Playing the New Game:
Managing the Velocity of Change

Ian Morrison PhD

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Outline

• Key Issues
• The Second Curve
• The Half Life of Healthcare
• Delivery System Transformation
Key Issues: ACA and Coverage Expansion

• ACA is the “the Law of the Land”...now we have to implement it, OMG!
  – The Duck Model: Serene and Calm on the Surface, Frantic underwater
  – Regional Variation versus National Solutions
  – Political Resistance to Coverage expansion both Medicaid and Exchanges

• Public Exchanges may get off to very rocky start
  – No extra federal implementation dollars approved
  – “Hat in hand” model
  – Dependence on the Few: California, the West, New York, Maryland and a few others
  – “Skinny networks” in California and elsewhere

• Private Exchanges gaining momentum
  – Retirees
  – Small Business
  – Enabling shift from Defined benefit to Defined Contribution

• Exchanges both public and private shift the market toward retail
  – Retail purchasers very price sensitive (Bronze and Silver)
Key Issues: Health Systems

• Accountable Care is a megatrend, but maybe not ACOs...lots of action and players
• Growing realization that health systems meets Medicare Advantage may be the end game
• Pressure on costs and and delivering value intensifies
  – Hospital “prices” under intense scrutiny by press and purchasers
• “Learning to live on Medicare” means taking out 10-20% of costs (more for academic institutions) and Medicare reimbursement rates will keep getting pressurized
• From Volume to Value means high cost procedure oriented specialties (cardiovascular, ortho, neuro, oncology) move from key assets to liabilities in a capitated environment, how long, how much is extremely uncertain
  – SGR debate may move to value
  – Episode and Global Payment methodologies grow from a miniscule base
  – Value purchasing tied to quality (“never” events, readmissions, value purchasing bonuses) and bundled payment are key incremental steps but rhetoric ahead of reality
• Focus on Primary Care—gatekeeper controls specialty care and referrals
Key Issues: Health Systems

• The Massive Consolidation continues toward 100-200 Large Regional Systems
  – Doctors running to hospitals
  – Hospitals consolidating regionally
  – Role of private equity and for profits in consolidation
  – Focus on “Essentiality” may run into Attorney Generals and Anti-Trust concerns
  – Rurals swept in
  – The rich get richer: significant returns to scale and to integration
  – Doctors discretion in selection of specific technologies and clinical protocols will be increasingly constrained by large motivated health systems that employ them
• Purchasers are using consumer incentive tools Skinny Networks and Spot Market trends are counter forces e.g. CalPers reference pricing
• Care coordination of transitions will be at a premium
  – Readmission penalties
  – The Care More Effect (de-medicalization of care)
  – Patient Centered Medical Home
• From fill the hospital to empty the hospital, it is going to be economically and culturally challenging
• Will doctors and consumers go along with all this?
• No matter what we must redesign the delivery system: and it needs to be science-based, technology-enabled and consumer friendly
The Second Curve

First Curve

Second Curve
Engage senior leadership in planning for the hospital of the future

- Must-do strategies to be adopted by all hospitals

  Second curve metrics measure success of the implemented strategies

- Organizational core competencies that should be mastered

  Self-assessment questions to understand how well the competencies have been achieved
First-Curve to Second-Curve Markets

How will hospitals successfully navigate the shift from first-curve to second-curve economics?

**Volume-Based First Curve**
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

**Value-Based Second Curve**
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination
- Increased patient severity
- Quality impacts reimbursement
- Payment rewards population value: quality and efficiency
Never mistake a clear view for a short distance...........Paul Saffo
Short Half Life

Cheetah
Fast and out in the open
Short Half Life

- Elections
- Budget Cuts
- Cost Shifting
- Reference Pricing
- Network Contract Changes
- Narrow Networks
- Focus on Prices
- Mergers and Acquisitions
  - Contractual integration: Short half life
  - Clinical integration: Long half life
Public’s View On Future

Which comes closer to your view about the 2010 health care law? Those opposed to the health care law should:

- ACCEPT THAT IT IS NOW THE LAW of the land and stop trying to block the law’s implementation
- CONTINUE TRYING TO CHANGE OR STOP IT, so it has less impact on taxpayers, employers, and health care providers

<table>
<thead>
<tr>
<th>Group</th>
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<tbody>
<tr>
<td>Total</td>
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<tr>
<td>Democrats</td>
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<tr>
<td>Independents</td>
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<tr>
<td>Republicans</td>
<td>17%</td>
<td>78%</td>
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</table>

Note: Don’t know/Refused answers not shown.
The Death of the Chargemaster

- The Brill Effect
- CDHP focuses the mind on price as much as use
- Reference pricing terrifies providers
- All payer transparency is coming soon at a theater near you from policy wonks, purchasers and toolmakers such as Castlight
CalPERS Reference Pricing Scheme

- Study conducted by Robinson and Brown of Berkeley
- Anthem PPO for CalPERS
- Reference Pricing scheme for joint replacement
- Impact on utilization: Consumers moved
- Impact on price: Much bigger effect (85% of the savings) because it brought prices down for all CalPERS members and non-members alike
- CalPERS moving on to more aggressive sourcing of integrated healthcare partners and competitive bidding, but others like Safeway and PBGH view this as a key way to tackle price outliers for “shoppable” conditions
  - (maternity, cancer care, orthopedics and routine diagnostics/labs/imaging)
Percentage of Surgery Patients Choosing Low-Priced and High-Priced Hospitals before and after the Implementation of Reference Pricing

Source: California Public Employees Retirement System (CalPERS) and Anthem Blue Cross.
* Through September of 2012 only.
Prices for Knee and Hip Replacement Surgery in California Hospitals before and after the Implementation of Reference Pricing

- CalPERS Non-VBPD
- Anthem Non-VBPD
- CalPERS VBPD
- Anthem VBPD

Source: California Public Employees Retirement System (CalPERS) and Anthem Blue Cross. All prices in 2011 dollars. VBPD: Value Based Purchasing Design. * Through September of 2012 only.
Consumers are willing to make trade offs: Lower premiums for restricted choice

**Relative Importance of Benefit**

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<tr>
<th>Benefit</th>
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<tr>
<td>Low monthly premiums</td>
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<td>152</td>
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<tr>
<td>Keeping my current doctor(s)</td>
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<td>133</td>
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<tr>
<td>Unrestricted access to all medical technologies (e.g. MRI or CT scans)</td>
<td>133</td>
<td>125</td>
</tr>
<tr>
<td>Direct access to leading specialist(s) in my area</td>
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<td>106</td>
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<tr>
<td>Low co-pay costs for generic drugs</td>
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<td>88</td>
</tr>
<tr>
<td>Direct access to all specialists</td>
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<td>105</td>
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<tr>
<td>Coverage for dependents</td>
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<td>95</td>
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<tr>
<td>Unrestricted access to cutting edge medical devices and procedures</td>
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<td>72</td>
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<tr>
<td>Reasonable co-pays for brand name drugs</td>
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<td>85</td>
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<tr>
<td>Unrestricted access to cutting edge drugs including cancer/specialty</td>
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<td>81</td>
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<tr>
<td>Access to all brand name drugs at low cost-sharing levels</td>
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<tr>
<td>Choice of hospitals</td>
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<td>67</td>
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<tr>
<td>Coverage for a wide selection of brand name drugs</td>
<td>56</td>
<td>52</td>
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<tr>
<td>Access to prestigious institutions</td>
<td>38</td>
<td>38</td>
</tr>
</tbody>
</table>

**Average Importance = 100**

Respondents were given a maximum difference trade off exercise in which they were forced to choose the most preferred and least preferred plan feature.

SOURCE: Harris Interactive Strategic Health Perspectives 2013 Consumer Survey
Base: All US Adults Less Than 65 (n=1983); All US Adults Older Than 65 (n=518)
Medium Half Life

Hippos and Elephants
Large, important and surprisingly quick for their size
Medium Half Life

- Coverage Expansion
  - Medicaid (maybe longer than you think)
  - Exchanges (and possible employer exit longer term)
- Meaningful Use
- Value Based Purchasing
  - Medicare at risk on quality 9% by 2015
- Large Group Practice Formation
State Decisions for Expanding Medicaid

Source: KFF, June 2013
New State and Federal Medicaid Expenditures under ACA, with All States and No States Expanding Medicaid, 2013-2022

$ in billions:

- ACA with All States Expanding Medicaid: $952
- ACA with No States Expanding Medicaid: $800
- Incremental Impact of Medicaid Expansion: $152

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.
Medicaid: Slow Pedal

- Most states were in within a few years, but....
- Medicaid took 18 years to reach all states: Arizona joined in 1982
- Canada took 20 years!
  - 1946 Saskatchewan Hospital Insurance
  - 1957 Hospital Insurance and Diagnostic Services Act
  - 1961 All Provinces join HIDS, Saskatchewan pilots Medical Insurance
  - 1966 All Provinces introduce Medical Insurance
Public Exchange Launch

Think Wright Brothers....

Not Indianapolis 500
Uneven Start to Exchanges

Great, we’re in!!!!!
Uneven Start to Exchanges

What the (bleep) is a deductible?
Uneven Start to Exchanges

$850 a month? I thought this was supposed to be free?
Uneven Start to Exchanges
How to Pick a Health Plan on an Exchange

• Step 1. Decide on the diseases you and your family are going to have in the coming year
• Step 2. Find the best doctors and hospitals for those diseases
• Step 3. Identify which plans offer those doctors and hospitals
• Step 4. Select the cheapest plan
• Step 5. If there are no affordable plans with all the doctors and hospitals you want, go back to Step 1 and pick some new diseases
HealthCare.gov

• Congratulations, you made it through those annoying security questions. Sorry about the delays, we got hacked by the Koch Brothers.... what can you do?
• Good news is we rummaged around in your IRS records and some stuff we got from that Snowden guy and found out you make $12 an hour. We know you lie about your tips, but we all do, right?
• If you ever get a raise you will be eligible for Health Insurance through the exchange which will allow you to buy a very high-deductible health plan with a limited network for FREE!!!!
• Meantime, the news gets better, you are probably eligible for Medicaid, that will provide totally free access to a very limited network of providers (maybe the ones you see now because you are uninsured).
• Q: So what state do you live in?
• A: Texas
• Good luck with that. Come back when you get a raise.
American Idol versus Covered California: Just Coincidence?

Great Logo

Genial Host

Small Accomplished Board

Number of Semi-Finalists  
32

Number of Finalists  
13

Number of Semi-Finalists  
32

Number of Finalists  
13
Covered California

The table below is a statewide average of the rates a 40 year old single individual might pay. That amount is shown in each box at the top and in black. The federal subsidies are shown in green. Starting this fall, individuals and families will be able to determine the exact amount they would pay based on family size, age and income. FPL = Federal Poverty Level

### BRONZE PLAN - 40 YR OLD

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<th>150% FPL</th>
<th>200% FPL</th>
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<tr>
<td>2nd Most Affordable</td>
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<td>$54</td>
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<td>$226</td>
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<td>$98</td>
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<tr>
<td>3rd Most Affordable</td>
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<td></td>
<td>$235</td>
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### SILVER PLAN - 40 YR OLD

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<th>150% FPL</th>
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<td>Most Affordable</td>
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<tr>
<td>2nd Most Affordable</td>
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<td>3rd Most Affordable</td>
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<td>$210</td>
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<td>$235</td>
<td>$171</td>
<td>$98</td>
<td>$17</td>
<td>—</td>
</tr>
</tbody>
</table>

Source: Covered California, May 23, 2013

- 2.6 million subsidy eligible in 19 regions served by 13 plans
- Statewide rates are more affordable than many analysts expected
- Multi Region Players are Kaiser (all but one region), Anthem Blue Cross (all), Blue Shield (all), Health Net (13) and Molina (5)
- Others:
  - Alameda Alliance 1
  - Chinese Community Health Plan 2
  - Contra Costa 1
  - LA Care 2
  - Sharp 1
  - Valley Health Plan 1
  - Ventura County 1
  - Western Health Advantage 2
Who is Eligible for Covered California?

Percentage of subsidy-eligible Californians by ethnicity:

Total: 2.6 million eligible for coverage

- Latino: 1,190,000 (46%)
- Asian: 370,000 (14%)
- White: 870,000 (33%)
- African American: 100,000 (4%)
- Other: 70,000 (3%)

Source: Covered California, May 23, 2013
Auto Insurance versus Health Insurance

Percent Uninsured (Autos)

Percent Uninsured (Health)

Source: Author Analysis of KFF, Insurance Research Council data for 2011
Employers express considerably more confidence in the viability of HIXs than they did last year

Confidence in HIXs as a Viable Alternative to Employer-Sponsored Coverage

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<tr>
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<th>Public Exchange</th>
<th>Private Exchange</th>
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<td>2012 (B)</td>
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<tr>
<td>Not sure</td>
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<tr>
<td>Not at all</td>
<td>16%</td>
<td>25%</td>
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<tr>
<td>Not very</td>
<td>37%</td>
<td>28%</td>
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<tr>
<td>Somewhat</td>
<td>18%</td>
<td>37%</td>
</tr>
<tr>
<td>Very</td>
<td>12%</td>
<td>35%</td>
</tr>
<tr>
<td>Extremely</td>
<td>9%</td>
<td>36%</td>
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<tr>
<td>2013 (A)</td>
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<tr>
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<td>21%</td>
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<tr>
<td>Very</td>
<td>11%</td>
<td>9%</td>
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<tr>
<td>Extremely</td>
<td>5%</td>
<td>6%</td>
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</table>

SOURCE: Harris Interactive Strategic Health Perspectives Employer Survey 2012-2013 (2013 n=302)

Q1400: How confident are you that public Health Insurance Exchanges will ultimately be a viable alternative to employer-sponsored healthcare coverage? Q1405: And how confident are you that private Health Insurance Exchanges will ultimately be a viable alternative to employer-sponsored healthcare coverage?
Four Scenarios for Exchanges

- **Scenario 1: Managed Competition Nirvana**
  - Public and Private Exchanges grow
  - Move from defined Benefit to Defined Contribution
  - Individual Consumers choose skinny network plans

- **Scenario 2: Minor Miracle**
  - Public Exchanges launch and cover modest numbers
  - Big Push by Feds to make it work
  - California is key

- **Scenario 3: Single Player**
  - Public exchanges grow enormously...in the long run
  - Looks like Medicaid for all

- **Scenario 4: Meltdown**
  - Exchanges don’t make it in high uninsured states
  - The Mandate is too weak and unenforceable: Young immortals stay away and high risk sign up
  - Small group and individual market becomes prohibitively expensive
  - Healthcare is the 2016 issue: Now what?
US Uninsured Apply to Join European Union

Population

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Population</th>
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<tbody>
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<td>1</td>
<td>Germany</td>
<td>80,640,000</td>
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<tr>
<td>2</td>
<td>United Kingdom</td>
<td>64,231,000</td>
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<tr>
<td>3</td>
<td>France</td>
<td>63,820,000</td>
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<td>4</td>
<td>Italy</td>
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<td>5</td>
<td>Spain</td>
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<tr>
<td>6</td>
<td>Poland</td>
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<td>7</td>
<td>Romania</td>
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<td>8</td>
<td>Netherlands</td>
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<td>9</td>
<td>Belgium</td>
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<td>10</td>
<td>Greece</td>
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<td>11</td>
<td>Portugal</td>
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<td>12</td>
<td>Czech Republic</td>
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<td>26</td>
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<td>27</td>
<td>Luxembourg</td>
<td>542,000</td>
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<tr>
<td>28</td>
<td>Malta</td>
<td>419,000</td>
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</tbody>
</table>

US Uninsured at 47.6 million would displace Spain as the 5th largest member of the European Union

EU head Jose Manuel Barrosco says: “We welcome the American Uninsured, 80% are working people and their families, they will boost our economy and be better behaved than the Scots”
Long Half Life

Lions
On top of the food chain and not in a big hurry to change
• Aging of the Population
• Reimbursement Reform
  – DRGs versus implementing successful pilots
  – Volume to Value
• Cultural Transformation
• Medical Education Reform
  – Choosing Wisely from the beginning
• Capital Investments
  – Built Environment
  – IT
  – Big Iron
  – Acquisitions (Practices, Alternate Site, Health Plans)
Ahead of the Curve on Value-Based Payment

• “The future is already here…it is just not evenly distributed”
  – William Gibson

• California has 41.8% value based payment

• US has 10.9% according to CPR

Source: Catalyst for Payment Reform, 2013
The proportion of reimbursement coming from Medicare has grown to be at parity with Commercial insurance

| Patient Insurance and Hospital Reimbursement Coverage (Mean %) |
|------------------|------------------|------------------|------------------|
| **2011**         | **2012**         | **2013**         |
| Commercial insurance | 31% (40%)       | 29% (37%)       | 29% (36%)       |
| Medicare          | 33% (32%)       | 35% (33%)       | 38% (37%)       |
| Medicaid          | 20% (18%)       | 20% (19%)       | 19% (18%)       |
| Uninsured         | 12% (6%)        | 12% (6%)        | 10% (5%)        |
| Other             | 3% (4%)         | 4% (5%)         | 3% (4%)         |

Q920: Please indicate what percent of your hospital’s/hospital system’s total patient population has the following types of insurance. If you are unsure, please provide your best estimate.

Q925: Now please indicate what percent of your hospital’s/hospital system’s total reimbursement comes from each of the following types of insurance. If you are unsure, please provide your best estimate.

SOURCE: Harris Interactive Strategic Health Perspectives Hospital Exec Survey 2012-2013 (2013 n=210)
Most hospitals anticipate significant movement towards capitation over the next 5 years

**Payment Model for Hospital – Current and Five Years from Now**

**CURRENT:**
- Completely Fee for Service (0)
- Evenly Split (36.8)
- Completely Capitated Payments (100)

**FIVE YEARS FROM NOW:**
- Completely Fee for Service (0)
- Evenly Split (59.6)
- Completely Capitated Payments (100)

SOURCE: Harris Interactive Strategic Health Perspectives Hospital Exec Survey 2012-2013 (2013 n=210)

Q705/Q706/Q707: Many hospitals are starting to be paid differently for their services, moving from a fee for service environment to more capitation or value based payments. Where is your hospital/hospital system on the spectrum today, and where will you be five years from now?
All new reimbursement models are becoming less popular over time

**Attitude toward Models of Reimbursement**

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<tr>
<th>Pay-For-Performance</th>
<th>Episode-Based Payments</th>
<th>Global Payments</th>
<th>Bundled Payments</th>
<th>Capitated Payments</th>
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<tr>
<td>Top 2:</td>
<td></td>
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<tr>
<td>2011 (A)</td>
<td>37%</td>
<td>2011 (A)</td>
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<td>13%</td>
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<td>2012 (B)</td>
<td>33%</td>
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<td>14%</td>
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<tr>
<td>2013 (C)</td>
<td>24%</td>
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<td>11%</td>
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</tbody>
</table>

**System level executives** are less apt to have a “not at all favorable” opinion towards global payments.

## Q700:
There are a number of different proposals being discussed for changing the way providers, including physicians and hospitals, are reimbursed. How favorable or unfavorable would your hospital/hospital system be toward each of the following models of reimbursement?

**SOURCE:** Harris Interactive Strategic Health Perspectives Hospital Exec Survey 2012-2013 (2013 n=210)
## Change is clearly a top-down initiative

### Level of agreement on need to make changes to address financial challenges*

<table>
<thead>
<tr>
<th>Party</th>
<th>Not in agreement</th>
<th>Somewhat in agreement</th>
<th>Very much in agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your CFO</td>
<td>3%</td>
<td>20%</td>
<td>77%</td>
</tr>
<tr>
<td>Your CEO</td>
<td>3%</td>
<td>25%</td>
<td>73%</td>
</tr>
<tr>
<td>Your board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other senior management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Physicians on your staff</td>
<td>16%</td>
<td>61%</td>
<td>22%</td>
</tr>
<tr>
<td>Specialists who do a lot of procedures in hospital</td>
<td>19%</td>
<td>63%</td>
<td>18%</td>
</tr>
<tr>
<td>Nurses</td>
<td>23%</td>
<td>59%</td>
<td>18%</td>
</tr>
<tr>
<td>Other medical staff</td>
<td>22%</td>
<td>61%</td>
<td>16%</td>
</tr>
</tbody>
</table>

### Greatest financial challenge for hospital*

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>17%</td>
</tr>
<tr>
<td>Cost</td>
<td>20%</td>
</tr>
<tr>
<td>Margin</td>
<td>16%</td>
</tr>
<tr>
<td>All of the above</td>
<td>55%</td>
</tr>
</tbody>
</table>

SOURCE: Harris Interactive Strategic Health Perspectives Hospital Exec Survey 2013 (n=210)

**Q940:** How much in agreement are each of the following parties on the need to make changes to address your financial challenges?

**Q945:** When thinking about the financial challenges your hospital faces, which of the following is more of a challenge for your hospital?
Physicians View of Potential Means of Reducing Health Care Costs

Changing how care is paid for and how physicians are paid

- Limiting access to treatments with little net benefits
- Using cost-effectiveness data to determine available treatments
- Reducing compensation for the highest paid specialties
- High deductible health plans
- Eliminating Fee for service payment models
- Penalizing providers for reavoidable admissions
- Paying a network of practices a fixed, bundled price for managing...
- Allowing Medicare payment cuts to doctors to take effect

Medical Staff will Negotiate Aggressively over Bundled Payments, Capitation and Global Budgets
The Work

- Centrality of Clinical Integration
- Health IT as platform not panacea
- Learning to live on Medicare
- Managing Business Model Migration
- Building a culture of Quality and Accountability

  – “We have the anatomy of an Accountable Care Organization but none of the physiology”
Most hospitals are either part of an ACO or working to become one

**ACO Affiliation**

- 43% are part of ACOs
- 31%
- 12%
- 41%
- 12%
- 12%
- 4%

Among rural hospitals, 26% say they have no plans to become an ACO.

**Q340:** Is your hospital part of one or more Accountable Care Organizations (ACO)?

**SOURCE:** Harris Interactive Strategic Health Perspectives Hospital Exec Survey 2013 (n=210)
ACO Early Lessons

- The most enthusiastic are often the least capable
- Pioneers are Ninjas: ACOs are a way to suck more FFS Medicare into Medicare Advantage and even pioneers are turning back
- Real question is can some big newcomers to risk pull off move from volume to value e.g. Aurora, Texas Health Resources, Inter-Mountain Healthcare, Sutter, Steward etc
- CMS Shared Savings Model: what happens if there are no shared savings?
- Small physician ACOs as a farm team of disruptors: training wheels for Medicare Advantage
- Pilots improve quality maybe not save much money
- Commercial ACOs: Lots of interest on both sides, making multi-payer pilots work is very challenging (especially quality and timeliness of data)
- 8 million Duals are a big opportunity for Managed Care 2.0 (but watch for segments “the Nice Old” versus the disabled, seriously mentally ill)
- Alternate site market is critical but it is messy, fragmented and alien
- Risk models: providers need help from plans e.g. Optum, Aetna, CIGNA and other private label offerings
- If this is such a good idea why do for-profit providers largely shy away?
Key Strategic Lessons: Providers

• Don’t conflate the future into a blur of simultaneous change
• But recognize some long half-life changes require action now (long-tailed decisions)
• Big short term priorities
  – Cost and contract competitiveness for value
  – HIT and meaningful Use
  – Physicians, retaining, acquiring and on-boarding
• Medium Term
  – Business Model Migration
  – Risk and Value
• Long term
  – Enduring culture of quality and accountability
  – Reimbursement changes to encourage the Triple Aim
Key Strategic Lessons: Health Plans

• Public programs will grow
• Cost is key for most employers and consumers
• Exchanges will grow: Both Public and Private
• Provider consolidation is a major, and growing, threat to purchasers
• Cost-shifting is also an increasing threat, especially as non-managed care government programs (e.g., Medicaid) continue to expand
Key Strategic Lessons: Health Plans

• Most national insurers are content to play “wait and see” with respect to roll out of ACA (especially the public exchanges)
• Health plans may be ill-prepared to deal with blowback from network shock
• Multi-state payers may balk at highly regional variation in exchanges, Medicaid expansion, ACO and PCMH development, etc.
Implications

• Politicized start to coverage expansion
• Many states are ill-prepared, can the feds really make it work?
• Not a national market
• Public cuts already happening under ACA
• Focus on private prices will get very intense
• Payment reform will move slower than you think
• Picking teams and now we have to play the game
• ACOs may be training wheels for providers taking risk with Medicare Advantage and direct value contracting
• We may be stuck between the curves for a while
• Policy Wonks are at odds with physicians
• We need to get on with the Work
• It is a Ten Year Journey and we have just begun