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US Health Reform – implications for Brain Resource

“the greatest threat to America’s fiscal health is not Social Security, though that is a significant challenge; and it is not the investments we’ve made to rescue our economy; it is the skyrocketing cost of health care.....In the past month alone, we have done more to advance that goal than we have in the past decade” President Obama, White House Forum on Health Reform March 5, 2009.

Change drivers:	Key areas relevant to Brain Resource
American Recovery and Reinvestment Act of 2009	<ul style="list-style-type: none">• \$20bn Electronic Health Records• \$1.1bn Comparative Effectiveness
Senate Finance Committee Roundtable on Reforming America's Health Care Delivery System (April 2009)	<ul style="list-style-type: none">• Including efficiencies, Wellbeing and bundled pricing
Mental Health Parity and Addiction Equity Act of 2008	<ul style="list-style-type: none">• Increased demands on Mental Health services

Brain Resource provides products that: (1) optimize brain health; and (2) generate process efficiencies in the delivery of healthcare services. As such, we are ideally positioned to benefit from many aspects of these reforms:

- The WebNeuro suite of web based products provide a standardized automated triaging and decision support system for behavioral health management - that is, connecting the right person to the right solution in the fastest possible time. Brain Resource is partnered with OptumHealth (part of The UnitedHealth Group) to deliver these solutions.
- The Brain Resource International Database (BRID) provides the standard of comparison for brain health and is thus uniquely positioned for assessing Comparative Effectiveness (including relative performance of different drugs and care provision). The iSPOT study currently underway, one of the largest in the world (~4,000 subjects), is in part a Comparative Effectiveness study comparing three most commonly prescribed antidepressants.
- The newly launched MyBrainSolutions.com is a personal change management portal focused on Wellbeing including helping users manage stress and build resilience.

1. Electronic Health Records

The Recovery Act includes significant incentives for adopting Electronic Health Records (EHR) for Medicare and Medicaid providers. Starting in 2011, adopting entities will receive incentives of around \$44,000 over 5 years, with penalties by 2015 for non-compliance. Two requirements are that the EHR be 'certified' and that 'meaningfully' used (definitions still being resolved).

Observations:

- This incentive provides users, including clinicians, a reason to change.
- Brain Resource essentially generates a personalized Electronic Health Record for the brain, a key module of any large scale EHR system.
- Brain Resource provides 'actionable' information for users. This extends process efficiencies and provides a reason for use as distinguished from the benefits of a say a traditional prescription system. That is, it provides users a benefit today beyond a process efficiency.
- The quality of measures could help users of EHR systems to meet the 'meaningful use' requirement.
- Brain Health is also one of the most common but challenging components of any clinical practice. It is also an area where there is little standardization of treatment or care, and limited clinician performance benchmarks. Both these components are integral to Brain Resource's system.

2. Comparative Effectiveness

The Recovery Act contains \$1.1 billion for Comparative Effectiveness Research (CER). CER compares treatments and strategies to improve health, information that is essential for payers, clinicians and patients to decide on the best treatment.

This funding is for research assessing the comparative effectiveness of health care treatments and strategies, through:

- comparing the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and
- the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

Observations:

- Progress in CER is a key part of any system that facilitates a move from payment for activity to one that rewards value.
- Brain Resource's standardized platforms are already providing this in three ways:
 - Brain Resource has the largest standardized brain database in the world;
 - the iSPOT study is among the largest comparative effectiveness studies being conducted today and is comparing the performance of the three most commonly prescribed antidepressants; and

- Brain Resource’s Behavioural Management System is providing a standardized and systematic approach to care and also intrinsically has a mechanism to quantitatively assess change in patient performance.
- If the reformative trend continues, Drug companies may increasingly face the need of having to build CER capabilities or face the risk that new drugs submissions are delayed until they can demonstrate relative performance.
- Similarly, payers will come under increasing pressure to demonstrate value in the way they manage client health spend, including demonstrating that payments to suppliers for the drugs and treatments are delivering value.

3. Health Reform (US Senate Committee on Finance Roundtable)

The US Senate Committee on Finance (Senators Grassley & Baucus) held the first in a series of Roundtable Discussions on Health Reform on April 21, 2009. This Roundtable focussed on Delivery System reform and there were 13 witness submissions.

There were many common themes including endorsement including the importance of the above legislative reforms. The summaries of The Pacific Business Group, Aetna and MedPAC captured the essence.

“Our health care system is broken: Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients; Payments reward quantity over quality and fixing problems over prevention; Lack of standardized performance measures makes it impossible to know which providers are doing a good job, and those who are not; Consumers lack information to make the choices that are right for them.” P. Lee, Executive Director, Pacific Business Group on Health.

“We need to harness the power of health information technology so that we can turn complex health data into knowledge that physicians and patients can act on to improve health outcomes; We need to make wellness and prevention a priority in our health care system. Our seat belt laws and anti-smoking efforts have achieved great results and we need this same type of commitment in the wellness challenges facing us in the areas of obesity and encouraging healthy behaviors; We must reform our payment system, utilizing public programs alongside private sector innovation, so that our focus rests on value and quality, rather than volume.” R. Williams, CEO of Aetna.

“Medicare’s fee-for-service payment systems reward more care, and more complex care, without regard to the value of that care. In addition, Medicare’s payment systems create separate payment “silos” (e.g., inpatient hospitals, physicians, post-acute care providers) and do not encourage coordination among providers within a silo or across the silos.... Under bundled payment, Medicare would pay a single provider entity an amount intended to cover the costs of providing the full range of care needed over the hospitalization episode.” G Hackbarth, Chairman Medicare Payment Advisory Commission.

Please see pertinent extracts from submissions made at this Roundtable at the end of this document.

Observations:

- Totally aligned with Brain Resource's focus discussed above.
- The recognition of the importance of WellBeing increases the relevance of MyBrainSolutions. Wellbeing and disability are part of the same health continuum and Brain Resource's MyBrainSolutions and the Behavioural Management system straddle the full extent of these bounds and offer an integrated solution.
- Were bundling of payments to gain further support, it will be critical to be able to separate brain disorders where they are coexisting (co morbid) with another disorder, such as where depression is co morbid with cardiac disease or diabetes. Failure to treat depression in these instances can significantly exacerbate the underlying condition (eg: a cardiac patient who is depressed fails to take their cardiac medication). Brain Resource can help to qualify any bundle pricing by having rules to provide differentiated pricing where brain health co morbidities are prevalent. Our view is that this is already an enormous opportunity but the introduction of bundling will bring an urgency to addressing this.

4. Mental health parity

The Mental Health Parity and Addiction Equity Act of 2008 was introduced to prevent health insurance practices that discriminated against mental health services by setting lower limits on treatment, including limits on doctor visits, or higher co-payments for mental health services than for other covered conditions. That is, if a group health plan includes medical/surgical benefits and mental health benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.

Observations:

- Studies have shown that only about 1/3 of Americans get mental health treatment for their condition, so it is a reasonable assumption that any reform such as this will significantly increase demand on an already loaded system.
- combined with the fallout from the current recession, which is expected to increase mental health problems, this will intensify demand for more innovative solutions like Brain Resource's products to manage treatment and costs.

Please contact Dan Segal on +61 2 9213 6600 should you have any queries regarding the above.

Extracts from select submissions to the Senate Committee on Finance, Roundtable to Discuss Reforming America's Health Care Delivery System, April 21, 2009, <http://finance.senate.gov/sitepages/hearing042109.htm>

1. Peter V. Lee, J.D., Executive Director, National Health Policy, Pacific Business Group on Health, San Francisco, CA

Our health care system is broken:

1. Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients.
2. Payments reward quantity over quality and fixing problems over prevention.
3. Lack of standardized performance measures makes it impossible to know which providers are doing a good job, and those who are not.
4. Consumers lack information to make the choices that are right for them.
5. We know there is huge variation in the quality of health care, but we don't know who is or isn't delivering the right care at the right time. All too often we don't know which drugs, devices or treatments are the right ones. Without better information, providers cannot improve their performance, consumers cannot make better choices and payers cannot know who or what to reward

These recommendations call for the development of robust, independent systems for collecting and reporting performance results on patients' outcomes, cost and patients' views of care, and whether the right processes of care are being delivered by doctors, medical groups, hospitals, nursing homes, and other providers.

we need to dramatically expand comparative effectiveness research so patients can have better information that they can use with their doctors to understand what's the right treatment for them.

The definition of "meaningful use" should hinge on whether information is being used to deliver care and support processes that improve patient health status and outcomes.

It would be a strategic mistake to assume that only a highly integrated EHR system can achieve the goals of meaningful use. Public policy and incentive programs must allow for innovation in the architecture and technologies used to deliver information to clinicians and patients.

Medicare should explore providing information and incentives for wellness and the selection of higher value providers. Private health plans are increasingly offering not just tools, but incentives for their enrollees to improve their health and make better choices among providers. Medicare should follow the same path to investigate how beneficiaries can be given tools and incentives to make better choices.

2. Allan Korn, M.D. Senior Vice President and Chief Medical Officer, Blue Cross and Blue Shield Association

Providing information on what works best by comparing the relative clinical effectiveness of new and existing medical procedures, drugs, devices, and biologics – this is a vital first step in addressing the approximately 30 percent of all healthcare spending that goes toward ineffective, redundant, or inappropriate care. (Wennberg, 2003)

- Changing incentives to advance the best possible care, instead of paying for more services that may be ineffective, redundant, or even harmful – because providers are generally paid based on the number of services they provide, regardless of quality or outcomes.
- Empowering consumers and providers with the information and tools they need to make informed decisions – because too often consumers and providers do not have what they need to encourage the right care done right at the right time for each and every patient.
- Promoting healthy lifestyles to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health – because one of the greatest challenges facing the healthcare system is managing the care for the growing number of people with chronic illnesses.

the bedrock of encouraging the right care at the right time for every patient is comparative information on the clinical effectiveness of different treatment approaches.

Most physicians and hospital staff are well-trained and well-intentioned, but need to spend more time improving the processes by which care is delivered, and using systems to support decision making that adheres to the scientific evidence that is available.

3. Richard J. Umbdenstock, FACHE, President and CEO, American Hospital Association, Washington, DC

Focus on Wellness. Good health – physical, mental and oral – is essential for a productive and vibrant America. A focus on wellness must be integrated into the lifecycle, from birth to death.

We must coordinate the treatment of physical and behavioral health needs; reward care outcomes, not the number of patients seen; and make palliative care more available and better understood.

Good information is the gateway to good care and good research. We have to accelerate the adoption of health information technology by addressing financial, regulatory and technological barriers, including inter-operability and standardization.

The AHA strongly supports comparative effectiveness research (CER) that provides clinicians, patients and others with valid and reliable information about the relative effectiveness of various treatment alternatives. CER is an important step in reforming the nation's health care delivery system, and will be a key mechanism to improve health care quality, eliminate variation in care, and reduce health care costs. Additionally, it will

provide credible information allowing patients, clinicians and others to make better medical decisions.

4. Ron Williams, Chairman and CEO, Aetna Inc., Hartford, CT

We need to change delivery paradigms by using health information technology (HIT) tools that enable providers and patients to make better use of the right data, at the right time to make quality care decisions.

While absolutely necessary, Aetna believes that EHRs are only a partial solution if we are to fully realize the \$80 billion in projected annual savings generated from the use of electronic record technologies. More important will be “smart” technologies that enable data exchange across providers as well as the companion services which deliver advanced, intuitive clinical decision support. These tools will ensure that providers are able to quickly rationalize the growing volume of data on their patients and to use that data to make the right treatment decisions. It is from these latter two areas – data exchange tools and clinical decision support tools – that the public will realize true value for its HIT investment.

Aetna believes the key to leveraging the power of health information technology is to make data actionable. Giving providers greater visibility to patient data to make better decisions for their patients – and Aetna members – has been a central driver for much of the \$1.8 billion Aetna has invested in HIT since 2005. This was the impetus for our acquisition and continued deployment of an interoperable clinical decision support service, ActiveHealth Management and its CareEngine® clinical decision support solution.

Today, our health care delivery system is largely oriented toward treating disease once it surfaces rather than preventing it before it has the chance to appear. Refocusing our system to prevent disease and promote wellness can shift the pendulum toward better health for all Americans, giving individuals the support and resources they need to lead longer, healthier lives.

Wellness and prevention require consumer engagement and sustained behavior change. The path to engagement and behavior change begins with involving people in programs that will set them on their way to improved health, while providing continuous support and interaction to keep them moving in the right direction. This can be achieved by providing education, interactive and easy-to-use tools and access to a range of services. These should include health risk assessments, fitness programs, weight management, disease management, smoking cessation, employee assistance and incentive programs.

Incentives in our payment system that reward providers for quantity of care rather than quality of care are an important part of the problem. Improving our delivery system starts with reforming our payment system to focus on quality and value. Aetna supports transforming the payment system into one that aligns provider reimbursement incentives with achieving high quality outcomes for patients. Various payment reform approaches linking payment to performance and aligning care across the continuum of providers are being piloted and tested across the country. I believe we must work together to test and

identify those that achieve value and sustain robust health care systems, including the following:

- i. Consider new payment models to align care and recognize performance;
- ii. Expand pay-for-performance;
- iii. Revitalize primary care and support the patient centered medical home
- iv. Increase transparency
- v. Include public programs in payment reform

5. Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission, Washington, DC

The health care delivery system we see today is not a true system: Care coordination is rare, specialist care is favored over primary care, quality of care is often poor, and costs are high and increasing at an unsustainable rate. Part of the problem is that Medicare's fee-for-service (FFS) payment systems reward more care, and more complex care, without regard to the value of that care. In addition, Medicare's payment systems create separate payment "silos" (e.g., inpatient hospitals, physicians, post-acute care providers) and do not encourage coordination among providers within a silo or across the silos.

Linking payment to quality. In a series of reports, we have recommended that Medicare change payment system incentives by basing a portion of provider payment on the quality of care they provide and recommended that the Congress establish a quality incentive payment policy for physicians, Medicare Advantage plans, dialysis facilities, hospitals, home health agencies, and skilled nursing facilities. In March 2005, the Commission recommended setting standards for providers of diagnostic imaging studies to enhance the quality of care and help control Medicare spending.

In our June 2007 Report to the Congress, we found that not enough credible, empirically based information is available for health care providers and patients to make informed decisions about alternative services for diagnosing and treating most common clinical conditions.

Evidence points to other potential reforms:

- Greater care coordination. Evidence shows that care coordination can improve quality. As we discussed in our June 2006 Report to the Congress, studies show self management programs, access to personal health records, and transition coaches have resulted in improved care or better outcomes, such as reduced readmission for patients with chronic conditions.
- Reducing preventable readmissions. Savings from preventing readmissions could be considerable. About 18 percent of Medicare hospital admissions result in readmissions within 30 days of discharge, accounting for \$15 billion in spending. The Commission found that Medicare spends about \$12 billion on potentially preventable readmissions.
- Increasing the use of bundled payments. The Medicare Participating Heart Bypass Center demonstration of the 1990s found that bundling hospital DRG payments and inpatient physician payments could increase providers' efficiency and reduce Medicare's costs. Most of the participating sites found that, under a

bundled payment, hospitals and physicians reduced laboratory, pharmacy, and ICU spending. Spending on consulting physicians and post-discharge care decreased and quality remained high.

The variation in spending around hospitalization episodes suggests lower spending is possible. There is a 65 percent difference in spending on readmissions between hospitals in the top quartile and the average of all hospitals; the top quartile is almost four times higher than the bottom quartile.

Under bundled payment, Medicare would pay a single provider entity an amount intended to cover the costs of providing the full range of care needed over the hospitalization episode. Because we are concerned about care transitions and creating incentives for coordination at this juncture, the hospitalization episode should include time post-discharge (e.g., 30 days). With the bundle extending across providers, providers would not only be motivated to contain their own costs but also have a financial incentive to better collaborate with their partners to improve their collective performance.