Hospitals on the Brink: An Rx for Population Health

Strategic Webinar

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What Hath 3rd Party Fee-For-Service Wrought?

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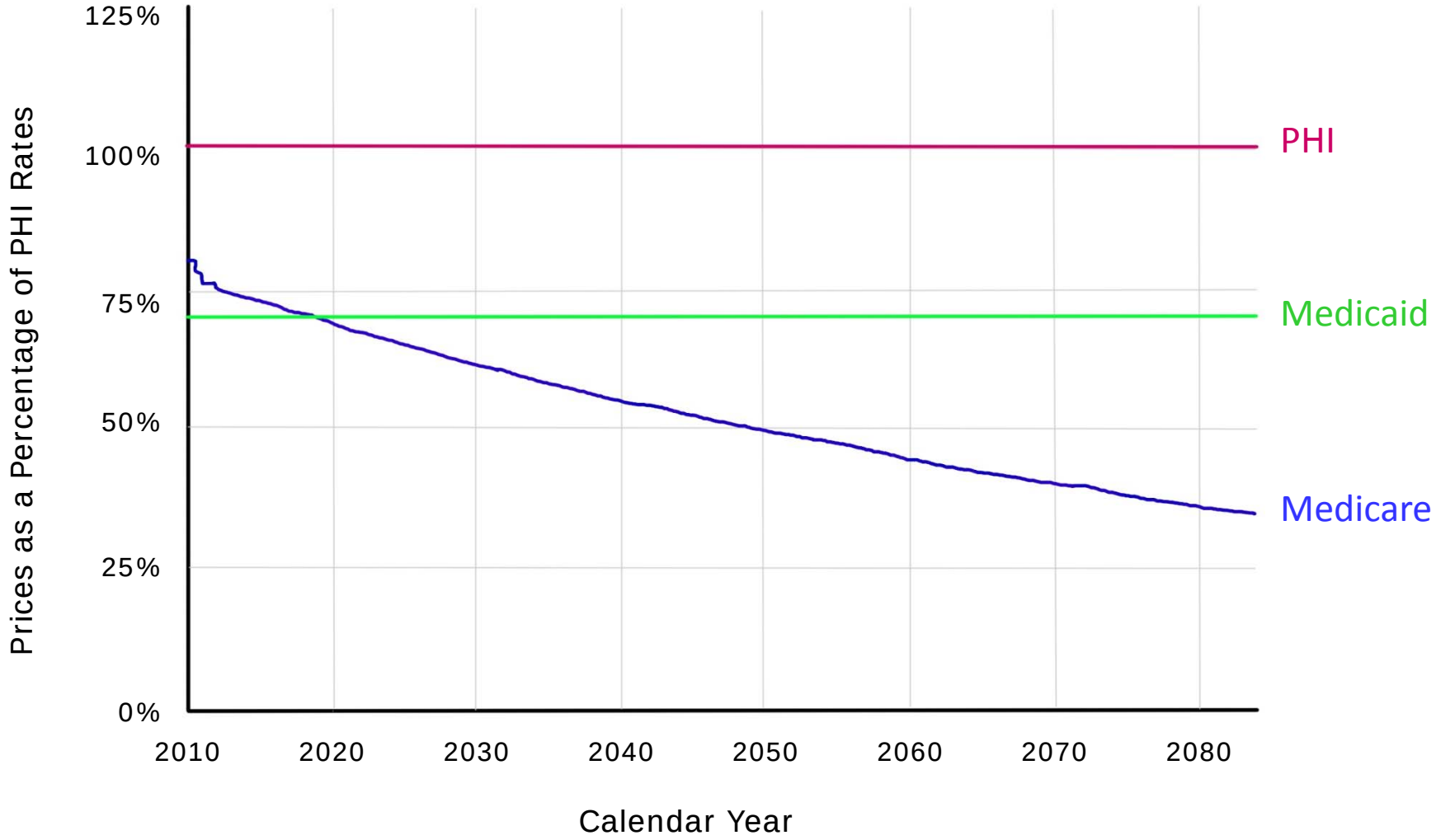
1. 30-40% of all medical expense is wasted[1]
2. Half of all medical care is substandard[2]
3. 75% of medical costs treat preventable disease[3]
4. Transaction costs consume up to 31% of every health care dollar[4]
5. Hospitals facing reimbursement pressure from *all* payers[5]

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
5 Hospital Revenues In Critical Condition; Downgrades May Follow Moody's Investors Services 8/10/11

Medicare FFS rates vs Medicaid and Private Health Insurance (PHI)

Insurance Reimbursements Under Current Law (assumes constant Medicaid, PHI rates)



Source: CMS Office of the Actuary - 2010

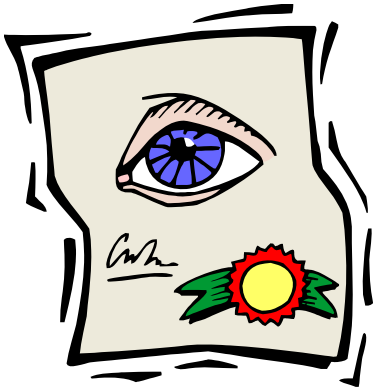
State Medicaid Cuts

- "White House Backs States' Power To Cut Medicaid Payment Rates"
- "California to reduce certain Medi-Cal payments by 10%"
- "13 States Cut Medicaid to Balance Budgets"
- New York State to eliminate most Medicaid FFS by 2016
- "State Medicaid hospice cuts deeper than originally portrayed"

Commercial Insurance Pressure

- Increased regulatory scrutiny of premium increases
- Expect lower hospital rate increases as payers face financial challenges
- Hospitals' ability to cost-shift to commercial payers will be reduced

Hospital Revenues In Critical Condition; Downgrades May Follow Moody's Investors Services 8/10/11



Wanted: Better patient value

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}$$

The good news & bad news about improved value

Higher quality generates lower per-capita patient costs...

... which, under FFS, can kill your hospital.

For example

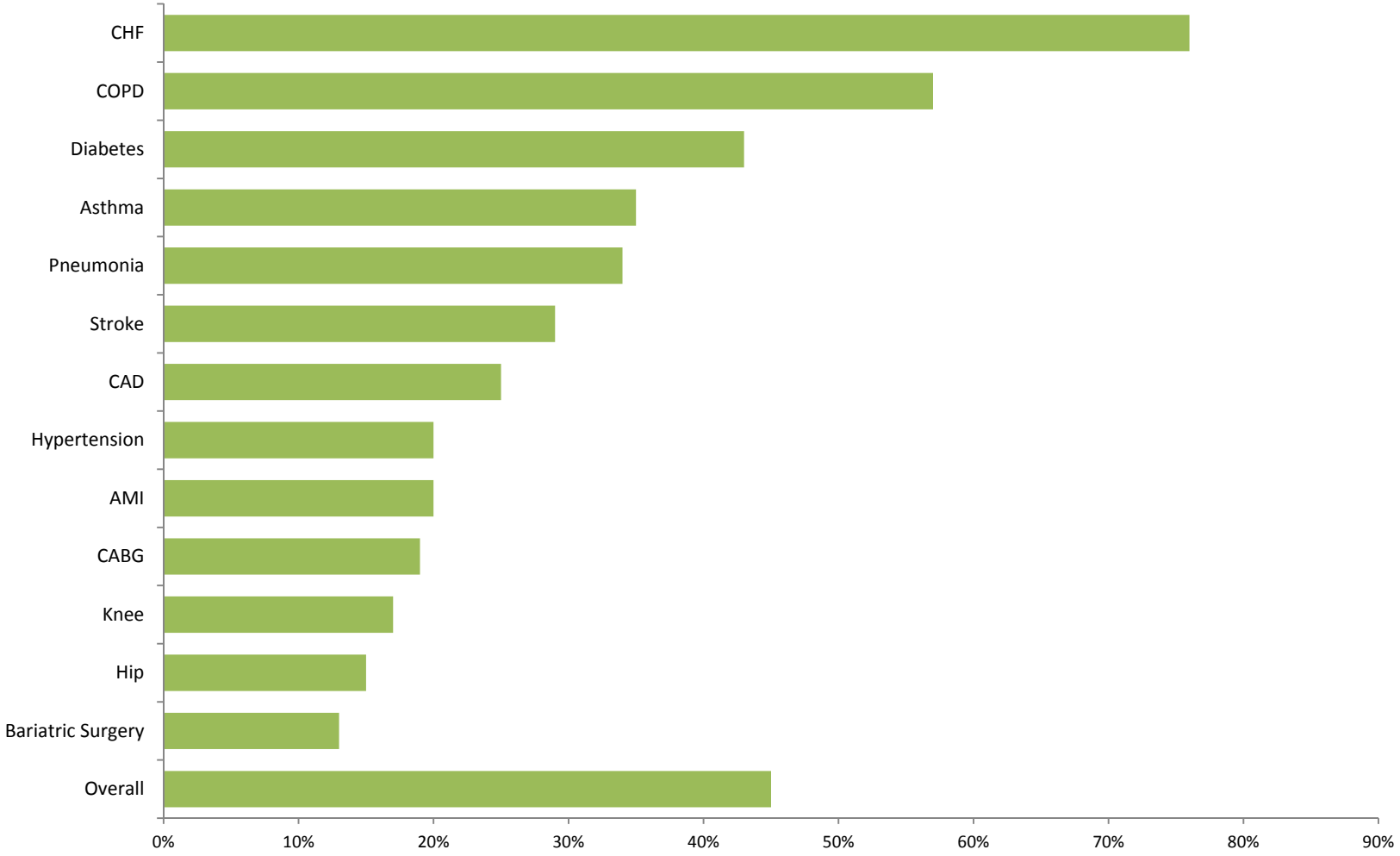
A Duke University Hospital CHF program reduced hospitalizations & lengths-of-stay and cut total costs by 40 %, or $8,600 per patient…

…but because there were fewer complications and hospitalizations, the hospital actually lost money from reduced FFS revenues, and the project was discontinued.

"Specialty Hospitals, Ambulatory Surgery Centers, And General Hospitals: Charting A Wise Public Policy Course," by David Shactman; Health Affairs, 04/05

Quality-Driven Cost-Reduction Opportunities

Cost of care defects as % total cost of care for each condition/procedure



Source: Health Care Incentives Improvement Institute, Inc.
Prometheus Payment 2009

Wanted: New provider revenue models…

1. …that incentivize & reward providers for improving quality and reducing per-capita costs, and…

2. …that penalize providers that don't.

3. If you want per-capita results , you need per-capita revenue models that allow you to capture the savings you generate, or…

The C-Word

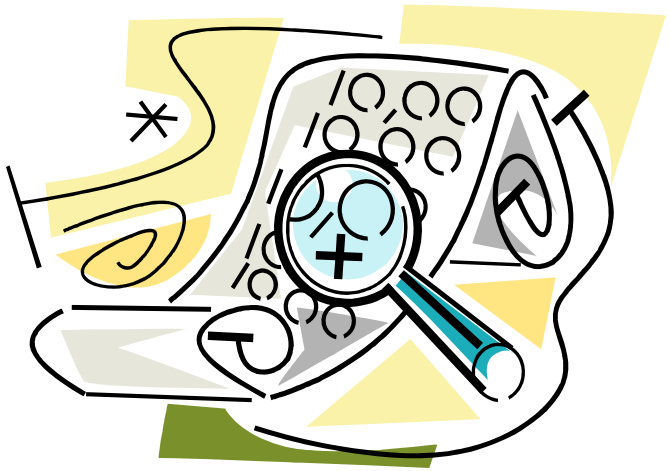
The new revenue model: capitation without decapitation

Successful capitation-based revenue models require 3 things

1. Focused commitment on improved quality and reduced per-capita cost

2. Actuarial confidence

3. PMPM cost measurement and management



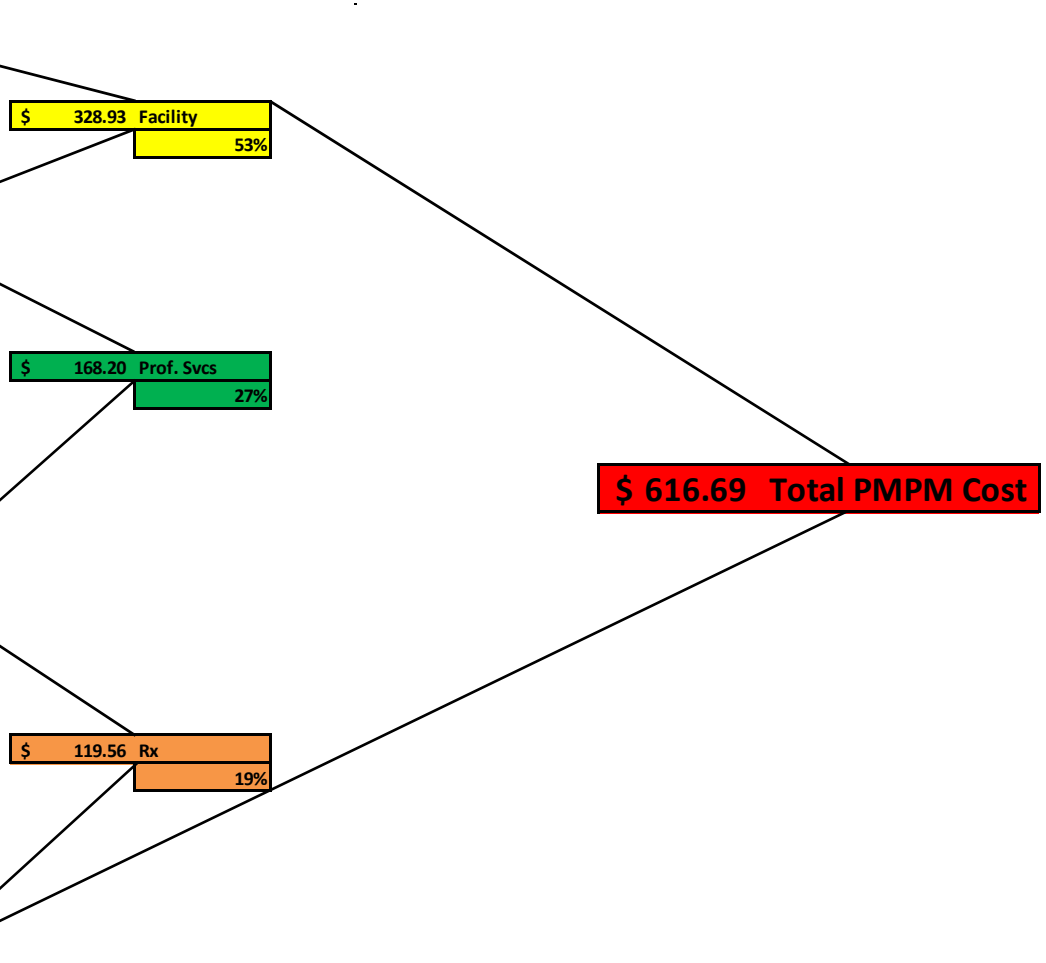
Getting there:
1. Develop your narrow provider network

- Get serious about quality
  - Provider selection
  - Quality credentialing
  - Quality measurement
  - Quality reporting
  - Quality management
  - Provider pruning
- Make available only for population-based payer contracts, *NOT* FFS.
- Develop value-based provider compensation system to reward
  - Achieving quality standards
  - Productivity
  - Cost effectiveness
- Develop your capitation-management system

Develop your capitation-management system

Capitation Management Dashboard ™

Period: Q1 2013	Mbrs (Avg)	8,000
Hosp IP Admissions/1000 MPY (incl SNF/Rehab)	65	PMPM
x Avg Length of Stay	5.0	
Bed Days/1000 MPY	350	
Avg Cost/Day	$ 3,500	$ 102.08
Ambulatory Facility Svcs/1000 MPY	4,303	
Avg Cost/Svc	$ 633	$ 226.84
MD PCP Visits PMPY	5.00	
Avg Cost/Visit	$ 140	$ 58.33
MD OB Visits PMPY	0.25	
Avg Cost/Visit	$ 275	$ 5.64
MD Specialist Visits PMPY	2.75	
Avg Cost/Visit	$ 170	$ 38.96
PA Visits PMPY	0.10	
Avg Cost/Visit	$ 100	$ 0.83
NP Visits PMPY	0.10	
Avg Cost/Visit	$ 125	$ 1.00
Non-Md Specialist Visits PMPY	5.25	
Avg Cost/Visit	$ 145	$ 63.44
Generic Rx's PMPY (<$1000)	13.0	
Avg Cost/Rx	$ 25	$ 27.08
Multi-Source Brand w Generic PMPY (<$1000)	0.25	
Avg Cost/Rx	$ 30	$ 0.63
Single-Source Brand PMPY (<$1000)	5.0	
Avg Cost/Rx	$ 150	$ 62.50
Multi-Source Brand wo Generic PMPY (<$1000)	1.1	
Avg Cost/Rx	$ 60	$ 5.78
Non-Drug Item PMPY (<$1000)	0.50	
Avg Cost/Item	$ 65	$ 2.71
Unk Item PMPY (<$1000)	0.002	
Avg Cost/Item	$ 180	$ 0.03
Rx >$1000 PMPY	0.20	
Avg Cost/Rx	$ 1,250	$ 20.83



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- Focus on PCP/PCMH as your new, highest level profit center.

Capitated PCMH profit-center potential

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Average PCP patient panel size	2,300*
x Average per capita patient spending	$7,087**
=Potential Capitation Revenue per PCP practice	**$ 16,300,100**
Bottom-line savings-capture potential per PCP:	
PMPM cost reduction @ 5%	**$ 815,005**
PMPM cost reduction @ 10%	**$ 1,630,010**
PMPM cost reduction @ 20%	**$ 3,260,020**

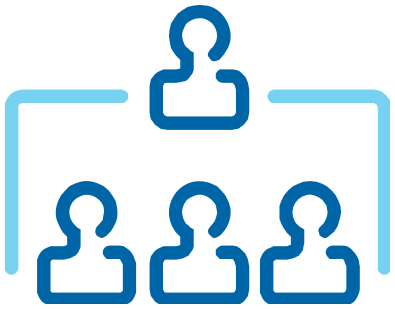
*http://link.springer.com/article/10.1111%2Fj.1525-1497.2005.0233.x
**http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf (Chart 1.3 (p5) $2.19T personal health care spending divided by 309 million pop from http://www.census.gov/2010census/popmap/)

Getting there:
2. Establish 4 rules for participating payers

1. Voluntary , positive PCP patient attribution
2. Claims and demographic data sharing
3. Capitation-based payment model
4. Collaborative relationship as feasible

Getting there:
3. Organize for population health

- Current org structure designed for FFS
- Begin restructuring for profit centers becoming cost centers
- 3 phases
  1. Multi-disciplinary Tiger Team with C-suite leader
  2. Morphs into Department of Population Health
  3. Reorganize for long-term population-health business model



Department of Population Health
Sample Org Structure

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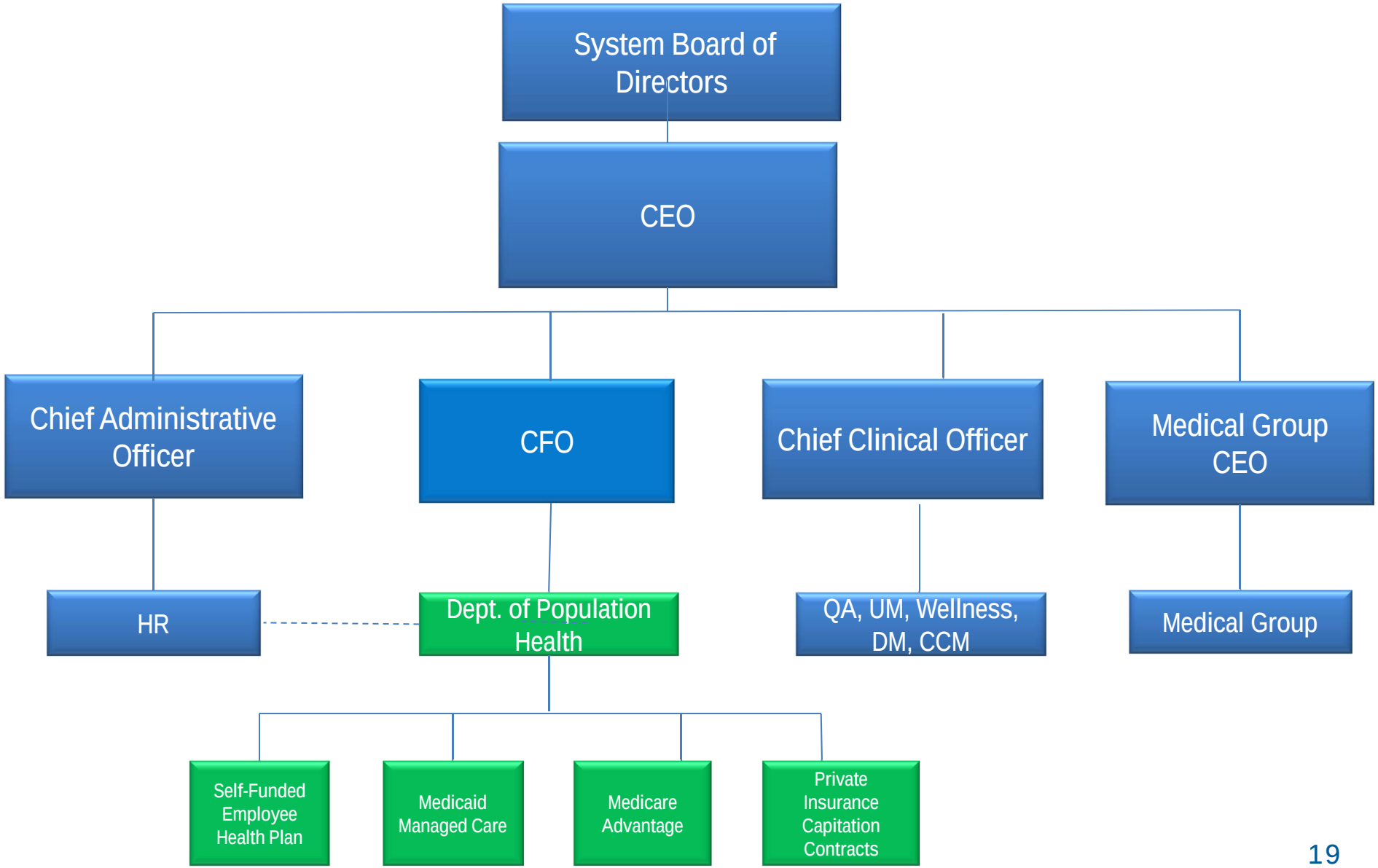
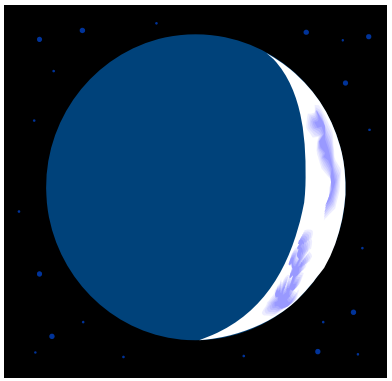


Getting there:
4. Prioritize your markets & take the initiative

- Optimize your self-funded employee health plan
- Private health insurers
- Medicare Advantage
- Medicaid managed care
- Insurance exchanges
- Self-funded employers

Getting there:
5. Capitation implementation

- Phase in capitation as actuarial confidence grows
  - FFS against capitation benchmark w/ shared savings
  - Partial capitation & sub-capitation options w/ shared savings
  - Global capitation
  - Reinsurance as indicated
- Capitation Management Dashboard (or equivalent) from Day 1



Getting there:
6. Advanced options

- Co-branded JV provider-sponsored-health plan
- Start or acquire your own health plan
- Medicare ACO

Getting there:
7. Operational efficiency improvement

- Baseline requirement
- Fine-grained cost accounting
- Waste reduction
- LEAN
- Six Sigma
- CQI, etc.

Getting there:
8. Adopt rapid learning curve

- Develop your strategy
- Start where beating your personal best is sufficient (e.g., ee health plan and/or private insurers)
- Rapidly move up your learning curve
- Expand into external government markets
- Borrow good ideas
- Ask for help

What success will look like

- Profitable arrangements with all private payers for population-based payments
- Medicare a significant profit center
- Medicaid profitable
- Five-Star ratings on quality, customer service, workplace
- Doctors getting A's on their quality scorecards
- Empty beds, ER, OR = better bottom line
- You're THE go-to brand

"What we have before us are some breathtaking opportunities disguised as insoluble problems."

- JOHN W. GARDNER

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