Managing Costs in an ACO Environment

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Reform has sparked reform. But results won't happen without reduction in costs.

At its roots, the ACO model is about changing the reimbursement structure of the U.S. healthcare system toward one that **pays for the quality of care delivered** (and, by derivative, the outcomes achieved) versus the units of service provided.

- Beyond ACOs: The Pending Risk Shift to Providers, William Blair

Hospitals with **strong market power and higher private-payer and other revenues have less pressure to constrain their costs**. Thus, these hospitals have higher costs per unit of service, which can lead to losses on Medicare patients. **Hospitals under more financial pressure**—with less market share and less ability to charge higher private **rates—often constrain costs and can generate profits** on Medicare patients.

- MedPac, Health Affairs, May 2010

Blue Shield of California gives $20M in **ACO Help**

- Healthcare IT News, October 18, 2011

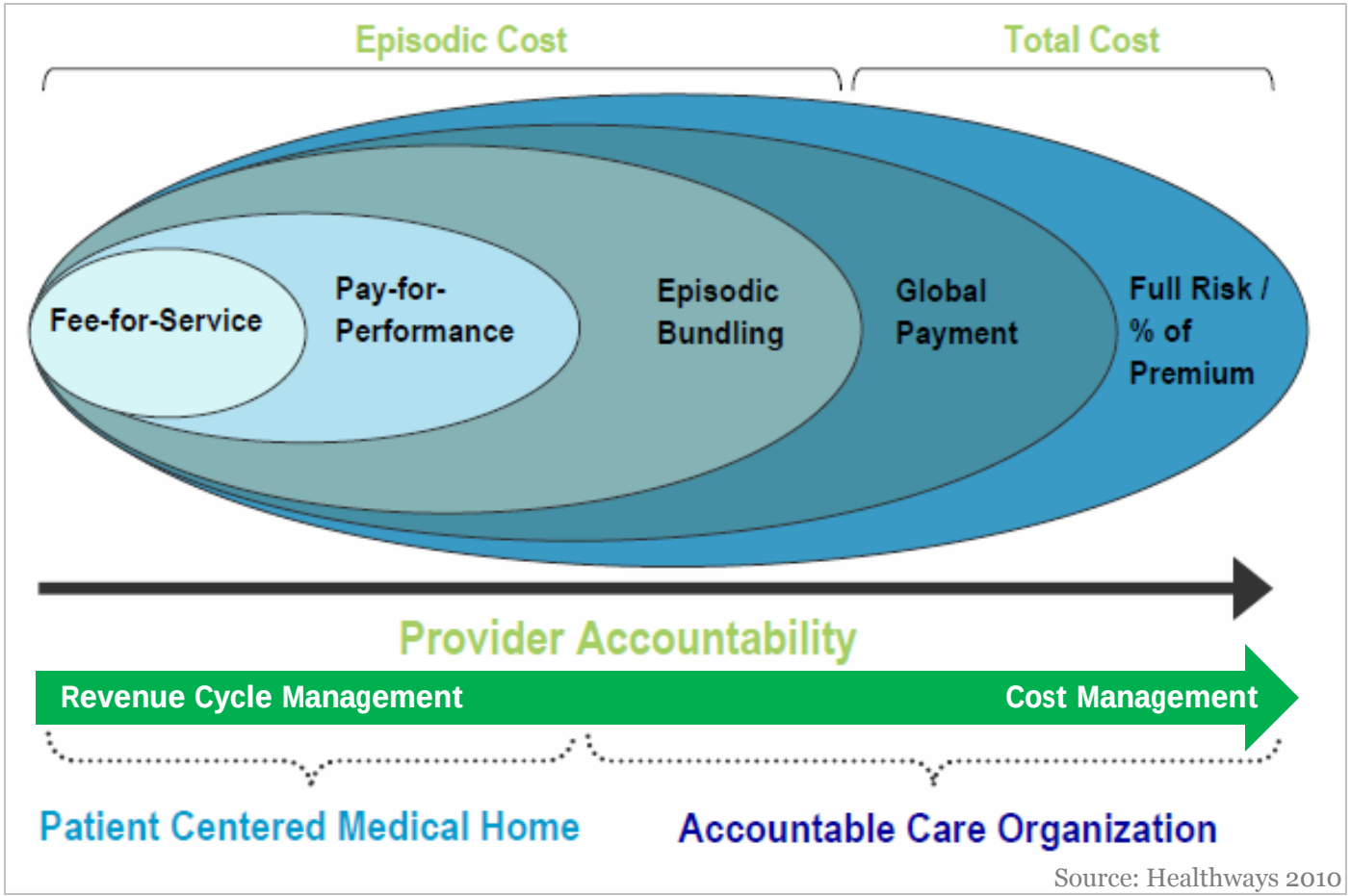
Advocate Health Care and Blue Cross and Blue Shield of Illinois have announced an agreement that **holds the health system and its physicians accountable** for the care they provide, essentially operating as an accountable care organization.

- Chicago Breaking Business, Oct 2010

Massachusetts Tries to Rein In Its Health Costs

- NY Times, October 17, 2011

ACOs require a shift in Provider accountability and a migration from focus on Revenue Cycle Management to Cost Management.



Source: Healthways 2010

The current system cannot sustain itself without a focus on cost management and lowering the total cost of care.

Hospitals and Specialists

- Improved Patient Care Efficiency
- Use of Lower-Cost Treatments
- Reduction in Adverse Events
- Reduction in Preventable Readmissions

Requires use of hospitalists, practice-based case management & outreach, and cost-effective hospitals and providers.

All Providers

- Improved Management of Complex Patients
- Use of Lower Cost Settings & Providers

Primary Care Practices

- Improved Prevention & Early Diagnosis
- Improved Practice Efficiency
- Reduction in Unnecessary Testing and Referrals
- Reduction in Preventable ER Visits and Admissions

Groups are provided information on services needed (prevention & chronic care) and are actively managing patients at risk for ER and hospital utilization.

There is an increasing emphasis on collaboration between Payors and Providers. Success will require an improvement in costs, efficiencies and outcomes.

Hospital	Hospital A (South Region)	Hospital B (Near West Region)	Hospital C (South Region)	Hospital D (Near West Region)	Hospital E (Far West)	Far West Median	South Median	Near West Median
Margin	11%	1	5	14	-9	2	4	1
Medicare Margin	-11%	-29	-6	-7	-10	-16	-1	-12
Cost per Discharge	$14,493	13,924	14,907	11,825	15,779	34,462	19,614	22,052
Medicare Cost per Discharge	$14,349	16,092	16,696	13,638	12,363	25,953	17,522	19,068
Supply Cost per Discharge	$6,274	5,157	6,726	4,928	4,870	14,462	9,151	9,861
Occupancy Rate	71%	52	91	75	42	79	80	71
FTE per Occupied Bed	7.7	11.7	7.7	5.5	8.3	10.6	8.6	10.2
ALOS	6.3	4.4	4.8	4.7	3.8	5.3	5.6	5.4

Source: 2009 Medicare Cost Reports

Same hospitals as compared to hospital medians from Chicago, Indiana and Wisconsin.

Hospital	Hospital A (South Region)	Hospital B (Near West Region)	Hospital C (South Region)	Hospital D (Near West Region)	Hospital E (Far West)	Chicago Median	Indiana Median	Wisconsin West Median
Margin	11%	1	5	14	-9	0	1	3
Medicare Margin	-11%	-29	-6	-7	-10	-19	-38	-33
Cost per Discharge	$14,493	13,924	14,907	11,825	15,779	15,334	23,540	21,675
Medicare Cost per Discharge	$14,349	16,092	16,696	13,638	12,363	14,313	17,401	16,724
Supply Cost per Discharge	$6,274	5,157	6,726	4,928	4,870	4,660	8,510	7,310
Occupancy Rate	71%	52	91	75	42	66	55	59
FTE per Occupied Bed	7.7	11.7	7.7	5.5	8.3	10.6	13.8	11.1
ALOS	6.3	4.4	4.8	4.7	3.8	8.3	4.3	4.3

Source: 2009 Medicare Cost Reports

Example of an Efficient System – GEISINGER

Geisinger Health
- Located near Danville, PA
- Physician-led health care system
- Serving 2.6 million people

Geisinger Health Plan
- More than 200,000 members
- Network of more than 37,000 providers (3,913 primary care, 33,337 specialists, 1,627 primary care sites and 96 participating hospitals

ProvenCare® Methodology

- Identify high volume DRGs
- Determine best practice techniques
- Deliver evidence based care
- Health Plan pays a global fee
- No additional payments for complications

Outcomes

- 80% improvement in in-hospital mortality
- 20% improvement in 30 day readmission
- 40% improvement in neurologic complication
- CABG
  - Hospital contribution margin + 17.6%
  - Health plan paid 4.8% less per case

Advanced Medical Home

- Partnership between PCP and Health Plan
- "Embedded" nurses
- Case management
- Personalized tools

Outcomes

- 25% reduced patient admissions
- 23% reduced days/1000
- 53% reduced readmissions

An Accountable Care Organization promotes high value care and higher margins.

Structure + High Value Efficiencies = Ability to take Risk and Increase Margin

Baseline Criteria

- Providers and Payors require a *structure* in the new, transformed state
  - Leadership must determine how broad they want to provide their integrated health system services
  - Determine organization (i.e. physician vs. strategic partnership)
- Providers must *consider the balance between geography and provider services offered*
  - Evaluate services, people, contractual status (risk/no risk) by geographical regions
- Providers must *inventory what tools, skills and capabilities* they have today, determine the gaps in current systems and how to fill those gaps
  - Understand what is required and how to fulfill need in technology, people and organization (buy, build, partner)
- Understand *best partnership options* in order to build a effective and efficient risk taking network
  - Also define who owns lives today to help access network and partnership options. Is it realistic to have a competitor also be a partner?

The landscape is complex and choosing partners requires understanding oneself and the target partner. Three types of partners meet different sets of needs.

- **Vertical**

  Knowledge and Tools for managing care (administrative services) can come from Vertical Partners, who have analytics, data and transaction processing capabilities that Health System will access and deploy. Vertical Partners may be managed care plans, management service organizations, or software vendors.

- **Horizontal**

  Markets and members that Health System desires to access will be aided by Horizontal Partners, who expand the service delivery capabilities of Health System across additional markets, segments or delivery modalities. Horizontal Partners include other hospital systems, organized physician entities, and community organizations within target service areas or clinical specialties

- **Global**

  Global Partners are entities who bring attributes of both horizontal and vertical partners, as they are provider organizations or delivery systems that own a full scale health plan and thus offer both market access as well as knowledge and tools.

Success Factors in the ACO World

1. Providers controlling the cost of health care and managing efficiencies within the system
2. Alignment of incentives and rewards for quality of care and outcomes
3. Technology and skills for population management and coordination of care
4. The ability to measure and report on the gaps and quality of care
5. Services taking place at the right time, at the right cost and in the right setting – shifting and balancing cost and revenues
6. A culture of collaboration between Payors, Providers and Patients
7. Infrastructure and skills for management of financial risk at the Provider level