WHITE PAPER

THE INFLUENCE OF REFORM ON LOCAL COVERAGE AND UTILIZATION

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THE INFLUENCE OF REFORM ON LOCAL COVERAGE AND UTILIZATION

The effects of healthcare reform on hospitals will be far reaching. For hospital executives, the effects can be organized into three major areas. One, insurance coverage will change as the ranks of the uninsured and underinsured enroll in state Medicaid programs or healthcare exchanges. Two, payment reform initiatives such as bundled payments, pay for performance, and episode-based payments will affect utilization rates. Three, the changes in coverage will force reductions in payments to hospitals — first from government insurance and then from private insurers. As a result, hospitals will need to work even harder than they already are to reduce expenses where they can.

The impacts of the law will not follow a neat 1-2-3 pattern; rather, they will stagger as different parts of the law are implemented over the coming years.

To successfully navigate the new world order under reform, hospital and health system professionals must understand more than just how the Patient Protection and Affordable Care Act (PPACA) will influence insurance coverage, utilization, and payment. They must also find effective data sources and methods to update estimates of insurance coverage and usage in their immediate geographic markets.

The goals of this paper are to:

- Outline the features of healthcare reform that pertain to insurance coverage and utilization projections.
- Review the industry's best general estimates of insurance coverage effects for the country as a whole.
- Present methods for estimating insurance coverage changes in a particular market.
- Discuss next steps for utilization trending.

ELEMENTS OF REFORM THAT WILL INFLUENCE INSURANCE COVERAGE

The major tenets of healthcare reform are to extend coverage to the estimated 47 to 50 million Americans[1] currently without healthcare insurance, to expand adequate coverage for those who are currently underinsured, and to offer affordable healthcare options for all Americans. In the following pages, we outline, by effective date, the individual aspects of the law intended to erase coverage gaps.

[1] Estimates based on national sources. See Table 3, page 8.

Effective 2010

- Adult children may stay on their parent's coverage plan until they are 26 years old (for many plans, dependent coverage currently ends at 18).
- A temporary reinsurance program will help companies maintain coverage for early retirees between 55 and 64 years old.
- People with pre-existing conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, subsidized high-risk pool.
- Small businesses (those with fewer than 25 employees who earn less than $50,000 per year, on average) that offer healthcare benefits will be eligible for tax credits of up to 35 percent of their premium costs for two years.

Effective 2011

- Federal subsidies to states will expand enrollment in high-risk insurance pools.
- Payments to Medicare Advantage plans will be at 2010 levels.

Effective 2014

- Medicaid will expand to include all individuals younger than 65 with incomes up to 133 percent of the federal poverty level (FPL).
- Employers with 50 or more employees who do not offer coverage will face a fine of $2,000 per employee.
- Health plans will be banned from excluding individuals with pre-existing conditions.
- State-based insurance exchanges will open for business.
- Individuals without insurance will face penalties of $695 per year or 2.5 percent of their income, whichever is more. Uninsured families will pay a maximum of $2,085 or 2.5 percent of their income. Exceptions may apply.

ELEMENTS OF REFORM THAT WILL INFLUENCE UTILIZATION AND PAYMENTS

Healthcare reform will certainly influence utilization of hospital services and payments for these services. Some of these effects will flow from coverage changes. As more people are insured, more will seek services. Conversely, some changes in coverage and payments will decrease service demands. The impacts on utilization require expert insight to estimate. Analysts at Thomson Reuters have worked to understand these impacts, and we have shared them in the text below. We followed a few general principles in our estimations:

- Spending for health services follows typical supply and -demand economic principles — as out-of-pocket prices go down, utilization will go up and vice versa.
- There must be a supply before the demand for health services can be filled. A limited supply of providers in an area will weaken the increase in utilization, especially for elective and preventive procedures.
- Any decrease in a procedure's reimbursement rate will reduce the supply of that procedure.
- Obtaining insurance decreases the enrollee's out-of-pocket costs for individual services once deductibles are met. Considering total spending, including health premiums, deductibles, co-pays, and co-insurance, enrollee costs may be higher or lower with or without insurance.
- Moving from no insurance to having insurance results in a temporary increase in utilization as the insured asks for services that they have previously deferred because of cost.
- The uninsured do get health services. There is a healthcare safety net that meets at least some of their needs. After the uninsured get insurance, their out-of-pocket costs will go down and their utilization will go up.
- Some of the uninsured are uninsured by choice. They are typically young, healthy, and willing to take a chance and save their health insurance premium. Forcing these people into an insurance pool will increase the overall health of that pool.
- More exposure to the healthcare system results in discovery of new health conditions and more follow-up procedures.
- Additional regulations can increase or decrease the complexity and cost of providing medical services.

Table 1 outlines the impact of specific healthcare reforms on utilization, as we have hypothesized.

Table 1. Impact of Healthcare Reform Law on Utilization and Payments

ELEMENTS OF LAW IMPLEMENTED IN 2010	OVERALL EFFECT ON UTILIZATION	EXPLANATION
Coverage for dependents up to age 26	Limited Increase	This is a generally healthy population.
No exclusions for children with pre-existing conditions	Limited Increase	Impacts a limited number of children. (A third of all children are covered by Medicaid or state children's health insurance programs, and 10 percent have no insurance.)
No lifetime limits	Limited Increase	An important issue for some cancer patients and the long-term chronically ill, but there are relatively few of them.
States optionally expand Medicaid	Limited Increase	Only a few states (perhaps seven) will request early expansion, and the impact will vary across those states.
High-risk pools for uninsured denied insurance	Limited Increase	Only 200,000 people are expected to join the high-risk pools.
New plans must provide coverage for preventive services without co-pays	Increase	Includes only select procedures. Will increase preventive procedures with the largest co-pays (e.g., colonoscopies). As a secondary effect, additional screening will identify more patients needing followup services.
35 percent tax credit to businesses with fewer than 50 employees who offer health insurance, increasing to 50 percent by 2014	Small Increase	May entice some small businesses to start offering insurance, but some with new employer-provided insurance will be shifting out of individual plans.
ELEMENTS OF LAW IMPLEMENTED IN 2011	**OVERALL EFFECT ON UTILIZATION**	**EXPLANATION**
Free annual checkups for Medicare enrollees	Small Increase	In addition to their initial impact, checkups will lead to the discovery of more health issues, leading to more followup tests, visits, etc.
Reduction in annual Medicare market basket payment updates	Decrease	May reduce the number of providers accepting Medicare patients.
10 percent Medicare bonus to primary care providers (PCPs) and general surgeons in health professional shortage areas (HPSAs)	Limited Increase	Limited to some physicians in HPSAs.
Medicare payments to qualifying hospitals in counties in lowest quartile Medicare spending (2011 and 2012)	Small Increase	Limited to hospitals in 20 percent of the country's counties. No direct effect on physician remuneration.
Medicaid medical homes for patients with multiple conditions	Increase	Will call for additional care management, care coordination, and health promotion services for these patients.
Additional funding for community health centers and other community clinics	Increase	$11 billion is currently budgeted.
ELEMENTS OF LAW IMPLEMENTED IN 2012	**OVERALL EFFECT ON UTILIZATION**	**EXPLANATION**
Medicare Accountable Care Organizations (ACOs)[2] established	Decrease	The goal of ACOs is to reward efficient providers of quality coordinated medical care.
Reduced Medicare payments for preventable hospital readmissions	Decrease	Impact will vary by hospital.
Establishment of a hospital value-based purchasing program that links hospital payments to outcomes	Decrease	Depending on the final program design, the impact could be large for selected hospitals.
ELEMENTS OF LAW IMPLEMENTED IN 2013	**OVERALL EFFECT ON UTILIZATION**	**EXPLANATION**
Increased Medicaid payments to PCPs (2013 and 2014)	Increase	May entice more PCPs to accept Medicaid patients.
Limit Flexible Spending Account (FSA) contributions to $2,500	Small Decrease	Will limit the tax savings for patients who spend more than $2,500 a year out-of-pocket.

[2] Accountable Care Organizations (ACOs) are provider groups that accept responsibility for the cost and quality of care delivered to a specific patient population. The PPACA directs the Centers for Medicare & Medicaid Services (CMS) to create a national voluntary program for ACOs by January 2012.

ELEMENTS OF LAW IMPLEMENTED IN 2014	OVERALL EFFECT ON UTILIZATION	EXPLANATION
Insurance required for all citizens. Significant changes to help individuals obtain insurance: • Medicaid eligibility expanded to all nonelderly individuals below 133 percent of the FPL • Individuals not eligible for Medicaid but below 400 percent of the FPL will receive credits to offset the cost of premiums • Companies with 50 or more employees required to provide health insurance or pay a penalty • States set up exchanges to help individuals and small employers obtain insurance	Increase	Of all the reforms, this will have the largest impact on utilization. By insuring the previously uninsured, it reduces the out-of-pocket cost of healthcare to those individuals and increases their utilization. For the majority of individuals already with insurance, there should be little impact.
Insurers can't charge higher rates or refuse coverage because of health status, sex, or pre-existing conditions	Limited Increase	Doesn't impact anyone with employer-provided insurance. Will reduce the premiums for unhealthy individuals with individual insurance and allow them to spend more on co-pays.
No annual limits on coverage	Limited Increase	Few patients currently affected.
Income based out-of-pocket limits for up to 400 percent of the FPL	Modest Increase	Impact limited to individuals below 400 percent of the FPL who already have insurance and are approaching their out-of-pocket limits.
Limited deductibles in small group insurance market	Some Increase	Effect depends on how much the deductibles decrease.
Limit insurance waiting period to 90 days	Small Increase	Effect limited to patients who would have waited more than 90 days and also needed care.
Minimum coverage for all plans	Increase	Effects depend on what the new minimum coverage will be.
Reduce Medicare and Medicaid Disproportionate Share Hospital[3] payments 75 percent but increase based on percent of population uninsured and amount of uncompensated care	Unsure	Effects could vary by individual hospital.
ELEMENTS OF LAW IMPLEMENTED IN 2018	**OVERALL EFFECT ON UTILIZATION**	**EXPLANATION**
Tax on "Cadillac" insurance plans	Minimal Decrease	There will probably be few "Cadillac" plans remaining by 2018.

ESTIMATING INSURANCE COVERAGE SHIFTS FOR THE U.S.

A number of agencies have estimated how many more Americans will enroll in Medicaid programs as a result of PPACA and how the law will affect the number of uninsured. Some of the most reliable estimates are thought to be from the Congressional Budget Office (CBO), the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT), and the RAND Corporation. All three of these sources use a micro-simulation approach to create models of how individual plan purchasing decisions are affected by economic factors such as subsidies, copayments, premiums, and penalties. These models are based on data from the Survey of Income and Program Participation (SIPP), the instrument of choice for studying enrollment changes over time. SIPP is a longitudinal survey that records monthly enrollment status over many months. The bullets below summarize the findings of these three sources. Tables 2 and 3 consolidate the data.

- CBO is the federal standard for national forecasting of impact of PPACA on enrollment by plan type. These projections are the main source of information for the long-term impact of the law on the federal budget and the deficit. They were published in an official report to House Speaker Nancy Pelosi on March 20, 2010[4]. The CBO forecasts an increase of 16 million individuals in the Children's Health Insurance Program and Medicaid by 2019, an increase of more than 27 percent. It further predicts that a total of 32 million more individuals will have some form of insurance, leaving 23 million uninsured in 2019.

[3] Hospitals that serve a significantly disproportionate number of low-income patients and are thus entitled to additional government payments. For more information, see http://www.hhs.gov/recovery/cms/dsh.html

[4] http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

- The CMS OACT released an independent set of enrollment and expense forecasts for PPACA on April 22, 2010[5]. This source predicted a greater increase in Medicaid enrollment, estimating it will rise nearly 42 percent between 2010 and 2019. Its estimates of the number of uninsured were similar to those of the CBO.
- The RAND Corporation has published its own detailed enrollment trends. Medicaid numbers are significantly lower than any of the other forecasts that we have reviewed. Uninsured numbers are significantly higher.

Table 2. Predicted Increase in Medicaid Enrollees as a Result of Reform

MEDICAID ENROLLEES, IN MILLIONS, BY YEAR

Source	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Congressional Budget Office	40	38	37	35	45	49	52	51	51	51
CMS Actuarial	59.2	60.5	61.6	62	83.6	84.6	84.1	82.1	82.9	83.9*
RAND	35	35	36	36	41	45	49	49	50	50

*Note: CMS figures show all individuals ever enrolled per year. CBO and RAND show average point-in-time enrollment.

Table 3. Predicted Decrease in Uninsured Americans as a Result of Reform

UNINSURED AMERICANS, IN MILLIONS, BY YEAR

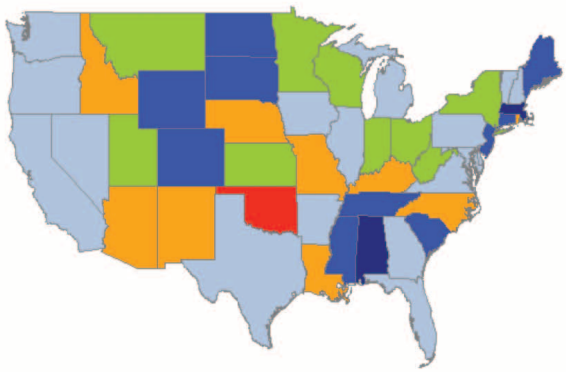
Source	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Congressional Budget Office	50	51	50	50	32	26	22	22	22	22
CMS Actuarial	47.5	48.1	47.4	47.6	23.8	22.2	21	22	22.8	23.1
RAND	49	50	50	51	44	32	24	24	25	25

IMPACT ON PRIVATE INSURANCE COVERAGE

Healthcare reform will also have an impact on private insurance coverage. Understanding the choices Americans have been making in private coverage options over the last several years also yields useful information. With premiums rising and unemployment at high levels, we might conclude that the number of people who individually purchase their own private insurance is declining across the board.

The data in Figure 1 illustrate vastly differing trends among the states. If we were to look at local markets within the states, we'd find even more variation. Analyzing such data teaches an important lesson: any assumptions about local market activity, especially in today's volatile healthcare market and economy, are inherently flawed. The wise hospital executive will study reliable local data compiled using proven statistical methods before making decisions.

Figure 1. Trends in Private Insurance* Membership Vary Greatly by Region



Percent Change 2007–2008

- Decline 50% plus
- Decline 10 – 50%
- Decline 0 – 10%
- Growth 0 – 10%
- Growth 10 – 50%
- Growth 50% plus

STATE	% CHANGE 2007-2008
Oklahoma	89.7
Louisiana	26.2
North Carolina	23.4
Nebraska	23.3
Alaska	21.9
Missouri	19.0
Hawaii	15.2
Rhode Island	14.6
Idaho	14.5
New Mexico	14.4
Arizona	13.8
Kentucky	11.1

*Purchased by individuals

Source: Bureau of Labor Statistics

[5] Memo, *Estimated Financial Effects of the Patient Protection and Affordable Care Act*, as Amended. Available for download at http://www3.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

FACTORS AFFECTING ENROLLMENT IN LOCAL MARKETS

Not all local markets will feel the same effects of healthcare reform. Simulation models have forecasted large national increases in the Medicaid population combined with dramatic decreases in the uninsured. However, differences in state implementation and local demographics will lead to very different trends by market. This section introduces these factors and points toward techniques that will support local market estimates of insurance coverage change.

As of 2014, PPACA will extend Medicaid eligibility to all adults younger than 65 with incomes below 133 percent of the FPL. This provision alone is expected to bring health insurance to more than 16 million people. But the expansion will not affect all states in the same way. Although Medicaid is mostly a federally funded program, it is administered by state agencies. To qualify for federal funds, state Medicaid plans must provide certain minimal services and must cover several mandatory populations. These include:

- Children younger than six years old whose families' incomes fall below 133 percent of the FPL.
- Children six years old and older whose families' incomes fall below 133 percent of the FPL.
- Parents below the state's Aid for Families with Dependent Children/Temporary Aid for Needy Families cutoffs. These cutoffs are quite low, generally below 50 percent of the FPL.
- Elderly and disabled adults who are eligible for Supplemental Security Income.
- Pregnant women whose income is below 133 percent of the FPL.

The vast majority of children who are covered by Medicaid qualify under one of the rules mandating a health insurance option for needy children. States may optionally extend Medicaid coverage to adult populations. Extending these benefits to adults, particularly childless adults, is at the discretion of each state, and the extended eligibility criteria vary dramatically by state. Understanding these differences is vital to forecasting how healthcare reform will operate differently in each state:

- States with the most limited Medicaid extensions will see the most dramatic increase in the adult Medicaid enrollment. Those that have already extended Medicaid benefits may see modest change or no change. Vermont, for example, extends Medicaid benefits to childless adults with incomes up to 160 percent of the FPL, and Massachusetts offers limited coverage to those with incomes up to 300 percent of the FPL. These states may see changes in covered services, but are unlikely to experience large enrollment increases.
- Not all states have been equally successful in enrolling individuals, even those who are covered under the mandatory rules. Outreach programs and access to information vary dramatically. For example, nearly half of all eligible children in Nevada are not enrolled in Medicaid. And in Massachusetts, which has had very high public and private support for reform, only 5 percent fail to enroll. These varying levels of participation (or public support) may presage enrollment levels when eligibility limits are expanded.
- The non-participating populations mentioned above are a substantial portion of the uninsured. They are already eligible for Medicaid, and this status will not change with healthcare reform extensions in 2014. It is reasonable to assume that most of this population will remain uninsured under healthcare reform.
- Local demographic and economic conditions are likely to affect enrollment in Medicaid and in new health exchanges. Studies in Massachusetts[6] have shown dramatic differences between population groups that continue to be uninsured. For example, despite the availability of Medicaid coverage, individuals living at or below 150 percent of the FPL are more than six times more likely to be uninsured than those living above 500 percent of the FPL. Hispanics or Latinos are more than 40 percent more likely to remain uninsured than non-Hispanic Whites.

[6] Health Insurance Care and Access in Massachusetts: Detailed Tabulations Based on the Massachusetts Health Insurance Survey, available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his_policy_brief_estimates_oct-2009.pdf

THE NEXT STEP: ESTIMATING FOR SPECIFIC LOCAL MARKETS

National estimates are useful for federal policy makers, but hospital professionals need more specific information. Big changes in healthcare begin locally, and hospitals need to understand changes in their local markets if they are to respond with decisions appropriate for their businesses. Thomson Reuters analysts relied on complex statistical analysis to devise the estimates outlined above. Making similar predictions for local markets is even more complicated. Different areas will witness different impacts based on what they currently offer because:

- All programs will be state based.
- All states have different uninsured populations.
- There are currently different Medicaid program policies and rates of participation throughout the states. Those who have done the least to prepare for reform, by making the fewest proactive changes to model the upcoming reform mandates, will see the biggest changes.

Thomson Reuters has devised strategies for localizing the coverage and utilization trends. These strategies will include three basic tenets:

- Study before and after adoption rates of insurance exchanges and Medicaid programs in Massachusetts by income segment, and apply these rates to local age-by-income information.
- Compile state-by-state Medicaid eligibility rules. This would be done by calculating state-specific and core-based statistical area (CBSA)[7]-specific, (where possible) Medicaid participation rates using the best available data sources and comparing participation rates with pre-2006 Massachusetts rates. This would measure the relative aggressiveness of each state in fostering participation.
- Apply adoption rates only to those currently uninsured in each locality, excluding those who are already Medicaid eligible. The assumption is that eligible individuals who are not participating in Medicaid now are unlikely to respond to expanded eligibility, because it is likely that they will also be exempt from penalties due to low income.

The Insurance Coverage Estimates database from Thomson Reuters analyzes how yearly changes will affect the local population payer mix. This database reports the total number of people covered by seven different types of insurance (Medicaid Non-Risk, Medicaid Risk, Medicare Non-Risk, Medicare Risk, Private Non-Risk, Private Risk, and Uninsured) by ZIP code, age group, and sex for every market in the United States for a base year and 10 individual forecasted years. The forecast year population reflects population growth and yearly payer shifts. Thomson Reuters uses multiple sources of insurance coverage data and various models to construct these local estimates. Going forward, this application can tell us how enrollment changes will affect specific areas and can be as detailed as ZIP code areas.

ESTIMATING MARKET-SPECIFIC VOLUMES FOR A PARTICULAR PROCEDURE

The ultimate result of changes in insurance coverage and utilization will be dramatic shifts in demand for services at the local level. Based on the Massachusetts experience, we expect increases in all areas, particularly in preventive and diagnostic services. Hospital executives will need to understand potential stress points where demand may exceed current capacity.

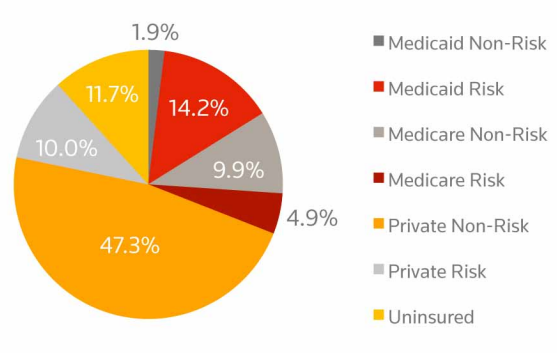
A simple set of calculations can be used to create an initial estimate of this increase. This is a first step — a short-term solution to address prospective changes in payer mix given implementation of healthcare reform legislation. The following example outlines a method that Thomson Reuters analysts used to model the effect of enrollment shifts on demand for services. This applies hypothetical enrollment changes to the demand for colonoscopies in Philadelphia. We have chosen this particular example because the demand for outpatient diagnostic procedures is highly payer-specific. However, the same methodology can be applied to any inpatient or outpatient encounter.

[7] A Core-Based Statistical Area is a functional region based around an urban center of at least 10,000 people, based on standards published by the Office of Management and Budget (OMB) in 2000. This replaces the definitions of metropolitan areas that had been used since 1990.

The specific steps used in this estimate are as follows:

Step 1: Calculate the payer mix without healthcare reform changes for the market area being studied.

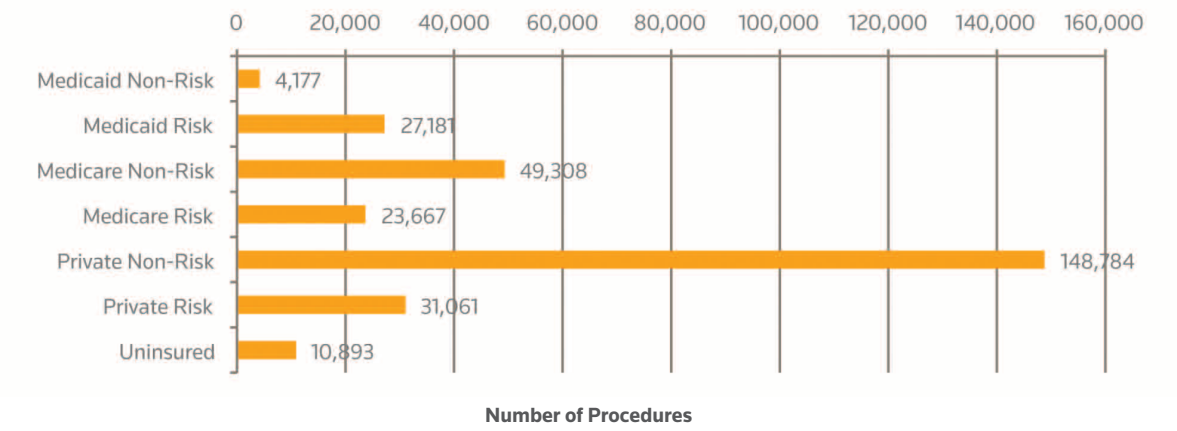
Figure 2. Projected 2014 Payer Mix in Philadelphia Metro Area



Source: Thomson Reuters Insurance Coverage Estimates

Step 2: Calculate procedure volumes, by insurance source, for the procedure being studied.

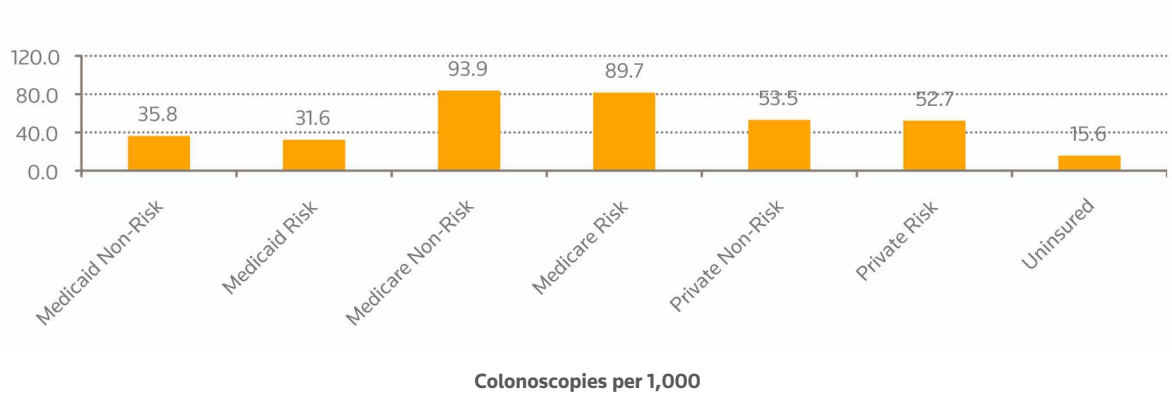
Figure 3. Colonoscopy Volumes in Philadelphia Metro Area



Source: Thomson Reuters Outpatient Procedure Estimates

Step 3: Calculate procedure rates, by insurance source, for the procedure being studied by dividing payer-specific volumes by enrollment totals. Note the large difference between the colonoscopy rates of the uninsured and the rates of Medicaid and privately insured populations. As healthcare reform draws the uninsured population into the insured groups, we expect demand to grow.

Figure 4. Colonoscopy Rates, by Payer Group, in Philadelphia Metro Area



Source: Thomson Reuters

Step 4: Distribute the uninsured population to private insurance and Medicaid.

Table 4 illustrates a simple set of assumptions about how healthcare reform will affect the uninsured population. Consistent with the CBO simulations, we assume that 80 percent of the uninsured population will gain some form of insurance and that they will migrate roughly equally into two groups, the Medicaid Non-Risk and the Private Non-Risk populations. Note that our local research indicates that Pennsylvania has already extended Medicaid eligibility to many low-income adults, so Philadelphia may not experience changes as large as those predicted by the CBO.

Table 4. Distributing Uninsured Population to Private Insurance and Medicaid, Philadelphia Metro Area

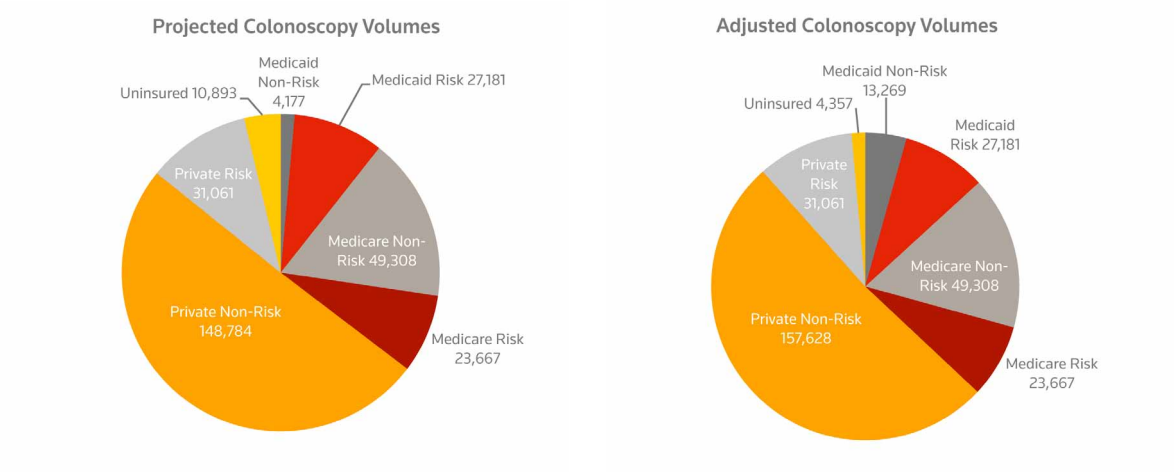
	PROJECTED POPULATION	ADJUSTMENTS	POPULATION CHANGE	ADJUSTED POPULATION	PERCENT CHANGE
Medicaid Non-Risk	115,008	Captures 50% of the uninsured	278,116	393,124	242
Medicaid Risk	842,791	No change	0	842,791	0
Medicare Non-Risk	589,794	No change	0	589,794	0
Medicare Risk	289,941	No change	0	289,941	0
Private Non-Risk	2,807,262	Captures 50% of the uninsured	278,116	3,085,378	10
Private Risk	595,799	No change	0	595,799	0
Uninsured	695,290	80% volume shift to private insurance and Medicaid	-556,232	139,058	-80

Source: Thomson Reuters

Step 5: Apply the adjusted population figured in the steps above to understand the possible future increase in colonoscopy rates.

The adjusted population figures are multiplied by the payer-specific colonoscopy rates from Figure 4 to calculate increased demand for colonoscopies.

Figure 5. Increase in Colonoscopy Rates, Philadelphia Metro Area



Source: Thomson Reuters

Note that the above example is a model of the effect of enrollment changes on demand, holding other factors constant. Utilization rates are assumed to hold constant, although reimbursement changes and payment innovations are likely to lower demand for colonoscopies. We feel that it is important to begin with a pure model of the full potential impact of enrollment changes. It is essential for hospital executives to understand the magnitude of the challenge facing local delivery systems, because these systems will bear the burden of managing this excess utilization.

LOOKING FORWARD

Throughout the industry, much has been done to estimate how PPACA will influence insurance coverage – especially at the national level. As described above, Thomson Reuters has also begun to construct these estimates for particular markets and services. Hospitals must acquire a better understanding of utilization rate changes and how coverage and utilization changes and specific aspects of reform law will impact hospital payments. To do so, hospital and health system professionals will need information on:

- **Utilization changes brought about by population shifts** – New populations will move into the privately insured market and into the Medicaid segment. This influx will greatly change the health profile of the different payer segments. These shifts in health profiles will, in turn, cause utilization changes (both outpatient and inpatient) over the next 10 years.
- **Reimbursement changes brought about by payment innovations** – This would include the effect of pay for performance, the introduction of ACOs, patient management, and episode-based payments. Local studies of efficient delivery systems will provide valuable benchmarks for decreasing unnecessary testing, minimizing readmission rates, and migrating inpatient procedures into more cost-effective outpatient settings.

Much has been done to dissect the healthcare reform law to understand how it will affect insurance coverage and how the subsequent utilization changes will impact hospitals and health systems. But healthcare executives hoping to thrive in this new market must take this analysis a step further — they must act to fully understand how these changes will impact their particular markets at the local levels. Finally, future efforts must focus on estimating reimbursement changes in local markets.

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The Center for Healthcare Improvement (CHI) is a knowledge creation center for the Healthcare business of Thomson Reuters. Its main focus is creating insights to guide the healthcare industry toward improved performance.

CHI performs research aimed at improving the future of healthcare. CHI experts mine treatment, outcome, safety, financial, operational, market share, and patient perception data across care settings to create new knowledge for providers. The team consists of pioneers who continually find new ways to integrate and analyze disparate data streams to develop unique measures and benchmarks. CHI seeks to support performance improvement cultures in hospitals and develop new methods to increase utility, reliability, and predictability of information for improving healthcare.

The members of CHI have subject matter expertise in hospital performance measurement, operations, statistics, epidemiology, demographics, patient care, managed care, and hospital cost reporting.

CHI also concentrates on pre-product research and development, and government and industry relations, and contributes data, analysis, and content to several annual reports and programs.

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