Surviving Health Reform: 1. The ACO is Dead…Long Live the ACO

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Three Trends That Will Change Everything…
Including Your Business Model

Three trends driving business model change

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1. Growing under-reimbursement for FFS
2. Rising patient out-of-pocket payments
3. Return of individual insurance choice

1. Growing under-reimbursement

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- Continued Medicaid FFS deterioration
- Medicare FFS rates below Medicaid's by 2020
- Employers less willing, able to endure cost shifting
- FFS penalizes high-value providers

2. Rising Patient OOP

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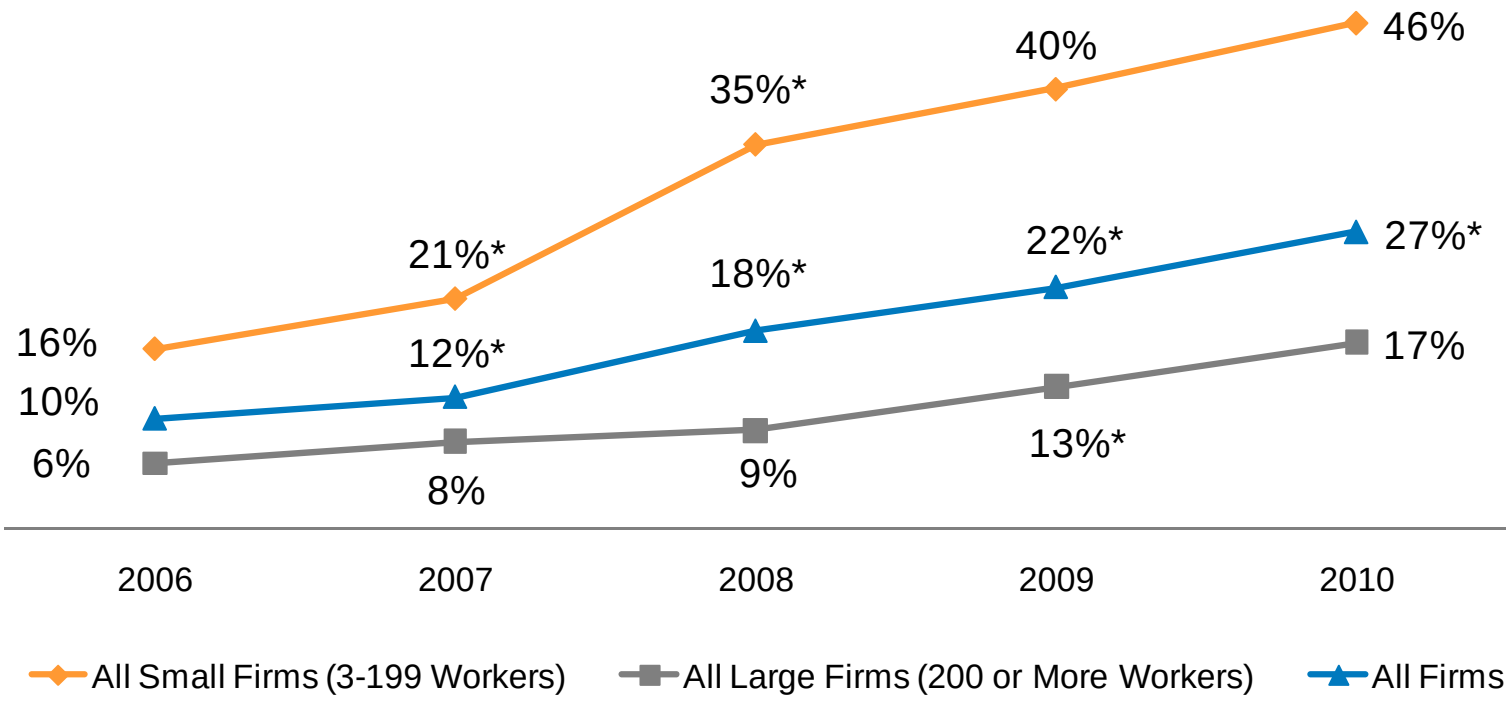
% of Workers With Deductible of $1,000 or More



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2010.; Single Coverage

2. As high deductibles become standard

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- Health insurance becomes less relevant for most
- Growing provider collection problems
- Increased patient demands for nonexistent info
- Changes in customer behavior—my knee

3. Return of individual insurance choice

1. Medicare Advantage
2. Medicaid Managed Care
3. Individual insurance exchanges
   a. 2014: Individuals and small employers
   b. 2017 (or earlier): All employers

Effects of the 3 Trends

- Individuals increasingly controlling ALL the money
- Employers leaving health benefits—an informal poll
- Transfer of insurance choice from HR to individuals
- Return of local insurance markets
- Opportunity for local, value-based provider health plans
- Current provider FFS revenue/collection model is dying
- Increasing emphasis on medical value over volume
- FFS-dependent providers financially stressed
- Medical providers must find new business models
- Remembering what happened last time

"Gentlemen, we have run out of money. It is time to start thinking."

Sir Ernest Rutherford, Nobel Laureate (Physics)

Monetizing Patient Value:

ACOs and Beyond

What is an ACO?

A mechanism for providers to capture savings generated from providing high-value patient care.

Medicare's proposed ACO is just one, disappointingly inadequate form of ACO.

What is patient value?

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

Whoever spends the money gets to define value.

Now, that would be CMS and large employers.

Increasingly, it will become the patient.

Higher quality actually generates lower total cost.

What is “Quality”?

- Quality = Fitness to satisfy a defined need
- Not an undefined intangible
- Objective measurement of processes and outcomes
- Includes everything that affects patient value…
- Including customer service

How Do Medical Providers Produce Value?

- Provide consistent, high quality medical care…
- That adheres to best practices…
- Minimizing variation…
- At lower total cost…
- Without providing unnecessary care…
- With superior customer service…
- All delivered to demanding patients who increasingly control *all* the money

What Are The Potential Savings?

4 fundamental problems with American health care

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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 31cents on dollar[4]

If we fix all these problems, then medical care will have twice the quality at a quarter the cost.

All fixable by Level 4 ACOs.

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

Medical Value Opportunities, Examples

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Hospital overutilization	>10%
Nosocomial infections	$28,750 ea
Peri-acute chronic readmissions	25% overutilization
Implantable defibrillators	20% @ $25k
Sleepy surgeons	83% higher complication rates
Unnecessary imaging	25+% overutilization
Prescription drugs	20-35% excess spending

Some of These Are Easy: Saving 35% on Rx in 60 Days

1. **Replace copayments with coinsurance**
2. **Hire 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

4-Component Value-Based Business Model

1. Measure medical quality and cost
2. Improve both with 80/20 priority
3. Selectively implement bundled/transparent patient pricing
4. To monetize above, implement continuum of ACO savings-capture mechanisms

ACO Value Chain → Value Proposition

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Level 4: Provider-Sponsored Health Plan	Full Premium Capture, 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: Full-Risk/Reward ACO	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, 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 VBPP/ACOs, Medicaid ACOs, Commercial ACOs

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Why Start At Level 2: Your Self-Funded Benefit Plan?

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1. It's already a provider-sponsored health plan.
2. No additional risk beyond what you already accept.
3. You're probably undermanaging it.
4. Allows full claims analysis for 80/20 management.
5. Beating your personal best is good enough.
6. It's a major expense; savings could be substantial.
7. You're probably enabling unhealthy behavior.
8. No additional government regulation.
9. If you can demonstrate savings here, you can do it anywhere.
10. If you don't do it here, how can you expect to sell value to others?
11. Do it well and you can skip to Level 4.

ACO Value Chain → Value Proposition

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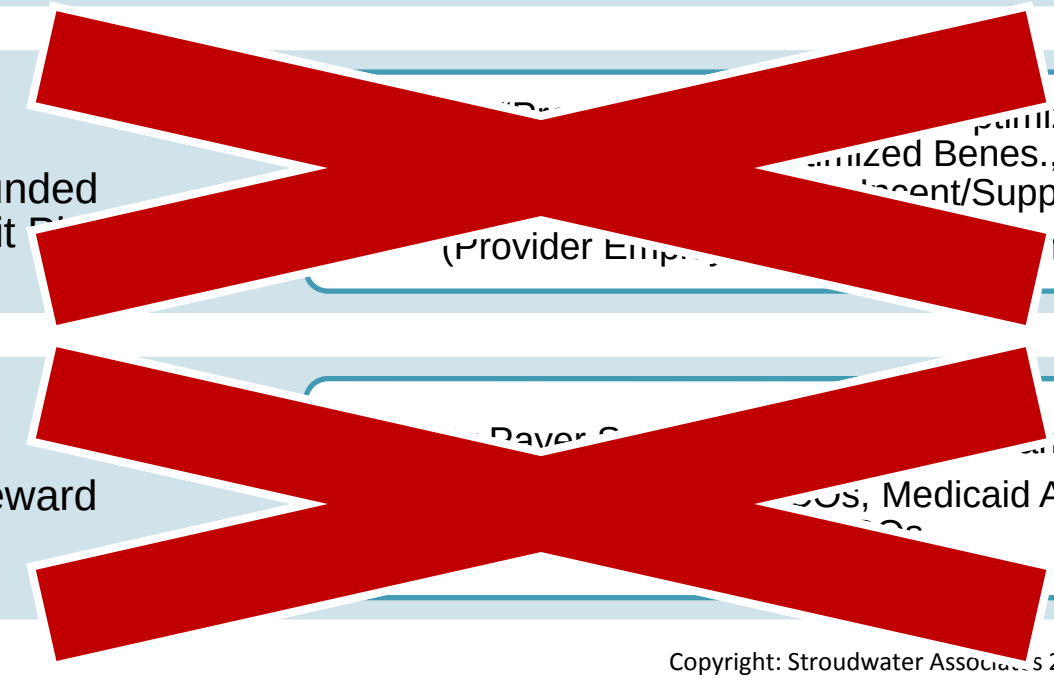

Level 2 ACO Self-funded Employee Benefit Plan Assessment

1. Review benefits & model options to optimize
   - Plan/patient cost-sharing & funding
   - Incentive structures
     - Individual utilization/cost
     - Individual prevention
2. Conduct claims analysis and ID initial 80/20 benefit-cost opportunities
3. Assess current medical value proposition & improvement processes
4. ID optimal limited-network opportunities, risks
5. Conduct financial modeling and projection scenarios
6. Make it so

If You're Interested:

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a) Email me a confidential copy of your self-funded health plan benefits brochure.
b) I'll conduct a preliminary assessment and options analysis.
c) I'll share my findings with you via telephone conference.
d) Without charge.

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Important to understand

This isn’t easy.

It is doable.

Others have done it.

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

- JOHN W. GARDNER

Some Strategic & Operational Provider Considerations

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- Viewing Provider Profit Centers as Value-Based Cost Centers
- Eliminating Dependence on 3rd Party Payer FFS Reimbursement
- Embracing Patient FFS Reimbursement
  - From Chargemasters to Pricemasters
  - Published Transparent Pricing
  - Pre-Service Estimates
  - Bundled Pricing
  - Services Warranties
- Significant Revenue Cycle Management Opportunities
- Significant Cost Accounting Opportunities
- Charge Capture/Cost Control Opportunities
- Physician/Hospital Functional Integration Issues
  - Quality measurement/management
  - Process reengineering/continuous improvement
  - Bundled payment approaches
  - Physician compensation formulas
- M&A
  - Physician/Hospital Integration
  - Product Hole-Filling
  - Referral Control (both ways)

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