Transformation of Health Care:

Moving past the Hype and Leveraging “ACO” Initiatives for Competitive Advantage

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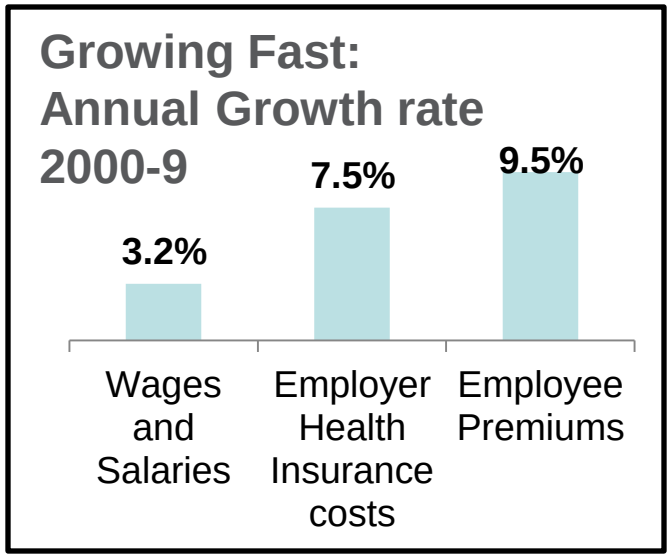
Summary of Our Thinking

1. **The pressure by all payors to reduce total medical expenditures will be drastic and unrelenting for providers**
2. **Until providers figure out how to reduce total medical expenditures, payors will continue to reduce payment per-unit under fee-for-service reimbursement**
3. **For a host of reasons, Medicare will likely not be the first patient population to be addressed for systematic restructuring**
4. **That said, we recommend that health systems:**
   a. **Deploy all infrastructure that is self-financing (i.e., EHR via ARRA, wellness visits, PQRI)**
   b. **Leverage their role as an employer to aggressively manage their own employees' healthcare; besides serving as an ideal "alpha client", the "employer" has complete control over all benefit and reimbursement policies**
   c. **Approach local employers to manage their health care costs, offering a customized health system that targets their specific needs**
   d. **Deploy new "ACO" capabilities to improve "system performance" for the goal of increasing market share, even under fee-for-service reimbursement**
   e. **Develop an explicit strategy for Medicare and for Medicaid, which includes determining when to form an ACO (based on projected financial performance versus FFS) and which patients to "enroll"**
5. **Since an "ACO" initiative involves redefining the scope of the organization, health systems should recognize that it is strategic in nature. Therefore, an ACO should be considered as a means to accomplishing the long-term goals of the organization**

Cost Pressures Will Continue to Grow on Providers

- Commercial premiums and employee costs have increased far faster than wages
- Employee benefit consultants project 60% growth in employer costs over the next 5 years on a "stand still" basis *
- Employers do not view PPACA as a solution:
  - 60% of all employers believe that the "intention of health reform [was] to eliminate the employer-based system and move to a single-payer system" **
  - "22% of all employers (and 12% of large employers) say it's likely they will drop coverage." **



- Many states are responding to budget difficulties by reducing Medicaid funding (both eligibility and provider reimbursement)
- The Medicare Trust Fund Balance (negative) was "improved" by PPACA only via provider payment reductions, most of which are forthcoming

Sources: * AonHewitt, "Health Care Strategy in a Post-Election World," November 4, 2010
** Midwest Business Group on Health, "Key Findings of Employer Reaction to Health Reform", December 2010

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Is today a repeat of the late 1990s? Are ACOs the new fad?

Key Elements of an ACO

- They emphasize ***primary care***
- They can ***achieve savings*** for a payer by ***effectively integrating care*** across providers
- ***Providers share*** with payers in the ***savings*** that providers generate
- The savings are not at the expense of ***quality***
- ***Providers*** are **at-risk** for ***improving quality and reducing costs***
- Improvements are measured ***across a specified population***

Source: Congressional Research Service

Advisory Board "Book"	Year
The Grand Alliance: Vertical Integration Strategies for Physicians and Health Systems	1993
Capitation Strategy	1994
Emerging from Shadow: Resurgence to Prosperity under Managed Care	1995
Medicare Strategy: The Race to Retail Coverage	1997
Partnership at Risk: The Precarious State of Specialist-Health System Relations	1998
Primary Care Strategy: Toward a Sustainable Partnership with Primary Care	1999
Playbook for Accountable Care	*2010*

Key difference: 1990s were focused on commercial payors,

2011 ACOs are Medicare-driven

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Concerns regarding Medicare ACOs

Structural issues with ACOs as designed by PPACA & CMS

1. Patients do not even know they are in an ACO
2. No ability to force care into a managed network
3. The initial financing vehicle, FFS with shared-savings-bonus, does not provide funding (or cash flow) for infrastructure
4. Reliance on FFS eliminates ability to use withholds, modify FFS rates at all, and purchase reinsurance (specific or aggregate)
5. Medicare's Fiscal Intermediaries lack capability to provide timely usage data
6. Limited to Part A and B (not prescription drugs)
7. No risk adjustment (announced yet)
8. Relatively unattractive incentives

Relative Difficulties: Medicare vs Commercial

1. Vast scope of covered services: inpatient (acute, rehab and SNF), outpatient, hospice, home health, and DME
2. Medicare only covers half of beneficiaries' total medical expenses
3. Average use rates (e.g., days/1,000 for medical DRGs) are multiples higher than Commercial lives
4. Virtually all beneficiaries have 1+ chronic conditions; annually the average beneficiary has 30 scripts and sees 5-7 physicians
5. Ten percent of the beneficiaries account for 63% of total expenditures (with $44,000 average expenditures)
6. End-of-life is costly: 25% of total Medicare expenditures
7. In some markets, seasonal migration complicates care (e.g., NY to Miami)
8. Patient outreach is relatively difficult (e.g., low Internet usage hinders common tools such as Health Risk Assessments)
9. "System design" faces regulatory barriers (Stark, anti-kickback, anti-trust)

Recent evidence does support some initiatives

Initiatives supported by recent research

- Patient-centered medical home
- Chronic care management (in particular heart failure)
- Worksite clinics
- Re-admission prevention efforts
- Intensive patient coaching

Employers are trying to manage care

- "Almost 60% of all employers will expand wellness programs in light of increased incentives allowed" *
- Employers with worksites of 500+ employees are increasingly operating worksite primary care clinics

*** Midwest Business Group on Health, "Key Findings of Employer Reaction to Health Reform – Post Election Survey," December 22, 2010**

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Relevance of "ACO" Initiatives by Payor

Payor	Observation	Implications
Medicare	Reimbursement reform will occur *eventually* in a fashion that is implementable by providers, since FFS is not sustainable	Prepare/plan for adoption in 3-5 years; providers will want to build experience in low-risk "experiments" over next 24 months
Medicaid	Payors are "preparing to capitalize" on anticipated explosion in Medicaid growth in 2014 *	Unless providers get aggressive in the management of total cost (which is not necessarily capitation), payors will squeeze any remaining *margin* for Medicaid care
Employers	52% of large employers want their own ACOs **	These firms are thereby open to restrictive networks, so market share is at risk for the payor that accounts for 200% of provider profits; very few regulatory constraints

*** "Insurers Bid for State Medicaid Plans," Wall Street Journal, December 29, 2010, B1.**

**** Midwest Business Group on Health, "Key Findings of Employer Reaction to Health Reform – Post Election Survey," December 22, 2010**

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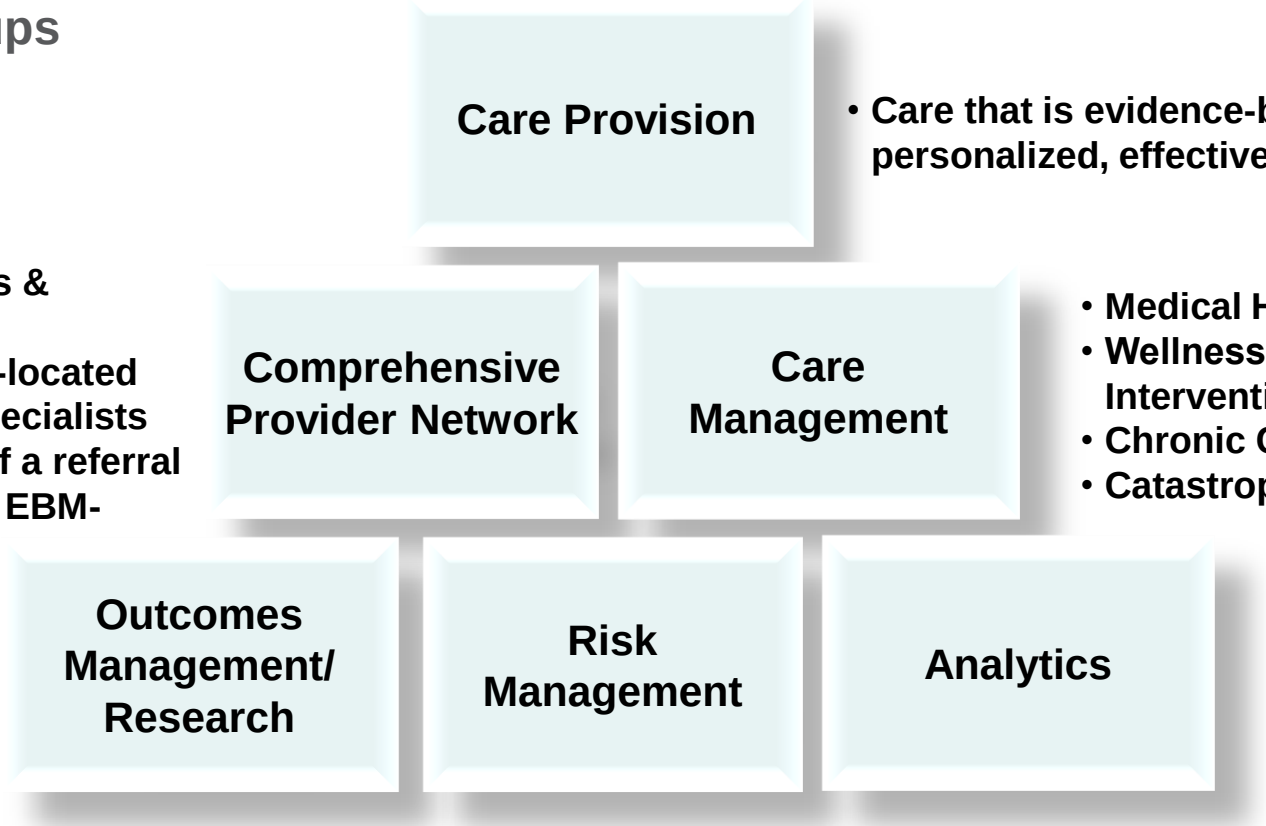
Competencies Required to Provide Value-Based Care

Once these core competencies are established, health systems will have the ability to align serve Medicare patients in an ACO, but also to serve other patient groups



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Competencies necessary for an ACO also support Direct Contracting with Employers and Growing Market Share under Fee-for-service

Competency	Competency Requirement			
	Health Plan	ACO	Employer Contracting	FFS Mkt Share
Care provision that is EBM, personalized, effective & efficient	◆	◆	◆	◆
Comprehensive Provider Network (access, goal-aligned, EBM-compliant)	◆	◆	◆	◆
Care Management (Medical Home, "At-risk" interventions, Chronic, Catastrophic)	◆	◆	◆	◆
Outcomes Management (measurement, efficacy, research)	◆	◆	◆	◆
Risk Management (risk pool mgmt, underwriting, pricing, reinsurance)	◆	◆	◆	
Analytics (complex segmentation & co-morbid, account-specific claims analysis, predictive modeling, "two-paradigm" analysis, actuarial)	◆	◆	◆	◆
Claims & Cash Mgmt. (claims processing, customer service, provider relations, member enrollment)	◆			
External Relations (regulatory compliance, advertising, broker mgmt & sales)	◆			

Virtually all capabilities of a successful ACO would be useful in (a) meeting the medical needs of an employer and (b) improving health system performance under FFS to grow market share

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Observations and Strategic Conclusions: Employers

1. Employers have turned to Worksite Clinics, Coaching/Wellness, and Disease Management because the healthcare system has failed them by not offering:
    a. Systematic population health management
    b. Identification of undiagnosed conditions
    c. Behavior change for chronic conditions and prevention
2. This has led to parallel health care systems:
    1. Employer-payor for employees/dependents
    2. Hospitals and MDs for patients
3. An integrated system would coordinate all efforts (employer and provider) to meet employee/patient needs
4. A health "system" should adopt proven vendor concepts and **organize its capabilities around the needs of employers**; this integrated *system* should outperform "point solutions" sold by vendors

Steps for Achieving Strategic Objectives via ACOs

1. Update the current strategic plan, including best-guess estimate for financial performance (including capital investments) under tough assumptions (e.g., reimbursements declining 2% per year in real terms); assume that current "vague" plans for physician employment are actually implemented
2. Evaluate the current strategic position in all three payor segments (Medicare, Medicaid, large employers (direct) and other commercial):
    a. Payor relations (profitability; strength of network versus competitors; non-traditional reimbursement)
    b. Clinical programs and scope of services, by population need
    c. Market share and financial performance
3. Assess current capabilities for each of six ACO competencies, quantify gaps, and identify potential approaches for eliminating each gap
4. Review the current physician/hospital integration strategy in terms of addressing ACO and other strategic needs (e.g., of the MDs needed for an ACO, how many are currently in the ideal integration setting)
5. Identify those ACO and integration capabilities that would help achieve some strategic objectives under fee-for-service
6. Prioritize efforts, focusing first on those which accomplish 2+ objectives (e.g., grow market share under FFS, prepare to manage care in an ACO)
7. Re-organize to match the needs of the new strategic priorities
8. Identify 3-5 short-term "wins" and execute (e.g., manage your self-insured employee health plan as your first "ACO")

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