care journeys, including where they are thriving, where they are falling short and what they are planning for in the year ahead.

The following is the summary of the results.

When it comes to M&A, health care organizations are going back to basics: Boosting existing services and capabilities, and operating them more effectively and efficiently.

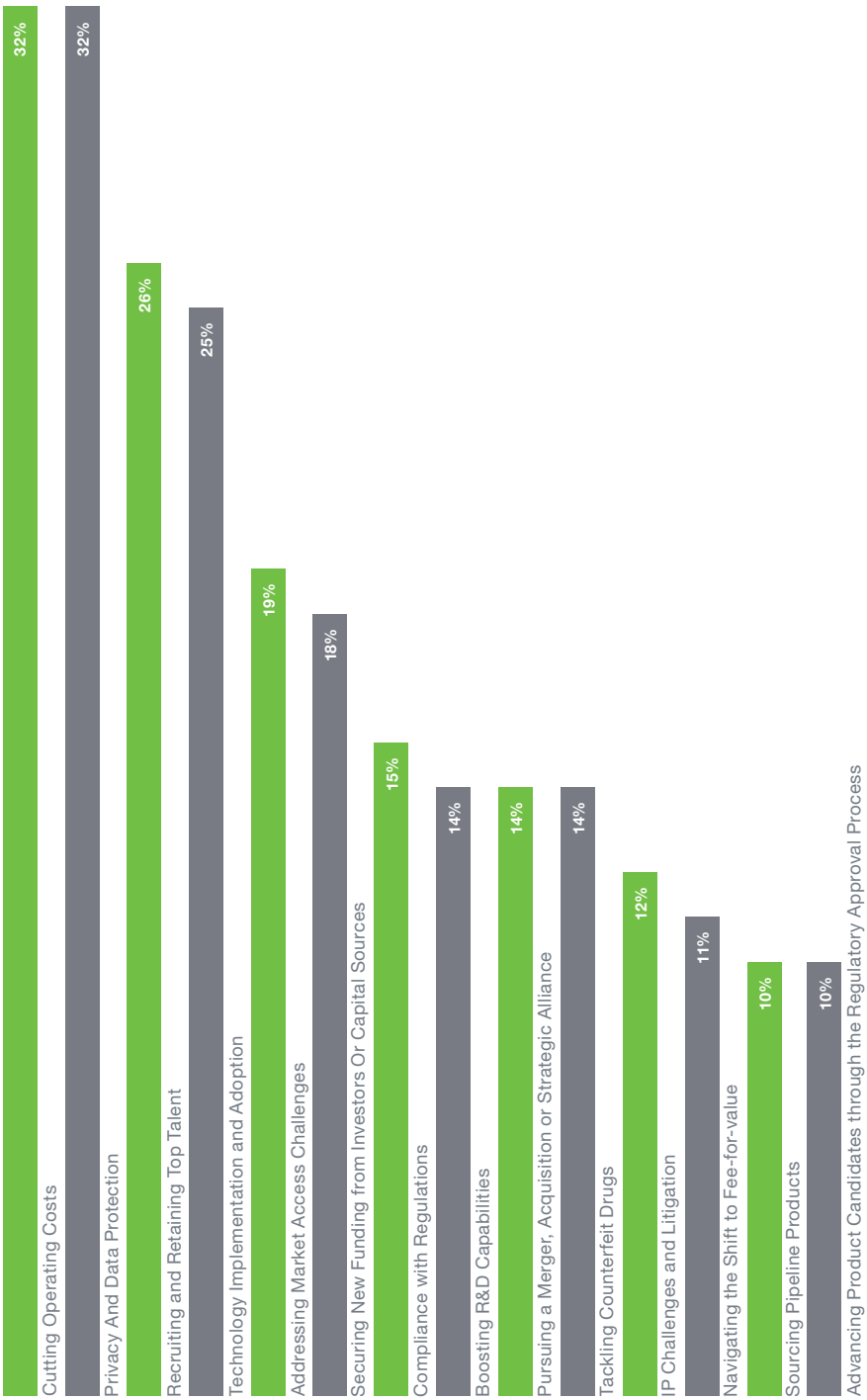
In the years immediately following the passage of the Affordable Care Act, the health care industry saw a massive uptick in M&A activity, both in terms of deal size and frequency. While hospital M&A activity has slowed in the years since, overall industry M&A remains strong—PwC found there were a record 1,182 deals in 2018, up more than 14.4% from 2017.

The impetus for such deals has followed a similar evolution. In the early years after 2010, health care M&A deals were based on the premise that bigger is better—believing that achieving economies of scale would provide more leverage when contracting with payers and supply chain partners. Bigger also meant access to a larger patient pool. As recently as 2017, Deloitte and the Health Care Financial Management Association found that 40% of acquirer health care organizations viewed increased market share as a top driver of M&A. But, that's changing.

Specifically, our survey found that, over the next year, executives will be focused on boosting existing services and capabilities, and operating them more effectively and efficiently. According to our survey results, streamlining operating costs and improving such efficiency is a primary business concern for executives—with a third (32%) ranking it as a top three business challenge over the next year. It's no longer about getting bigger, but instead about getting better.

Top Three Business Concerns for Health Care Executives

When asked about their top three business challenges over the next year, health care executives reported the following as their most pressing concerns (includes responses that received at least 10%).



One of the strategies by health care organizations will be to focus on acquiring technology capabilities. This is a marked departure from previous targets, yet one that is increasing rapidly. For example, provider acquisitions of start-up digital health companies reached 19% of all Q1 2019 digital health M&A deals, according to Rock Health.

Our survey findings validate these market reports, while pinpointing a growing interest in artificial intelligence (AI). When asked about their top M&A targets over the next 12 to 24 months, 31%—the plurality—of respondents (with an identified target in mind) cited an interest in acquiring AI technology assets, as their top M&A target. Nineteen percent are also eyeing technology companies to help streamline non-R&D business operations, the fourth most popular target.

Taken together, this reevaluation of M&A deals to prioritize those that improve existing services and capabilities and allow organizations to operate more efficiently is in clear alignment with the Triple Aim's objective to reduce the per capita cost of health care. As a result of newfound efficiency, health care organizations will be able to better utilize existing services, reduce wait times and enable both medical and non-medical staff to focus on higher-value tasks.

Health care C-suite executives agree: technology acquisition targets are important to meeting business challenges.

29% of health care CEOs say their top M&A target is a company with technology that streamlines non-R&D business operations

33% of health care CLOs say their top M&A target is the acquisition of AI capabilities

48% of health care CFOs say their top M&A target is the acquisition of AI capabilities

Not all technology companies are created equal. While there is broad agreement across the C-suite about the importance of technology acquisitions, most agree that one technology solution will not fit all needs.

When considering the acquisition of new technology:

1. The reasons for buying today. In the long run, is it a better financial decision to license the technology on an ongoing basis or acquire the technology company?

2. The technology needs of tomorrow. What are your short- and long-term goals and how does the acquisition target meet those needs? Does it make sense to build such technology in-house (or upgrade legacy systems) or do you need to buy the company to ensure long-term support?

3. Its cyber defenses. How robust are its cybersecurity safeguards? Has the technology suffered a breach before? Where is its information stored?

4. Your definition of success. Does it impact your bottom line? Are you looking to speed up patient waiting times or improve the customer experience? How does the acquisition target support your intended goals?

Health care organizations are eager to improve the patient experience and service efficiency with better data, but believe they need to improve employee training in the use of technology and incentivize interoperability.

A key component to this is the free-flow of patient data and information, albeit within the confines of HIPAA.

The second pillar of the Triple Aim involves improving the patient experience. A key component to this is the free-flow of patient data and information, albeit within the confines of HIPAA.

Undoubtably, electronic health records (EHRs) have been critical to this effort. As a result of its near-universal adoption—up from 9% in 2008 to 96% in 2015—health care organizations have faster and deeper access to patient data, in turn improving patient care. Industry-wide adoption is also benefiting consumers as they are now able to freely access their own health information, with 92% of patients reporting they are able to view their medical records online.

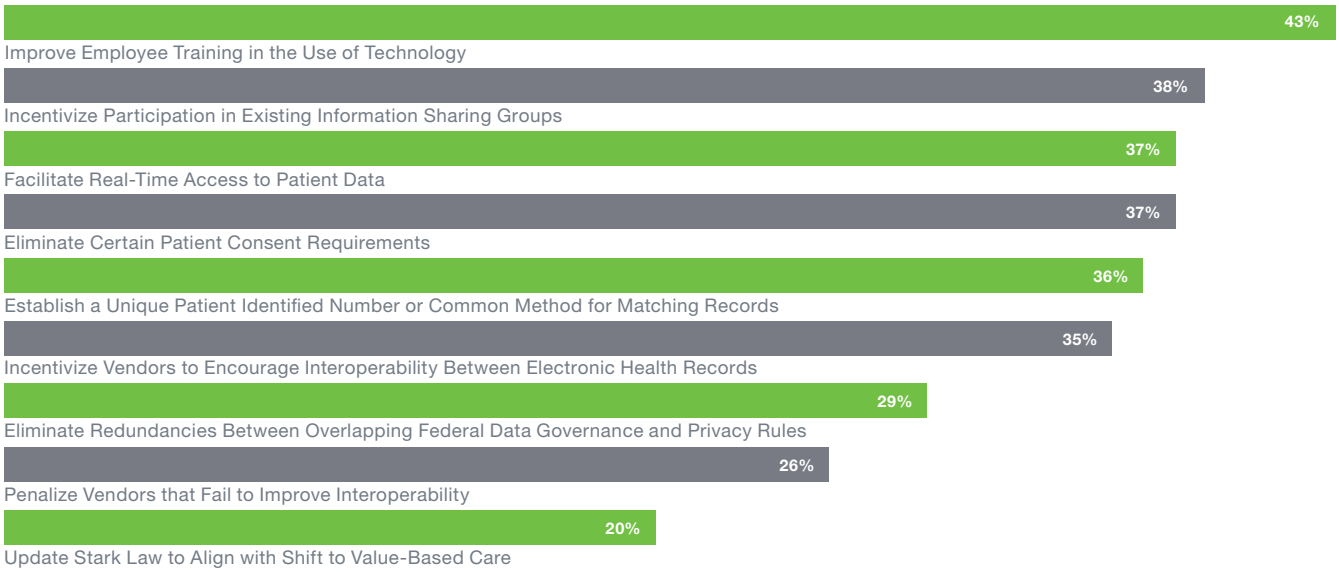
Yet, there are still significant advancements that must be made when it comes to leveraging patient information to improve the health care experience.

Specifically, when asked about the top industry-wide changes and updates that need to happen for health care organizations to better promote value-based care, executives noted the following as the top changes required:

- improving employee training in the use of technology (44%)
- incentivizing participation in existing information sharing consortia (37%)
- incentivizing vendors to encourage interoperability between EHRs (36%)

The good news for clinical organizations is that improving employee training in the use of technology—the top change required—is a relatively low-cost solution that will drive outsized outcomes.

Industry-Wide Changes and Updates Required to Better Promote A Coordinated, Innovative and Value-Based Care Approach (Clinical Organization)



Implementing such changes would also go a long way toward addressing and resolving a primary patient complaint: that physicians spend too much time "clicking" to record and access their data, and not enough time engaging with them. In fact, studies show there is a link between improved technology usage and the patient experience. A 2018 study published in Applied Clinical Informatics found that there is an inverse correlation between daytime EHR usage by physicians and patient satisfaction, impacting factors such as showing patient respect, knowing patient history, overall communication quality and likelihood to recommend the provider. Taking the time to implement these reforms will therefore be critical to achieving the second pillar of the Triple Aim.

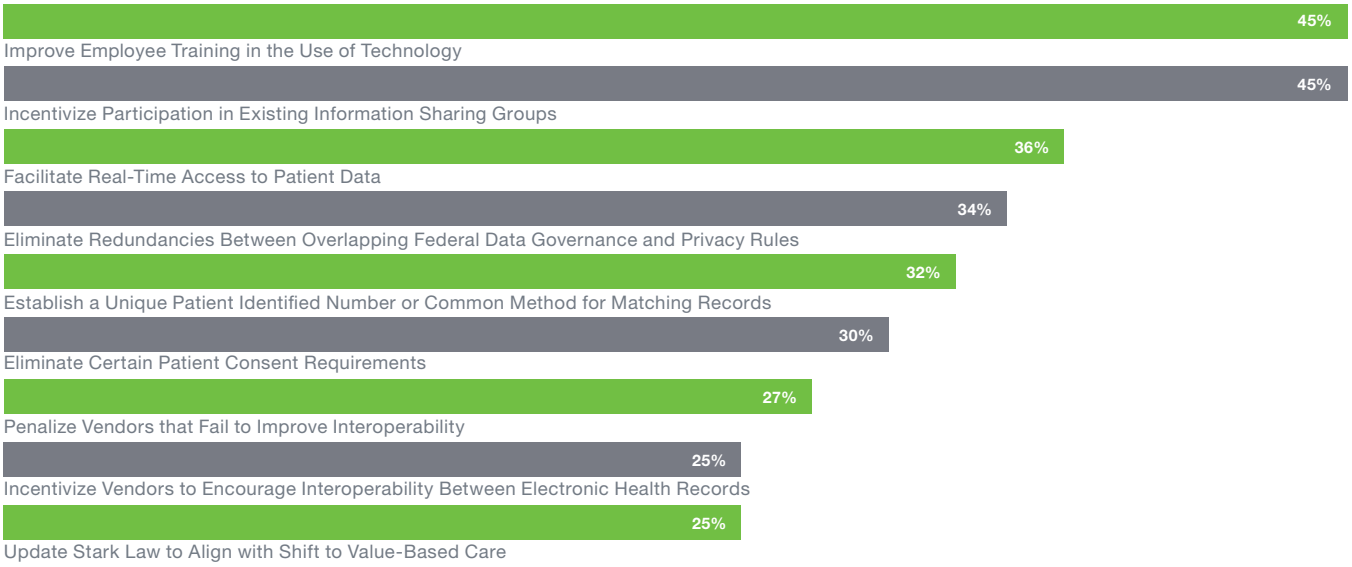
Preparing for CMS Primary Cares

In April 2019, Centers for Medicare and Medicaid Services (CMS) announced "CMS Primary Cares Initiative," designed to deliver value-based transformation in primary care. It is centered around five new payment models that will "transform primary care to deliver better value for patients throughout the health care system…reducing administrative burdens and empowering primary care physicians to spending more time caring for patients while reducing overall health care costs." (CMS)

The average overall physician salary for primary care providers is $223,000, according to Medscape. According to our survey, when it comes to achieving value-based care and the goals of programs like CMS Primary Care Initiatives, small health care organizations believe the following changes and updates are required.

Small health care organizations believe improving employee training in the use of technology and incentivizing participation in existing information sharing groups are the most necessary changes required to promote value-based care.

Industry-Wide Changes and Updates Required to Better Promote A Coordinated, Innovative and Value-Based Care Approach (Small Health Care Organizations)

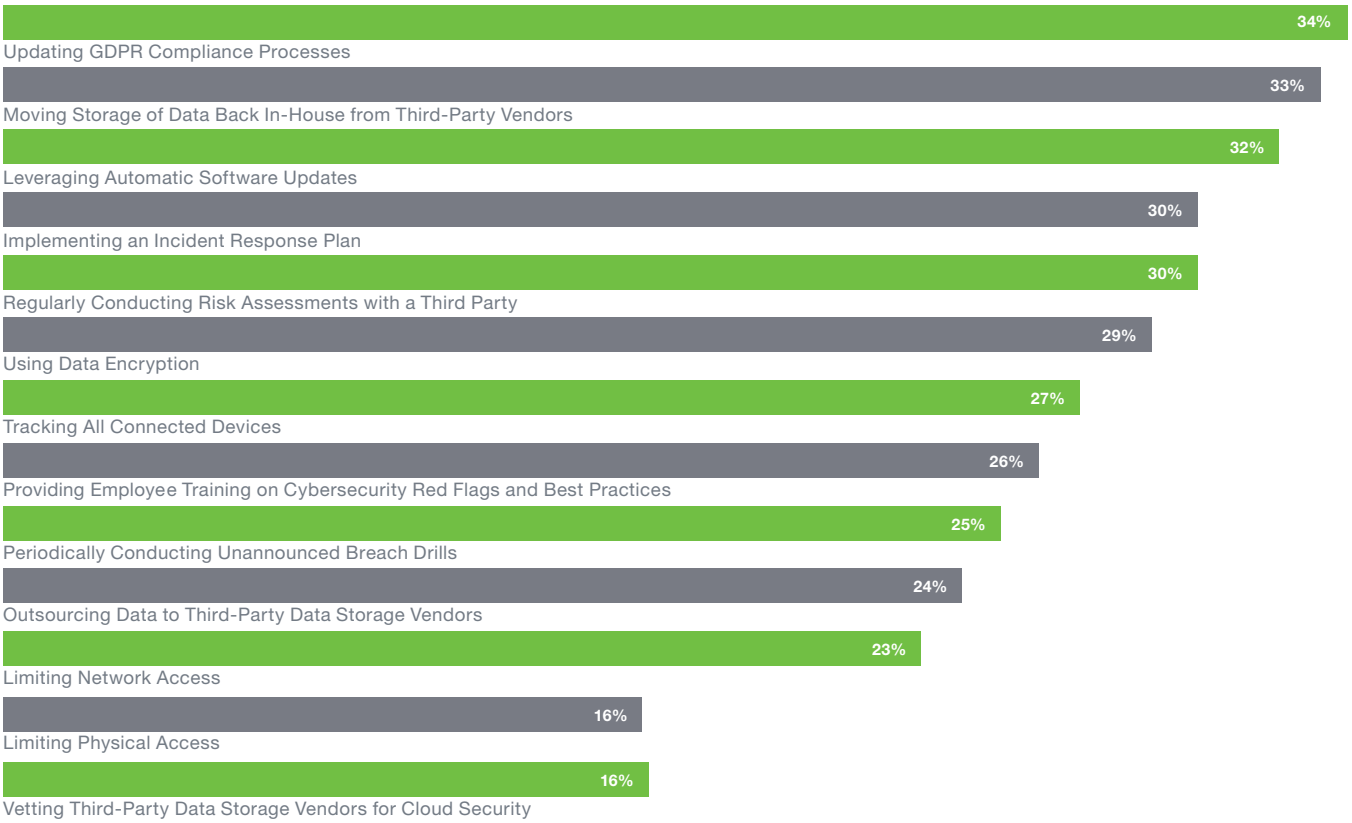


Unfortunately, as health care organizations solve one issue, another often emerges. If anything, as interoperability and data sharing practices improve, it invites more risk and new concerns, including a heightened cybersecurity exposure. Yet, our findings show that health care organizations are not prepared to handle increased risk.

According to the survey, with the exception of updating GDPR compliance processes, no more than a third of health care organizations currently leverage any single cybersecurity best practice. However, our survey also found that health care organizations recognize this gap and are prioritizing improvement—with a third (32%) of health care organizations citing privacy and data protection as a top three business challenge over the next year. Addressing such exposures is a necessary first step to improving data sharing. Failing to act now could render future interoperability and data sharing efforts worthless.

The majority of health care organizations fail to implement even the most basic of cybersecurity best practices

Cybersecurity Measures Health Care Organizations are Taking to Protect IP



Health Care organizations and regulators (finally) recognize they are on the same side when it comes to improving outcomes.

For many years, health care organizations have viewed overlapping federal, state and local health care regulations as a minefield to navigate. While such regulatory oversight can still be a burden for health care organizations, there are signs the industry's attitude toward the Centers for Medicare and Medicaid Services (CMS)—its main regulator—is evolving.

Driving this attitudinal shift is the Center for Medicare and Medicaid Innovation's (CMMI) initiatives to advance reimbursement models that are more closely linked to quality and outcomes, not volume. Specifically, through CMMI, CMS has created pilot programs for forward-thinking providers to take steps toward risk-based pricing and to encourage value-based care arrangements, including bundled payments, revised physician protocols, and structures such as the Pioneer and Next Gen Accountable Care Organization program.

More recently, CMS is pursuing reimbursement transformation beyond just traditional services to also address social determinants of health. For instance, beginning in 2019, CMS will expand how it defines primary health-related benefits that insurers are allowed to include in their Medicare Advantage policies, including air conditioners for people with asthma, healthy groceries, rides to medical appointments and home-delivered meals.

As mentioned, the results are changing perception, but in more ways than one. On one hand, the data suggest CMS and CMMI's programs are working toward improving outcomes—more than 90% of both hospitals and nursing homes report that they consider CMS measures clinically important. Further, 90% of hospitals and 83% of nursing homes say that performance on CMS quality measures reflect improvements in care.

On the other hand, results are also driving a change in perception when it comes to viewing regulators as an ally, not as an adversary. According to our survey, which asked health care executives to rank CMS on a scale of one to 10 (with 10 being highly effective) when it comes to fostering innovation, more than half (52%) of executives gave CMS a score of 8 or higher. Additionally, just 15% of health care organizations cited complying with federal, state and local regulations as a top three most pressing business challenge in the year ahead.

No one benefits more from this new alignment than patients, as it means less red tape when it comes to piloting and approving care innovations that will improve outcomes—in turn addressing the third and final leg of the Triple Aim.

Of major regulators, health care executives have the most favorable view of CMS

Ranking Effectiveness of Major Federal Regulators in Driving Innovation

6.49

Average effectiveness of CMS ranked on a scale of 1–10

5.94

Average effectiveness of State Health Departments on a scale 1–10

About the Survey:

This survey was commissioned by Proskauer and conducted by Rabin Research Company, a market research firm based in Chicago. Results are based on 100 completed surveys of C-suite health care executives from across the care continuum. The survey was conducted in February 2019.

Health care companies are defined as those working in the following spaces: hospitals/health systems, medical group/physician organization, post-acute care (skilled nursing facility, home health, hospice, long-term acute care, rehab), behavioral services, ambulatory care/ambulatory surgery/imaging, telehealth/remote care, health care technology and care management.

Health care company size is defined as: small (under $500 million in revenue), medium (between $500 million and $1 billion in revenue) and large (more than $1 billion in revenue).

About Proskauer's Health Care Practice:

Proskauer has a sophisticated health care practice with lawyers across different service offerings bringing unrivalled experience and a keen understanding of the industry's dynamics. Our team combines specialized health law and industry experience with specific practice concentrations that allow us to provide the full range of services for clients across the industry. We advise service providers and health plans, operators, investors and lenders, among others, in matters ranging from complex transactions and regulatory compliance to commercial litigation and defense of government investigations.

We act as a trusted advisor, partnering on the most important, complex and sensitive challenges facing health care organizations today.

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