The Journey to Accountability: Essential Competencies Necessary to Address Health Reform’s Failures and Fixes

-A Practical Guide-

1. There is no new money!
2. Avoid becoming a ‘false positive’
3. R³

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N8’s Qualifications

- 35 years in healthcare
  - Strategic advisor to health systems and medical groups
  - 72 publications
  - Faculty for ACHE, The Governance Institute, AHA, MGMA, AAFP and many hospital and physician associations
  - Focus: strategy, physician-hospital transactions, managed care, financial turnarounds, payer negotiations, education
  - 2005 Presentation Theme: Shelter from the Storm

- As Managing Director of Kaufman Strategic Advisors (since 2007)
  - On-site 305 health systems in 45 states
  - 230 physician transactions and valuations

- Hit rate of .800!

2011-2012 Publications

- Clinical Integration: Déjà vu All Over Again? Futurescan 2012, Health Administration Press
- Weathering Changes to Provider-Based Reimbursement, Hospitals and Health Networks Daily, May 30, 2012
- Streamlining Strategy, Hospitals and Health Networks, June 27, 2012
- Medicare ACOs: Not the Best Way to Start, Hospitals and Health Networks Daily, Aug 29, 2012
- The Co-Management Conundrum, Hospitals and Health Networks Daily, Sept 26, 2011
I think you should be more explicit here in step two.
“The data is out there, it is open, it is freely available; but openness alone does not drive change!”
Old habits die hard!

Five Reasons That Many Comparative Effectiveness Studies Fail to Change Patient Care and Clinical Practice

~Health Affairs October 2012

Ranking 37th - Measuring the Performance of the U.S. Health Care System

~Christopher J.L. Murray, M.D., D.Phil., and Julio Frenk, M.D., Ph.D., M.P.H.

In order to avoid being stuck in the past and change for the better we must:

• Be open to changing our minds
• Actively challenge and create conflict around our traditional beliefs
• Rapidly resolve resistance (R³)

~Margaret Heffernan TED Talk

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Critical Core Competency: Embrace Constructive Conflict

The ability for multiple provider entities, with divergent economic interests and different backgrounds, to work together and AGREE to care redesign to better meet the needs of defined populations of patients using a process such as LEAN.

- Invite Leaders Representing Divergent Views
- Radical Transparency of Information and Opinions
- Engage In Constructive Conflict and Reach Resolution
- Global Support For The Result
Who the Gods Want to Destroy They First Give 40 Years of Success

1975

Shrinking Sales
Kodak’s film revenue disappeared and it has shed businesses.

$10 billion
$15 billion
$20 billion
$2.5 billion

1980 85 90 95 00 05 10 11 12

*Estimate for businesses slated to remain with Kodak
Sources: FactSet, the company
The Wall Street Journal

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Is Bigger Better?

1980
• 618,365 Employees – largest world market share

1988
• Profits peaked at $4.6 Billion

2007
• Loss of $38.7 Billion – THE ultimate false positive

Independent Distributers

Parts Manufacturer

Financing Company

Complete Line of Repair Services

Unionized Workforce

Full Line of Niche-based Products

Low End Market

Senior Market

Male Market

High End Market

R&D

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Why GM Failed

- Focused on silo management vs. interrelationships
- Obsession with profits to the detriment of innovation, creativity and product quality (“the stranglehold of the accounting princes”)
- Minimized the impact of competitive threats
- Fought regulation
- High legacy pension/health costs and labor impeded the ability to flex cost with demand
- Culture suppressed dissent and bad news
- They made cars of variable quality that many people did not want to buy

It is unfortunate that most of the time “the gods must teach through suffering”

- Homer
Ford Returns to Profitability In 2009

ONE TEAM
People working together as a lean, global enterprise for automotive leadership, as measured by:
Customer, Employee, Dealer, Investor, Supplier, Union/Council, and Community Satisfaction

ONE PLAN
• Aggressively restructure to operate profitably at the current demand and changing model mix
• Accelerate development of new products our customers want and value
• Finance our plan and improve our balance sheet
• Work together effectively as one team

ONE GOAL
An exciting viable Ford delivering profitable growth for all

Expected Behaviors
Foster Functional and Technical Excellence
• Know and have a passion for our business and our customers
• Demonstrate and build functional and technical excellence
• Ensure process discipline
• Have a continuous improvement philosophy and practice

Own Working Together
• Believe in skilled and motivated people working together
• Include everyone; respect, listen to, help and appreciate others
• Build strong relationships; be a team player; develop ourselves and others
• Communicate clearly, concisely and candidly

Role Model Ford Values
• Show initiative, courage, integrity and good corporate citizenship
• Improve quality, safety and sustainability
• Have a can do, find a way attitude and emotional resilience
• Enjoy the journey and each other; have fun - never at others’ expense

Deliver Results
• Deal positively with our business realities; develop compelling and comprehensive plans, while keeping an enterprise view
• Set high expectations and inspire others
• Make sound decisions using facts and data
• Hold ourselves and others responsible and accountable for delivering results and satisfying our customers
Is there a collective goal in this delivery system?
Steal This Concept!

- Try to digitize everything
- Business purpose: make *truly great* products
- Components must be easy-to-use and seamlessly integrated
- Product design based on what they would LOVE to use
Who believes that they are overpaid for the work they do today in healthcare?

The Law of Reciprocal Economics:

One person’s cost is another person’s revenue.
Good strategy clearly defines a specific pathway through complexity, uncertainty, and resistance to achieve a desired level of performance.¹

**Bad Strategy**²
- Lofty goals, high hopes and unrealistic ambitions
- Long on gibberish short on specifics
- A budget
- A long list of things to do

**Good Strategy**
Careful definition of:
- The essential competencies for future success (national)
- Honest identification of challenges (local)
- Specific actions to overcome challenges (local)

Ultimately makes an organization sustainably differently better as measured by market share and profitability.

¹ Overestimating the Importance of Culture By Dan Beckham
HH&N 8/16/2012

² Good Strategy, Bad Strategy
Richard P. Rumelt
Success = Strategy + Competency + Luck

Failure is always an option… the cost of failure can be greater than the rewards of success
- Wrong leader
- Wrong strategy
- Lack of competency to execute
- Unlucky
Industry disruptions usually originate from outsiders using new technology to deliver products/services of proximal quality which are more affordable, accessible, and customer friendly.

Retail clinic visits grew from 1.48 million in 2006 to 5.97 in 2009.
Rand Study: Retail clinics provide less costly treatment than physician offices or urgent care centers for 3 common illnesses, with no apparent adverse effect on quality of care.
Michigan Governor Signs Telemedicine Bill

Michigan Governor Rick Synder has signed a bill in the state that requires health insurance providers to recognize claims for health services delivered by telemedicine methods.

GET TREATED ONLINE ▶

For $44.95

1. Create your free MeMD account.
2. Consult with a medical provider using a webcam.
3. Get the right treatment plan for you!
The Classic Approach to Strategy Will NOT Work During Turbulent Times

The Classic Approach To Strategy

There is a predictable path to the future from that of the past.

Just In Time Strategy for a Turbulent World ~McKinsey

“\text{The State [MA] has no idea what's driving cost growth!} ~\text{J. Gruber, PhD, MIT Economist}

\text{New 385 pg Law } \rightarrow \text{ Price Controls}

\text{Bond ratings threatened} – \text{37\% of hospitals losing money} – \text{64 days of cash!}

\text{20\% of households have medical debt}

\text{Strategies: Big Bets} – 5 yr. ROI

- \text{No defined ROI: R&D - Small Bets}
Government eventually responds to a perceived threat to the well-being of its citizens with solutions that are:

- well meaning but confusing,
- over-reaching and clunky,
- usually influenced by special interests and,
- fraught with unintended consequences
The pending economic crisis will be the most predictable crisis in our nation’s history!” *

~Senator Tom Coburn

Bundled payments, ACOs, medical homes can reduce cost levels but not the overall growth rate... Medicare spending will grow faster than projected. .. The Trust Fund will be insolvent by 2024... and Congress won’t be able to avoid changing course.

~Richard S. Foster, Chief Actuary for CMS February 28, 2012

Total state spending on Medicaid now surpasses spending on K-12 education

~Report of State Budget Crisis Task Force

Notes: Data are from GAO’s Spring 2012. This also includes spending for insurance exchange subsidies and the Children’s Health Insurance Program.
PGP Demonstration

## IOM Estimate: $765B in Waste

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate of Excess Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>$210 billion</td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>$130 billion</td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$190 billion</td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>$105 billion</td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>$55 billion</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 billion</td>
</tr>
</tbody>
</table>

**Implications:**

1. There is no new money
2. Success will come from doing less for more!

Source: Adapted with permission from IOM, 2010; from The National Academy of Sciences; “Best Care at Lower Cost: The path to Continuously Learning Health Care in America.”
FFS Spending is Highly Concentrated

Note: FFS (fee-for-service). Excludes beneficiaries with any group health enrollment during the year.

How is Care Managed for the Frail Elderly?

78 y/o WF

Problem List:
1. Type II diabetes with neuropathy
2. Iron deficiency anemia
3. Breast cancer
4. Pernicious anemia
5. Coronary artery disease
6. Peptic ulcer disease
7. Osteoarthritis
8. Hypertension
9. Allergic rhinitis
10. Eczema
11. Glaucoma
12. Dementia

18 Medications
- Calcium
- Metformin
- Enalapril
- Temazepam
- Timoptic eye gtts
- ASA, KCL
- Simvastatin
- Lumigan eye gtts
- Glipizide
- Vitamin B12
- Omeprazole
- Metamucil
- Lasix
- Diltiazem, Requip
- Lasix
- Lantus insulin
- Zyrtec

12 Current Physicians
- PCP
- Neurologist
- Ophthalmologist
- Gastroenterologist
- Podiatrist
- Oncologist
- General Surgeon
- Cardiologist
- Endocrinologist
- Hospitalist
- ENT
- Dermatologist
How is Care Managed for Cancer Patients: Provider vs. Patient Centered Care?

- Competing Entrepreneurs
- Multiple Medical Records
- No Central Navigator
- No Standardized Protocols
- No Outcome Data
- No NCI Designation
- Cost > MD Anderson

Is this a delivery system that you would LOVE to use?
2004 US Olympic Basketball Dream Team
Dear Doctor:
RE: Patients Incur Lower Out-of-Pocket Expenses When Using a
Free Standing Imaging Center

Anthem

<table>
<thead>
<tr>
<th>Providers within 10 miles Back – MRI Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Freestanding Imaging Center</td>
</tr>
<tr>
<td>Northern Medical Center</td>
</tr>
<tr>
<td>Saint Steven’s Regional Med Center</td>
</tr>
<tr>
<td>Memorial Medical Center</td>
</tr>
</tbody>
</table>

We appreciate your partnership in considering the financial impact to your patients, especially during these challenging economic times.

Sincerely,

Director
Provider Engagement and Contracting

Friday, September 21, 2012

LOS ANGELES TIMES

Cedars, UCLA Doctors Cut from L.A. Health Plan
“...Costs are up to 50% higher than competitors and the quality of care isn’t measurably better”...taking out those groups produces a substantial difference in cost.”

Highmark announces expansion of defined-contribution plans
October 25, 2012
Pittsburgh Post-Gazette
Predictions: 2012-2018

ACA is fundamentally flawed law --Worry about: ACA-2

- No empirical evidence to support sustainable control of costs
- The goal is to provide:
  - World Class Quality
  - Affordable Care
  - Coverage for Everyone
  - Immediate Availability When Needed
  - Top Tier Provider Payments

- We are ‘stuck’ with fee-for-service w/ value-based penalties as the dominant form of payment for at least the next five years: (HHS has missed 20 of 42 ACA deadlines)
- No malpractice reform
- Lack of attention to heroic end of life care
- Health insurance companies remain exempt from antitrust
- State participation in Medicaid expansion is still optional
- No focus on the exorbitant cost of medical education
- Nothing addresses personal responsibility

Choose 3!
Predictions: 2012-2018
Payment Will Be Modified and Provider Quality and Cost Evaluated by “Actual vs. Expected”

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Reimbursement</th>
<th>LOS</th>
<th>Relative Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urosepsis:</strong></td>
<td>MS-DRG 690 - $4,170 (^1)</td>
<td>3.5</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Sepsis due to UTI:</strong></td>
<td>MS-DRG 872 - $6,164 (^2)</td>
<td>4.7</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Sepsis due to UTI w/ cc:</strong></td>
<td>MS-DRG 871 - $10,022 (^2)</td>
<td>5.5</td>
<td>High</td>
</tr>
</tbody>
</table>

1. Principal diagnosis: Urosepsis (ICD-9-CM 599.0, 041.4)
   Secondary diagnosis: Acute renal insufficiency (ICD-9-CM 593.9)
2. Principal diagnosis: Sepsis with SIRS due to urinary tract infection (E. coli in urine)
   (ICD-9-CM 038.9, 995.91, 599.0, 041.4) Secondary diagnosis: Acute renal insufficiency
   (ICD-9-CM 593.9)
3. Principal diagnosis: Severe sepsis with SIRS due to urinary tract infection (E. coli) (ICD-9-CM 038.9, 995.92, 599.0, 041.4)
   Secondary diagnosis: Acute renal failure or acute kidney injury (nontraumatic) due to sepsis, MCC (ICD-9-CM 584.9)

"CMS, DOJ and the FBI are initiating more extensive medical reviews to ensure that providers are coding accurately and will take action where warranted." —— RAC Auditors to focus on 99215!
HHS Secretary Kathleen Sebelius and AG Eric Holder 9/25/2012
Predictions: 2012-2018
Hospitals Will Become More Accountable, a.k.a., Exposed to Increased Penalties, For Care (Physicians are Next)

"From the patient perspective, death is a key outcome."

Value Based Purchasing/Patient Safety Initiative

8-10% Medicare Rev:
- Process adherence
- HCAHPS: Patient Satisfaction
- Mortality
- Readmissions
- HAIs

2014 Proposed ‘Values’
- Clinical Outcomes
- Medicare Efficiency
Beware Physician Compare: Medicare Site Inaccurate

Doctors say if CMS can’t get simple biographical information right, expanding the website to include quality scores by 2013 might not produce a trustworthy resource.

~Charles Fiegel, amednews staff; posted May 9, 2011
Starting 2015 Medicare will implement the Physician Value-Based Payment Modifier

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CONFIDENTIAL
2010 QUALITY AND RESOURCE USE REPORT
MEDICARE FEE-FOR-SERVICE

Dr. [Physician Name]
National Provider Identifier (NPI) [#]
Specialty: [ ]

<table>
<thead>
<tr>
<th>ABOUT THIS REPORT FROM MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHAT</strong></td>
</tr>
</tbody>
</table>
| **WHY** | - To enable you to compare the quality and cost of your Medicare patients’ care with that of Medicare patients treated by physicians in your specialty and by all physicians in Iowa, Kansas, Missouri, and Nebraska.  
- To highlight your degree of involvement with all patients you treated, based on claims you submitted to Medicare.  
- To identify possible components of a payment modifier required by the Affordable Care Act of 2010. The payment modifier will provide for differential payment to physicians or to groups of physicians under the physician fee schedule based upon the quality of care furnished compared with cost. This report begins to provide you with quality-of-care and cost information that can be used in a future payment modifier. |
| **WHEN** | Medicare is required by federal legislation to phase in the payment modifier beginning in 2015. By 2017, Medicare is required to apply the payment modifier to all physicians and groups of physicians. |
| **WHO** | Medicare is providing this confidential feedback report to you and other physicians who practice in Iowa, Kansas, Missouri, and Nebraska. We chose physicians in these states because they share a common Medicare Administrative Contractor that could help disseminate the reports. |
| **WHAT YOU CAN DO** | - Consider the information in this report to help you identify clinical areas in which you are doing well and those areas that might need improvement.  
- Share your thoughts about how to make these reports more meaningful and actionable. You can email CMS at CMS_Medicare_Photic_Feedback_Program@mathematicampr.com with your comments, or you can participate in one of the conference calls that CMS has scheduled with report recipients.  
Medicare Is Evaluating Per Capita Costs of Patients “Whose Care YOU Directed” By Physician

Per Capita Costs of Patients Whose Care You Directed

Exhibit 6 shows the distribution of total risk-adjusted and price-standardized per capita costs, by percentile, among physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska, for patients whose care was directed.

Exhibit 6. Distribution of the 2010 Total Per Capita Costs of Patients Whose Care Was Directed by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska

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# Medicare Is Evaluating Actual vs. Expected Quality Performance By Physician

## Clinical Condition and PQRS Measure


<table>
<thead>
<tr>
<th>PQRS Measure Number</th>
<th>Clinical Condition and PQRS Measure</th>
</tr>
</thead>
</table>

## Physician PQRS Performance

### Chronic Obstructive Pulmonary Disease (COPD)

<table>
<thead>
<tr>
<th>Number</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>Spirometry Evaluation</td>
</tr>
<tr>
<td>52</td>
<td>Bronchodilator Therapy</td>
</tr>
</tbody>
</table>

### Diabetes

<table>
<thead>
<tr>
<th>Number</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hemoglobin A1c Poor Control</td>
</tr>
<tr>
<td>2</td>
<td>Low-Density Lipoprotein Control</td>
</tr>
<tr>
<td>3</td>
<td>High Blood Pressure Control</td>
</tr>
<tr>
<td>117</td>
<td>Dilated Eye Exam in Diabetic Patient</td>
</tr>
</tbody>
</table>

### Coronary Artery Disease (CAD)

<table>
<thead>
<tr>
<th>Number</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Oral Antiplatelet Therapy Prescribed for Patients with CAD</td>
</tr>
<tr>
<td>118</td>
<td>ACE or ARB Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
</tbody>
</table>

### Heart Failure

<table>
<thead>
<tr>
<th>Number</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>ACE Inhibitor or ARB Therapy for LVSD</td>
</tr>
<tr>
<td>8</td>
<td>Beta-Blocker Therapy for LVSD</td>
</tr>
<tr>
<td>186</td>
<td>Left Ventricular Function (LVF) Assessment</td>
</tr>
<tr>
<td>199</td>
<td>Patient Education</td>
</tr>
<tr>
<td>200</td>
<td>Warfarin Therapy for Patients with Atrial Fibrillation</td>
</tr>
</tbody>
</table>

### Preventive Care and Screening

<table>
<thead>
<tr>
<th>Number</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>Influenza Immunization for Patients 50 Years Old</td>
</tr>
<tr>
<td>111</td>
<td>Pneumonia Vaccination for Patients 65 Years Old</td>
</tr>
<tr>
<td>112</td>
<td>Screening Mammography for Women &lt; 69 Years Old</td>
</tr>
<tr>
<td>113</td>
<td>Colorectal Cancer Screening for Patients 50 to 75 Years Old</td>
</tr>
<tr>
<td>173</td>
<td>Unhealthy Alcohol Use Screening</td>
</tr>
</tbody>
</table>
“Quality is a Law Enforcement Issue.”  
~Lewis Morris, Chief Counsel to the Inspector General HHS Ret.

Medicare Taking Lessons From Commercial Payers

Recovery Audit
Prepayment Review

Prepayment audit on 15 DRGs in 11 states (cardiology and orthopedics) – no payment for hospitals and ‘take back’ from physicians for unnecessary admissions!
-Starts August 27, 2012

FL, CA, MI, TX, NY, LA, IL, PA, OH, NC, MO

June 21, 2012

A New Jersey System has agreed to pay $9 million to settle claims that they admitted Medicare patients into the hospital who should have been treated in less-expensive settings.

August 30, 2012

Feds Use Data-Mining Techniques: Notify Hospitals of Liability for Wrongly Implanted Heart Devices
Core Competency:

- Educate providers and implement a system to consistently produce exceptionally accurate clinical documentation
- Develop systems to standardize care and achieve top decile performance on current and future Value Based Purchasing Metrics
Predictions: 2012-2018
The Game Changer - The Ability to Cost-Shift Will Be Diminished

Note: Medicaid includes DSH

- Deductibles/co-pays
- Medicaid Expansion
- Exchanges
- Aging
- Premium Caps


1Center for Studying Health System Change, November 2010
Dear n8,

A hospital wanted a double digit increase. We said ‘no’ that our customers could not afford the resulting premium increase. They started a smear campaign. It backfired, we eventually settled after allowing them to experience being out of network for a month.

I contrast this with our recent deal with another major provider who is going all out with agreement to be our partner in the exchange, bundled payments, risk for quality outcomes, etc. This group will prosper...Those that can’t get over the old models will not

President X-BCBS FOn8
Clearly Providers Must Reduce the Cost of Care

“The biggest problem in health care isn’t with insurance or politics…There is almost a complete lack of understanding of how much it costs to deliver patient care, much less how these costs compare with outcomes achieved…making matters worse, participants in the health system do not even agree on what they mean by costs.”

Predictions: 2012-2018
Significant Shortage of Physicians

The AAMC predicts a shortage of about 45,000 primary care physicians and 46,000 surgeons and medical specialists during the next decade.
### Predictions: 2012-2018

Ongoing Marginal Patches for SGR

<table>
<thead>
<tr>
<th>Proposed 2013 Medicare Fee Schedule</th>
<th>(Note: Without Fix SGR = -27%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Physicians</td>
<td>+7% New code of post discharge care</td>
</tr>
<tr>
<td>Other Primary Care Physicians</td>
<td>+3 to 5%</td>
</tr>
<tr>
<td>Radiology</td>
<td>-3 to -4%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>-3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>-3%</td>
</tr>
<tr>
<td>Pathology</td>
<td>-3%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>-3%</td>
</tr>
<tr>
<td>Urology</td>
<td>-2%</td>
</tr>
<tr>
<td>Allergy/Immunology, Gastroenterology, General Surgery, Plastic Surgery, and Rheumatology,</td>
<td>0%</td>
</tr>
</tbody>
</table>
Predications: 2012-2018
Physicians Will Intensify Efforts to Stabilize Their Incomes

Illustration by James Lee
Predictions: 2012-2018
Current Physician Employment/Engagement Economics are Not Sustainable

Physician Investment

- Medical Directorships
- On-Call
- Loan Guarantees
- Other
- Locums and Nighthawk
- "FQHC Grant"
- Recruitment
- Practice Administration
- Net Investment in Employment

TAMPA BAY ONLINE 5/25/2012
Doctors at USF Take $5M Hit in Wallet
Employed Physicians--Your Highest Paid Workforce Perfectly Designed to Produce the Results You Get!

1. Most health systems lack the competency to develop and operate an embedded, integrated medical group.

2. Most physicians lack the competency to behave as high value employees focusing on the overall success of the system.

Are YOU engaged, partners or just stuck in a lousy relationship?
March 28, 2012

Dear Acting Administrator Tavenner:

The undersigned [50+ physician] organizations are writing to express our profound concern about the imminent storm that is about to occur due to simultaneous implementation of multiple programs that will create extraordinary financial and administrative burden as well as mass confusion for physicians.
Managing Population Health
Medicare Accountable Care Organizations (ACO)

- How will Medicare patients be “assigned” to an ACO? Based on where they get the “bulk” primary care.
- Will patients know they are in an ACO? -YES but participation is voluntary
- Can patients seek care outside the ACO? -YES, no limits on choice.
- Will the ACO have to invest in sophisticated infrastructure? -Yes $1-3M/Yr
- How much money can an ACO doctor make? -Nobody knows --ACOs will have a “cost of failure risk and possibly downside payment risk!”
What Will Be the Primary Source of Shared Savings in ACOs?

“I would expect Medicare savings to come from reductions in inpatient days, imaging referrals, and referrals to specialists and ancillary services.”

-CMS OFFICIAL
Email to N8

Three Member Alliance Cut Costs by $20M

-15% readmissions
-13% elective surgeries

Blue Shield - $16.7M
Hospital - $1.6 M
Med. Group - $1.6M
Predictions: 2012-2018
FTC and CBO Predict that Cost Savings From ACOs are ‘Doubtful’

Hitting the “spending reduction targets” [in PPG] had more to do with coding than with actual cost reduction.

~Berenson, RA: Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere? Am. Journal of Managed Care, Oct 2010 721-725

Loss Before Volume 1
-7,500,000
3,088,850
-7,370,732
-7,500,000
-3,761,155
48,650,667
-7,500,000
-1,826,823
6,427,660
5,148,493

1 Assumes $1.5 Million/yr for ACO infrastructure
Which Animal Best Describes an ACO?
Independent providers form an integrated, seamless delivery system designed to consistently provide coordinated, high quality, efficient, patient-centered care.

**STEP 1: CLINICAL INTEGRATION**

- Provider-governed organization aligned with hospitals (requires rules of engagement)
- Deliver *PREDICTABLE, MEASURABLY BETTER* clinical quality, safety, coordination, and efficiency *CONSISTANT WITH THE BEST SCIENCE IN MEDICINE*
- Significant investment in infrastructure including IT focused on clinical improvement, ($1-4 Million initial investment)
- Contracts with payers designed to compensate network participants for value created and achieved
- Able to function across a wide range of reimbursement modes, from fee-for-service to capitation
Clinically Integrated Network

Infrastructure and Policies to improve Clinical Performance

Clinically Integrated Network Governance

Rules of Engagement

Hospital #1
- Employed Medical Group
- SNF & Home Health

Hospital #2
- Specialist
- PCP's

Full Continuum of Care

Single Signature Contracting

BC/BS
- Aetna

United Health
- Humana MA

Specialists
- PCP's

PCP's

PCP's

PCP's

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CI Physicians - Metrics

Average Length of Stay
APR-DRG, Severity, Hospital-Type Adjusted

CI Physicians - 3.71 Days
full standard deviation below predicted

Other Physicians - 5.26 Days
consistent with National Average

Patients discharged by CI physicians have a 29% lower length of stay than those treated by other physicians within the health system.

72,093 Patients Discharged
CI Physicians - Metrics

**Average Charges**
APR-DRG, Severity, Hospital-Type Adjusted

- CI Physicians - $23,430
- Other Physicians - $34,885

Patients discharged by CI physicians have total charges 33% lower than those treated by other physicians within the health system.

72,093 Patients Discharged
CI Physicians - Metrics

Complications of Condition
APR-DRG, Severity, Hospital-Type Adjusted

CI Physicians - 4.67%
Other Physicians - 5.73%

Patients discharged by CI physicians have a rate of complications of condition that is 18% lower than those treated by other physicians within in the health system.

72,093 Patients
Predictions: 2012-2018
Most of the Cost Savings Will Come From Reducing Hospital Utilization/Revenue

“I would expect Medicare savings to come from reductions in inpatient days, imaging referrals, and referrals to specialists and ancillary services.” — CMS OFFICIAL Email to N8

Traditional FFS

- DRG 871
- Hospital Receives $10,022
- LOS: 5.5 Days

($10,022/5.5 = $1,822/Day)

Medicare Risk Entity

- Receives Population-based Payment from Medicare and Contracts with Hospital @ $1822/day
- Entity Keeps $2,734
- Hospital Receives $7,288
- LOS: 4 Days

Medicare Pays PMPM

HMO Pays
Core Competency:

- To capture shared savings, begin the development of a clinically integrated ‘a’-ccountable delivery system:
  - Digital connectivity of EMR with point of care protocols
  - Ability to measure the cost and quality of care in near real time
  - Primary care capacity (medical homes using “mid level providers”)
  - Engaged physician champions
  - Evidence-based inpatient and outpatient protocols
  - Programmatic approaches to chronic diseases
  - Dedicated infrastructure
  - Performance-based rewards/consequences for providers
  - Pilot testing on hospital employees
  - Collective negotiating for managed care contracting
  - Consider owning or developing a private label Medicare Advantage product
Predictions: 2012-2018

The OIG will Intensify Their Review Process

“Doctors should be aware that we are scrutinizing records and detecting fraud and kickbacks…”
“We hope that our aggressive enforcement will deter doctors from cheating the taxpayers and endangering patients.”

~U.S. Attorney Barbara L. McQuade (January 11, 2012)

OIG Work Plan

• OIG is conducting unannounced on-site compliance reviews
• Program Integrity Command Center: Data mining partnership between HHS and commercial health plans

IMPORTANT NEW Insights:

• An uninformed business valuation can create, rather than minimize, risk.
• One Purpose Rule

638 qui tam lawsuits were filed in 2011

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Hospital-Physician Culture: “Fellow Citizens” or UN

“A more perfect union.”

“Protect individual rights and self-determination.”
Some Physicians and Hospitals Just Don’t Get IT

“Medicare is cumbersome, an unnecessary interface between us and our patients, and most importantly, it doesn't pay us sufficiently to justify the work we do.”

(Dr. Marc Siegel, 12/20 Fox News)

Everyone has a plan until they get punched in the mouth!
MUST Reads

- The Southwest Airlines WAY
  - Using the Power of Relationships to Achieve High Performance
  - Jody Hoffer Gitter

- UNACCOUNTABLE
  - What Hospitals Won’t Tell You and How Transparency Can Revolutionize Health Care
  - Marty Makary, M.D.

- Transforming Health Care
  - Virginia Mason Medical Center’s Pursuit of the Perfect Patient Experience
  - Charles Kenney

- How the Mighty Fall
  - And Why Some Companies Never Give In
  - Jim Collins

- On the Mend
  - Revolutionizing Healthcare to Save Lives and Transform the Industry
  - John Toussaint, MD and Roger A. Derienzo, PhD with Emily Adams

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1975 Kodak
The Shotgun Wedding of Healthcare Providers

Involuntary Co-Branding: Payment Based on Collective Performance
- Readmissions
- RAC Audits
- 3 Day Rule

Cost per Episode
- Tiered Networks
- Value-based Penalties

ACO
- Fraud

Meaningful Use

- MSPB

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High-Performing Health System

Organized System of Care
- Continuum of care provided for populations
- Integrated or has partnerships
- Physicians as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

Efficient Provision of Services
- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

Quality Measurement & Improvement Activities
- Preventive care & chronic disease mgmt.
- Patient outreach programs
- Continuous learning & benchmarking
- Research to validate clinical processes & outcomes
- External & transparent internal reporting
- Patient experience surveys

Care Coordination
- Team-based approach with team members working at the top of their field
- Single plan of care across settings & providers
- Shared decision making

Compensation Practices
- Incentivize improved health & outcomes of populations
- Affiliates with patient experience or quality metrics

Use of IT & Evidence-based Medicine
- Meaningfully use IT, scientific evidence & comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of Rx

Accountability
- Shared financial & regulatory responsibility & accountability for efficient provision of services
Good Luck and Thank you!

“no Fear, no Envy , no Meanness.” ~Bob Dylan

“The greatest danger in times of turbulence is not the turbulence, it is to meet the turbulence with yesterday’s logic.”

We can no longer tolerate a healthcare industry that markets non-existent excellence, fraught with kickbacks… that allows clinicians to use outdated treatments and/or perform surgery even when they lack adequate training

Dr. Marty Makary, Johns Hopkins Pancreatic Cancer Surgeon, Author of Unaccountable
Mission

Improving healthcare delivery by enhancing the strategic/financial performance of providers.

Nathan Kaufman, Managing Director

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www.KaufmanSA.com
<table>
<thead>
<tr>
<th>Rate Your System’s Readiness</th>
<th>1-5</th>
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<tbody>
<tr>
<td>1. The strategic plan defines the essential competencies for future success and is based on an objective assessment of both the market and existing local competencies. Challenges are clearly defined. Strategies focus on adding value for patients, are ROI-based, and are expected to measurably improve quality, market share and profitability.</td>
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<td>2. Governance structure provides role clarity and avoids historical provincial allegiances. The trustees and system leadership support the system’s strategic plan which delineates a clearly defined unified direction, regardless of institutional inertia or resistance.</td>
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<td>3. Critical functions and systems are standardized, coordinated and controlled centrally. People are held accountable for achieving targets. Critical performance metrics are routinely measured and reported. When necessary, action plans are developed to rapidly bring performance in line with established targets. Assets are rationalized.</td>
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<td>4. The board, management and medical staff differentiate between valid strategic issues and ‘noise’ or the latest fad and they possess the competency to respond to unforeseen challenges quickly and effectively.</td>
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<td>5. There is an organized approach to engage physician leaders in planning, execution and conflict resolution.</td>
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<td>6. Multi-year projections are based on conservative assumptions of reimbursement, volumes and expense growth.</td>
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<td>7. An expense reduction plan is in place, focusing on standardization and elimination of waste using a proven redesign method. There is a process to eliminate unnecessary duplication of services in multiple sites.</td>
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<td>8. Clear accountability is assigned for MANAGING and optimizing the performance of hospital-based physicians and medical directors.</td>
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<td>9. A third party, objective performance assessment has been completed and implementation plans are in place for optimizing critical functions: e.g., revenue cycle, clinical documentation, IT, cost accounting, reporting on quality/outcomes, clinical integration, capital allocation, employed physician practices and performance of key services, e.g., ED, ICU, hospitalist, surgery, radiology, etc.</td>
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<td>10. A process is underway to develop a digitally connected network of physicians committed to delivering efficient-predictable-evidence-based-coordinated care and share in payer savings --starting with system employees.</td>
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<td>11. The hospital is able to negotiate commercial reimbursement rates in excess of 145% of Medicare for institutional services and 130% of Medicare for its employed/clinically integrated physicians.</td>
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<td>12. The system places a heavy emphasis on “who” vs. “what” decisions. That is, recruitment self-motivated leaders who share the system’s core values and will focus on ‘the cause,’ (not themselves,) inspiring others through their actions.</td>
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<tr>
<td>13. The employed physicians are coalescing into a medical group vs. a virtual collection of private practices. Practice performance is benchmarked and reported. Compensation is based on individual and group and/or system performance. There is significant focus on maximizing the use of Mid-level providers.</td>
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