A Realistic Pathway to ACOs…and Healthier Employees

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STROUDWATER ASSOCIATES

What is an ACO?

A mechanism for providers to capture savings generated by providing higher quality, lower cost patient care.

Medicare's proposed ACOs (MSSP & Pioneer) are just two, very limited forms of ACO…

But they're getting most of the attention.

Strategic ACO Value Chain → Value Proposition

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Level 4: Provider-Sponsored Health Plan	Full Premium Capture w/ retail bundling, 80/20-Optimized Quality/Cost Improvement, Optimized Benefits, Retail Pricing, Individual Prevention Incentives/Support, VB Provider Compensation (e.g., HMO, MA, MMC, Exchange-Based Individual Insurer)
Level 3: Partial/Full Capitation	Global/Partial Capitation from 3rd Party Payers (e.g., MA Capitated Medical Groups/Integrated Medical Systems)
Level 2: Provider Self-Funded Employee Benefit Plan	Full "Premium" Capture w/ retail bundling, 80/20-Optimized Quality/Cost Improve., Optimized Benes., Retail Pricing, Indiv. Prevention Incent/Support (Provider Employees/Dependents Only)
Level 1: Partial-Risk/Reward ACO	3rd Party Payer Savings/Loss-Sharing Arrangements (e.g., Medicare ACOs, Medicaid ACOs, Commercial ACOs
Level 0: Fee-For-Service	FFS Medicare, Medicaid, commercial insurance, managed care

Are Medicare ACOs the Best Place To Start?

ACO goals are simple: Improve quality & lower costs

Not-so-simple CMS regulatory requirements:

- Highly prescriptive process and structure mandates
- Involuntary membership attribution
- No control over provider choice/utilization
- Cliff-effect quality reporting & compliance
- Inflexible benefit limitations
- Burdensome compliance & reporting
- Large startup costs
- Many requirements not relevant to non-Medicare business
- ACO does all the work for only a portion of the savings
- Downside risk
- Retrospective savings reconciliation and payment by CMS
- Antitrust requirements

Net-net: Too many requirements that do nothing to improve quality or lower costs.

Start At Level 2: Your Self-Funded Benefit Plan

- It's already a full-risk, provider-sponsored health plan
- Membership numbers comparable to CMS ACO requirements
- No additional risk beyond what you already accept
- You're almost certainly undermanaging it
- You're probably enabling unhealthy behavior
- You have comprehensive utilization & cost data
- You can use 80/20 management techniques
- Self-benchmarking: Beating your personal best is sufficient
- Major savings opportunity for a very large cost item
- 100% of savings flows directly to your bottom line
- No additional government regulation—focus on adding value
- Opportunity to tailor quality/cost enhancement to actual patients
- If you don't do this, how can you sell value to others?
- If you can demonstrate savings here, you can do it anywhere

Net-Net: An ideal beta test before embarking on higher-value Strategic ACO development

Health Care Workers & Dependents Sicker, Riskier

- 10% higher medical costs
- 13% higher dependent costs
- 8.6% greater illness burden, higher rates of…
  - Asthma
  - Diabetes
  - Congestive heart failure
  - HIV
  - Hypertension
  - Mental illness
- Fewer physician office visits(!)
- 22% higher ER utilization

They more resemble Medicaid patients than a model of healthy behavior and appropriate medical resource use.

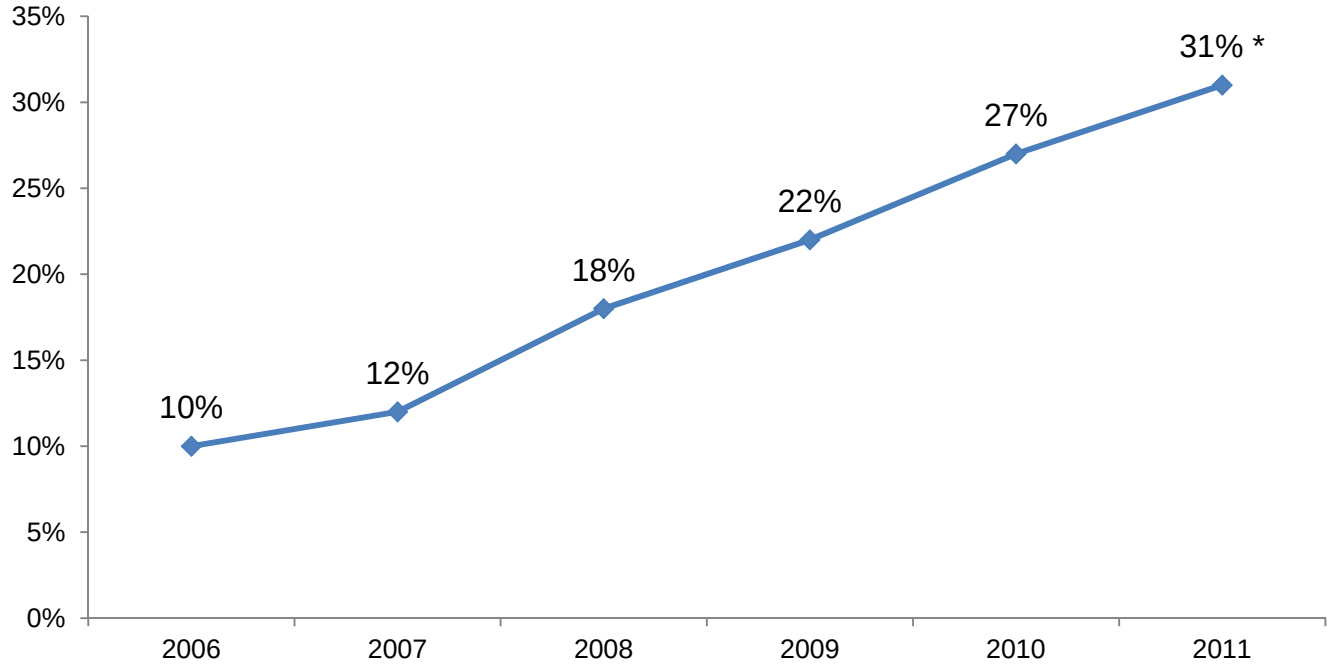
- http://thomsonreuters.com/content/press_room/healthcare/hospital_employees_less_healthy

Higher Benefits and Costs

- Benefits better than market
- Employee premium contributions lower
- First-dollar coverage still common
  - Fixed-dollar copayments
  - Low deductibles (if any)

Industry Trend: Rising Patient Deductibles

Percentage of All Workers With Deductible of $1,000 or More



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2010.; Single Coverage; and The Wall Street Journal.

Higher Benefits and Costs

- Benefits better than market
- Employee premium contributions lower
- First-dollar coverage still common
  - Fixed-dollar copayments
  - Low deductibles (if any)
  - Zero price signalling
- Cost trends even more out of control than for employers generally
- Ineffective prevention/wellness incentives (if any)
- Inadequate chronic disease management (if any)
- Little or no pre-employment risk selection where allowed

Big Savings Potential From Prevention & Wellness

A hospital with 16,000 employees can save $1.5 million/year in health benefit costs for each 1 percent reduction in health risk.

http://thomsonreuters.com/content/press_room/healthcare/hospital_employees_less_healthy

What Are The Potential Savings?

1. **Waste:** 30-40% of all medical expense[1]
2. **Mediocre Quality:** 1/2 medical care substandard[2]
3. **Preventable Disease:** 75% of total costs [3]
4. **Billing/Collection Costs:** Up to 31 cents on dollar[4]

1 2005 report by the National Academy of Engineering and the Institute of Medicine

2 NEJM http://www.nejm.org/doi/full/10.1056/NEJMsa022615#t=articleResults

3 CDC http://www.medicaid.state.al.us/documents/News/Transformation/Workgroup3-8-07/Chronic_Disease_Overview.pdf

4 Richard L. Clarke, “Healthcare Complexities Work Against All of Us,” WSJ 11/28/03

Assess, Analyze, Modify, & Repeat

1. First, we consult the lawyers
2. Claims analysis & 80/20 improvement opportunities
3. Benefits review and & option modeling
4. Medical-value improvement assessment & alignment
5. Limited network & payment structure modeling
6. Financial modeling
7. Organizational structure review and modification
8. Making it so

1. Legal Coordination

- HIPAA privacy
- ERISA compliance
- Prevention/wellness incentives re ACA and state laws
- Employment discrimination rules re health risk behavior/status
- Collective bargaining issues
- COBRA
- Etc.

2. Claims Analysis

- Patient costs by intensity, demographics, health risk factors (if available)
- Major condition utilization & costs (e.g., asthma, diabetes, CHF…)
- Utilization rates & unit costs, e.g., …
  - Physician encounters (primary & specialty)
  - IP bed-days
  - ER
  - Readmissions
  - Out of system (whether in or out of PPO network)
  - Etc.
- Provider cost variability (and quality if available)
- Year-end cost concentration
- Determine 80/20 priorities for action

3. Benefits and Cost Sharing

- Competitiveness in your labor market
- Employer/employee “premium” contribution mix
- Dependent coverage issues
  - Contribution levels
  - Is your coverage preferable to their own employers’?
- Patient out-of-pocket (OOP) cost structures
  - Copayments
  - Deductibles
  - Coinsurance
  - Patient OOP maximums
  - FSA, HRA, & HSA use
- Incentive structures re
  - Individual cost consciousness
  - Individual prevention/wellness
  - In-network utilization
  - Savings accounts
- Model and evaluate options

Sample Questions Re Your Current ERISA Plan

- Do you incentivize cost-conscious medical use?
- Do you *effectively* incentivize prevention and wellness behavior? (Do you hire smokers?)
- Do you offer a high-value limited provider network?
- Do you financially reward use of affiliated providers?
- Are they always better, less expensive than available alternatives?
- Are you unnecessarily paying PPO access fees?
- Are you still using fixed-dollar copayments?
- Are your deductibles in line with your market?

E.g., Changing Your Rx Benefits & Saving 20% in 60 Days

1. **Replace copayments with deductible/coinsurance**
2. **Change to pass-through PBM**
3. **Adopt single-tier, value-based formulary (no Nexium)**
4. **Employee Training: "Doctor, can I save money with:"**
   - Alternatives to drugs?
   - OTC drugs instead of Rx?
   - Generic drugs?
   - Lower-priced brand drugs?
   - Tablet-splitting doses?
   - 90-day mail-order Rx's?
   - Extra free samples?

"Prescription Drugs for Half Price or Less" (2006, Bantam-Dell/Random House) by Stephen S. S. Hyde

1. ID patient intervention priorities (from claims analysis)
2. Map against internal quality/cost improvement program
3. Realign processes to improve employee-patient value
   - Quality enhancement
     - Quality management (e.g., core measures, HCAHPS surveys)
     - Evidence-based medicine
     - Rx reconciliation
     - Discharge planning
     - Medical home coordination
   - Focused disease management activities
   - Prevention/wellness programs & incentives
   - LEAN process reengineering
   - Formal utilization controls

Net-Net: Focus internal quality/cost improvement on actual patients

Two Questions:

- Where do you want your employee-patients to go?
  - Your employed physicians chosen for their quality and ability to work within your system?
  - Your facilities?
  - Your staff specialists?
  - High-value tertiary facilities & specialists chosen by you?

    Or…
  - Anywhere they want?
- How can you change reimbursement to…
  - Reward high quality and low cost
  - Reduce claims transaction costs

Conduct what-ifs re improvements in…

- Health risk-factor control
  - Smoking
  - Obesity
  - Alcohol abuse
  - Serum lipids
  - Hypertension
  - Hyperglycemia
- Better PCP/ER utilization mix
- Chronic disease management
- Formal utilization controls
- Limited-network steering
- Etc., etc., etc.

7. Implementation Issues: Authority & Reporting Structures

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1. CEO & C-Suite commitment absolutely necessary
2. Consider ERISA management separate from, but in parallel with HR

Employer-Focused Prevention

"Your performance evaluations and sales figures are exceptional, but the company's a little bit concerned by your cholesterol numbers."

7. Implementation Issues: Authority & Reporting Structures

1. CEO & C-Suite commitment absolutely necessary
2. Consider ERISA management separate from, but in parallel with HR
3. Consider having both report to CFO or even CEO

8. Make It So

- Employee communication
- Phasing in
- Reporting & feedback
- Coordination with value-improvement efforts
- Course corrections
- Keeping your eye on the big picture
  - Moving up the Strategic ACO Value Chain
  - Expanding to external market (M’care, M’caid, commercial)
  - Continuous improvement

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Hospital Workers & Dependents Sicker, Riskier

"Ideally, the health care workforce would be a model for healthy behaviors and the appropriate use of medical resources. Unfortunately…the opposite is true…(they) have higher-than-average health risks and carry a greater burden of chronic illness."

Raymond Fabius, M.D., Thomson Reuters' Health Care CMO

https://www.asrt.org/Content/News/PressRoom/PR2011/hospitalwo110921.aspx