

Introduction

Patients and payers are seeking greater value for their health care dollars. And that concern will only grow as overall health care spending continues to rise: a recent government report predicts that spending on health care will reach 20 percent of the nation’s Gross Domestic Product (GDP) by 2024.¹

Why? There are as many reasons as there are health conditions. The graying of America is one major contributing factor: people’s health care needs become more complex as they age and nearly 3 million baby boomers are reaching retirement age each year. Chronic health conditions are also on the rise: about half of Americans suffer from a chronic condition such as heart disease, diabetes or arthritis, significantly adding to the nation’s health care tab.² Roughly 80 percent of all health care dollars spent in America go to just 20 percent of its people, most of whom have a chronic condition.

The U.S. devotes more money to health care per citizen than any other industrialized nation.³ While progress has been made in bending the cost curve – for example, health care spending as a share of GDP has remained relatively constant since 2009 – more needs to be done. Hospitals are on the front lines of advancing this trend, and have made great strides in improving patient care quality while simultaneously promoting increased value. For example, a patient entering the hospital today is much more likely to receive evidence-based care and achieve a positive health outcome

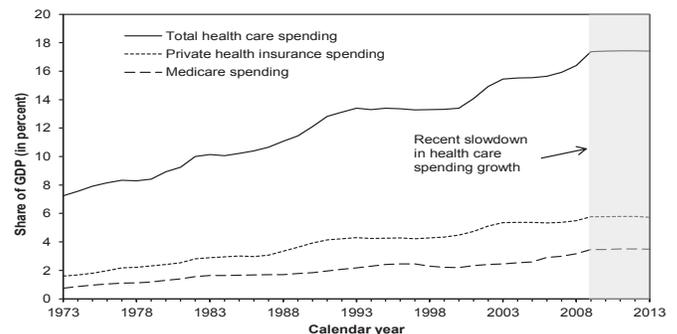
What Hospitals are Doing

Hospitals and health systems are focused on redefining the hospital “H” – that is, exploring what it means to be a provider in a rapidly transforming health care environment. They are replacing the traditional silos of care with a continuum that improves not only the quality of care delivered and the health of their communities, but also produces greater value. Included in these efforts are the active exploration and implementation of strategies to redesign how care is provided, improve quality and patient safety, and improve the health of their entire community.

than a decade ago. In addition, because of hospitals’ proactive initiatives to ease the transition back into the community after discharge, patients are less likely to experience a relapse and need to visit the emergency department or be readmitted to the hospital.

But, hospitals cannot do it alone. Increasing the affordability and value of care will involve promotion of accountability, better stewardship of resources and the encouragement of innovative ways to transform care for an aging and increasingly diverse population. It will take a real effort by everyone involved – insurers, hospitals, businesses, physicians, nurses, employers and individuals. However, as the hub of health care in their communities, hospitals and health systems are adopting changes to help achieve greater value for our health care dollars.

Chart 1: Historically, health care spending has risen as a share of GDP; recently, its growth has slowed



Note: GDP (gross domestic product).

Source: Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program. June 2015.

Redesigning Care

Hospitals and health systems are working to develop new delivery systems and innovative payment models to better meet the needs of their organizations and communities.

Redesigning care delivery requires them to disrupt conventional thinking and reimagine care from the patient’s perspective so that the new models can be woven into the fabric of local communities and the lives of patients and families. Included in these efforts are the active exploration

and implementation of alternative payment models that reward better, more efficient, coordinated and seamless care for patients. These initiatives include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations.

Hospitals are also moving into the community to deliver care beyond their four walls at locations and times that are more convenient for patients.

Improving Quality and Patient Safety

Hospitals and health systems have made incredible strides in patient safety and are eagerly working to accelerate quality improvement. Avoiding complications and readmissions not only improves care and patients' lives, they help to reduce costs. Following specific care guidelines and protocols also cuts costs by reducing variation and ensuring that patients get only the care that is most beneficial.

The AHA and its member organizations have worked to achieve important and meaningful improvements in quality through the rigorous adoption of evidence-based processes that have been shown to prevent errors in care. For example, the Agency for Healthcare Research and Quality estimates that, between 2010 and 2014, hospital-acquired conditions declined 17 percent, saving 87,000 lives and nearly \$20 billion in averted costs.⁴ But more must be done to get to zero.

Hospitals across America are working hard to improve the quality of care each person receives and advance the health of every community they serve. Critical to these efforts are understanding why health care disparities exist

for certain patient populations and developing solutions to end those disparities. This is challenging work. Each community is unique, and individuals often are exposed to different environments and workplace hazards, have different diets, interact differently with health care providers and face different challenges in complying with medical advice. For these reasons and many others, some still unknown, patients from some racial and ethnic minority groups often receive a lower quality of health care. Ending these disparities is a priority in every health care setting, and hospitals and health systems are leading the way to ensure equitable care is delivered to every person in every community.

As the field tackles these challenges locally, leaders from the AHA and other national health care organizations have come together to create a national call to action to eliminate health care disparities and improve quality of care for each and every patient. As part of the call to action, these organizations are providing the field with tools and resources to increase the collection and use of race, ethnicity and language preference data; increase cultural competency training; and increase diversity in governance and leadership.

Promoting Population Health

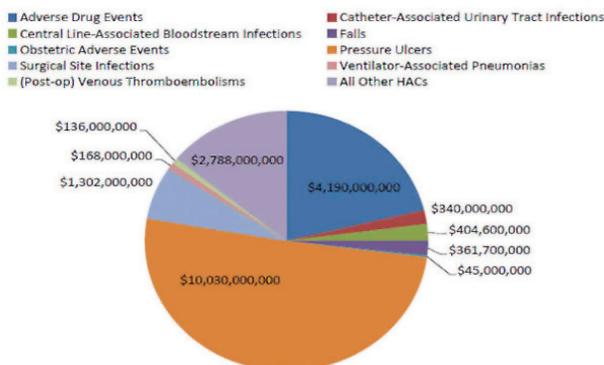
Much of the cost of health care is tied to chronic conditions that are preventable. Specifically, the rise in chronic diseases is contributing to the growth in health care spending and other societal costs, such as sick time and disability. Lifestyle choices and early detection and management of risk factors can go a long way toward making America healthier.

Hospitals and health systems are doing their part to help confront the many societal conditions that lead to poor health. They are addressing the specific health and social needs of their communities through outreach and assessment. For example, they are engaging their communities to offer health education, care in community locations such as schools, and other programs, which will, among other things, help individuals understand and monitor key indicators of their health, such as blood pressure, cholesterol and glucose levels. They also are taking on responsibility for the health of whole populations through new risk-based payment models such as ACOs, medical homes and bundled payments.

Advanced Illness Management

A substantial number of health care dollars are spent on providing care near the end of life, and the financial burden on families can be tremendous. However, patients and their families are often not well-informed about their end-of-life

Chart 2: Estimated Cost Savings, by Hospital-Acquired Condition (HAC), 2011-Interim 2014



Source: Agency for Healthcare Research and Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update." Dec. 2015.

care choices and are not engaged in advanced illness management (AIM). Having these difficult, emotional conversations are a critical part of better honoring patients' wishes and removing barriers to expanding access to palliative care. They will help ensure that appropriate, compassionate care can be provided at the right time, in the right setting, as many patients prefer to spend their last days at home with hospice rather than in hospital intensive care units.

Hospitals and health systems are uniquely positioned to implement best-practice strategies to integrate AIM into the normal continuum of care, and ensure that the wishes

of the patient and his or her family are carried out by the entire multidisciplinary care team throughout disease progression. To that end, the availability of AIM services in U.S. hospitals is increasing. Hospitals and health systems are working to ensure that clinicians and families view AIM not as an alternative to chronic and curative treatments, but rather as a simultaneously delivered adjunct to disease-focused, superior quality treatment. They also are working to raise community awareness of the availability, utility and benefits of these services so that every patient and his or her family will have the knowledge and skills to understand the benefits of advanced illness planning.

Barriers to Progress

The task of delivering enhanced value is not without challenges. In fact, other health care stakeholders have recently taken actions that could reverse much of the progress that has been made. For example, we have seen large increases in the prices of prescription drugs, and proposed market power consolidation among insurers. Hospitals are working to ensure that there are appropriate policies and agency oversight in place to protect health care affordability. Hospitals also are working to reduce other long-standing barriers to affordability, including regulatory burdens and liability costs.

Outdated Laws and Regulations

Standing in the way of hospitals' abilities to change how care is delivered is an outdated regulatory apparatus predicated on enforcing laws no longer compatible with the new realities of health care delivery. Chief among these outdated barriers are portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the "Stark Law"), and certain civil monetary penalties. The field is actively pushing for the adoption of a single, broad exception for financial relationships designed to foster collaboration in the delivery of health care, as well as to incentivize and reward efficiencies and improvements in care.

In addition, hospitals and health systems are reshaping the health care landscape by striving to become even more integrated, aligned, efficient and accessible to the community. To support these changes, it is important to standardize the merger review process between the two federal antitrust agencies. The Federal Trade Commission has frequently used its own internal process to challenge a hospital transaction, an option not available to Department of Justice (DOJ), which increases the time and expense of defending a transaction and the likelihood of an outcome

that favors the agency. To help rebalance the merger review process, the AHA is urging the Senate to pass the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act (S. 2102).

Drug Pricing

The high cost of prescription drugs is putting a strain on Medicare, Medicaid and the entire health care system. Specifically, prescription drug spending spiked in 2014 and 2015, largely as a result of high prices for both new and some existing brand name drugs. Even some common generic drugs have experienced dramatic price increases. Such sudden and excessive price increases threaten access to and the affordability of critical drug therapies for patients, with some hospitals having reported that their physicians have begun to change their prescription ordering practices and courses of treatment because of high costs to patients.

Hospitals are working with a number of stakeholders, including insurers and consumers, to raise awareness of and develop solutions to help rationalize drug prices while still supporting innovation. For example, the AHA and its members are bringing media and policymaker attention to the issue, seeking greater transparency on drug pricing and charity policies by drug companies, fighting to protect and expand the 340B Drug Pricing Program, and engaging the presidential candidates on the issue in the 2016 campaign. We also are working to develop policy options to help reign in the costs of drugs.

Health Plan Consolidation

The proposed acquisitions involving four of the five major U.S. health insurance companies are being challenged in court by the DOJ, Congress and a number of state Attorneys General. If allowed to proceed, the increased market power of

the merged companies would have harmful and far-reaching repercussions for both consumers and providers, including increased costs, limited choices and reduced access for consumers. The deals also could stifle innovative efforts by hospitals and health systems to work with insurers.

The hospital field has shone a light on these potential repercussions, including the effect on health care affordability, with DOJ and Congress, and in the media. We successfully urged the DOJ's Antitrust Division to challenge Cigna's acquisition by Anthem and urged both DOJ and the Department of Health and Human Services to view with great skepticism Aetna's acquisition of Humana because of the potential impact on seniors who choose Medicare Advantage for their care. Our fundamental concern with both acquisitions is that they threaten the vitality of our health care system and the health and welfare of consumers across the nation.

Administrative Burden

Today's health care system is rife with administrative burden. The hospital field faces duplicative regulation and compliance burdens, along with myriad requirements from insurance plans, each of which have different claims processing, recordkeeping and medical necessity requirements. Administrative costs – costs not associated with the delivery of patient care – comprise as much as \$294 billion of our nation's annual health care spending. Affordability can improve if health care professionals spend more time at the bedside and less on paperwork.

For example, hospitals, post-acute care organizations and clinicians are asked to provide data on a dizzying array of quality measures. While the field is committed to quality

improvement and transparency, complying with these data requests is burdensome, and consumers can be confused by the volume of information. Data collection and reporting would be more valuable if those asking for data agreed on a manageable list of high-priority aspects of care on which providers would be asked to make meaningful improvement, and then use a small and critically important set of measures to track and report on progress toward improving the care delivered and the outcomes for patients. The Institute of Medicine proposed a list of high-priority topics from which this work could begin.

Liability Reform

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also their patients and communities. Across the nation, access to health care is being negatively impacted as physicians move from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. An estimated \$50 to \$100 billion is spent annually on defensive medicine – services not provided for the primary purpose of benefiting the patient, but rather to mitigate the risk of liability.

To help make health care more affordable and efficient, the current medical liability system must be reformed. As such, the hospital field is working to advance the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act (H.R. 4771), which would reduce health care costs and promote access to quality, affordable health care for all Americans. It is based on the proven model of reform enacted decades ago in California. We also will work to advance other proposals that will deliver meaningful medical liability reform.

Summary

Consumers seek – and expect – greater value in everything they purchase, and health care is no exception. As the hub for care in their communities, hospitals and health systems are adopting changes to meet consumer demands for convenience and increased access, and to deliver greater

value. But they cannot do it alone. Increasing affordability and enhancing the value of care will take a real effort by everyone involved – insurers, hospitals, businesses, physicians, nurses, employers and individuals.

Endnotes

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf>.

² <http://www.cdc.gov/chronicdisease/overview/>.

³ <http://www.healthsystemtracker.org/chart-collection/how-does-health-spending-in-the-u-s-compare-to-other-countries/>.

⁴ Agency for Healthcare Research and Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update." Dec. 2015.



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