



# Adapting To The “New” Urgency To Lowering Health Care Costs

Presentation by Susan Dentzer  
Editor-in-Chief, *Health Affairs*  
Massachusetts Association of Health Plans  
November 18, 2011

# This presentation at a glance

- The “new” urgency to lower costs: key points
- Emerging themes from providers, plans and payers
- Some case examples
- Conclusions

**HEALTH REFORM IMPACT**

The Number Of Underinsured US Adults Could Be Cut By 70%

**RAREFIED MATTERS**

A Children's Hospital Confronts Its Worst Nightmare

**THE CARE SPAN**

Complex Medicare Advantage Choices May Overwhelm Seniors

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

# Health Affairs

**The New Urgency To Lower Costs**

**Impact Of High Health Costs On US Families**

David I. Auerbach & Arthur Kellermann  
Patricia Ketsche et al.

**We're Paying Our Doctors More Than Other Countries Do**

Miriam Laugesen & Sherry A. Glied

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**The Problem: Growth In Cost Per Case**

Charles Roehrig & David M. Rousseau

**The Need To Prevent Chronic Disease Before People Enroll In Medicare**

Kenneth E. Thorpe & Zhou Yang

**The Growing Cost Of Care For The Working-Age Disabled**

Gina A. Livermore, David C. Stapleton & Meghan O'Toole

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**Model Safety-Net Systems That Cut Costs For The Uninsured**

Mark A. Hall, Wenke Hwang & Allison Snow Jones

**Virginia Mason's Collaborative To Transform Care**

C. Craig Blackmore, Robert S. Mecklenburg & Gary S. Kaplan

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**PLUS: Bundled Payments For Acute & Postacute Care**  
Neeraj Saad et al.

**Health Plans & Providers**  
Aparna Higgins et al.  
Glenn A. Melnick et al.  
Robert E. Mechanic et al.

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Our September 2011 Issue

# The Triple Aim

- Better health
- Better health care
- Lower costs
- Core principle now at heart of major U.S. payment and delivery system reform efforts

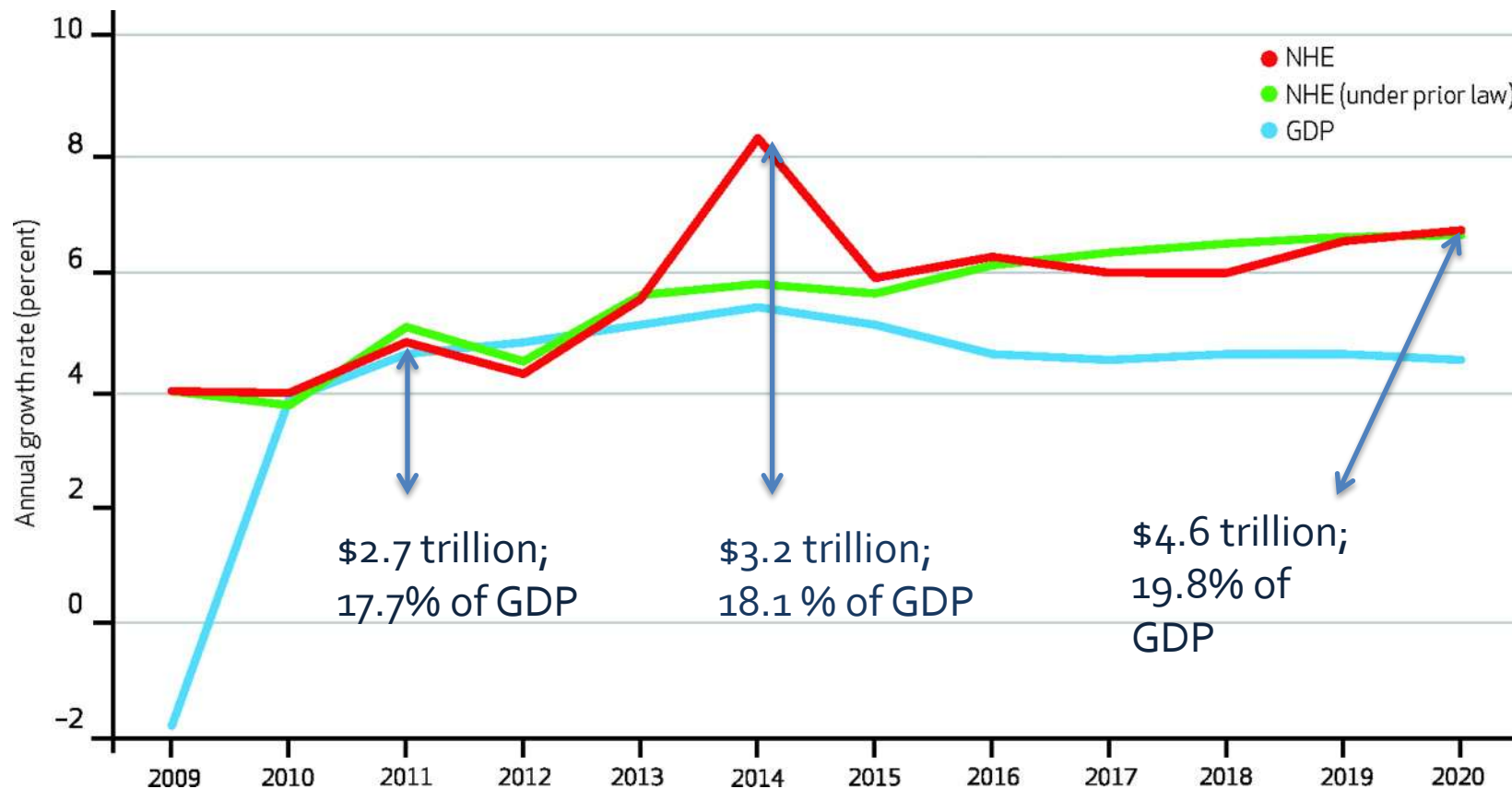


**Donald Berwick, MD**  
**Administrator**  
**Centers for Medicare**  
**and Medicaid Services**

# Lower Costs



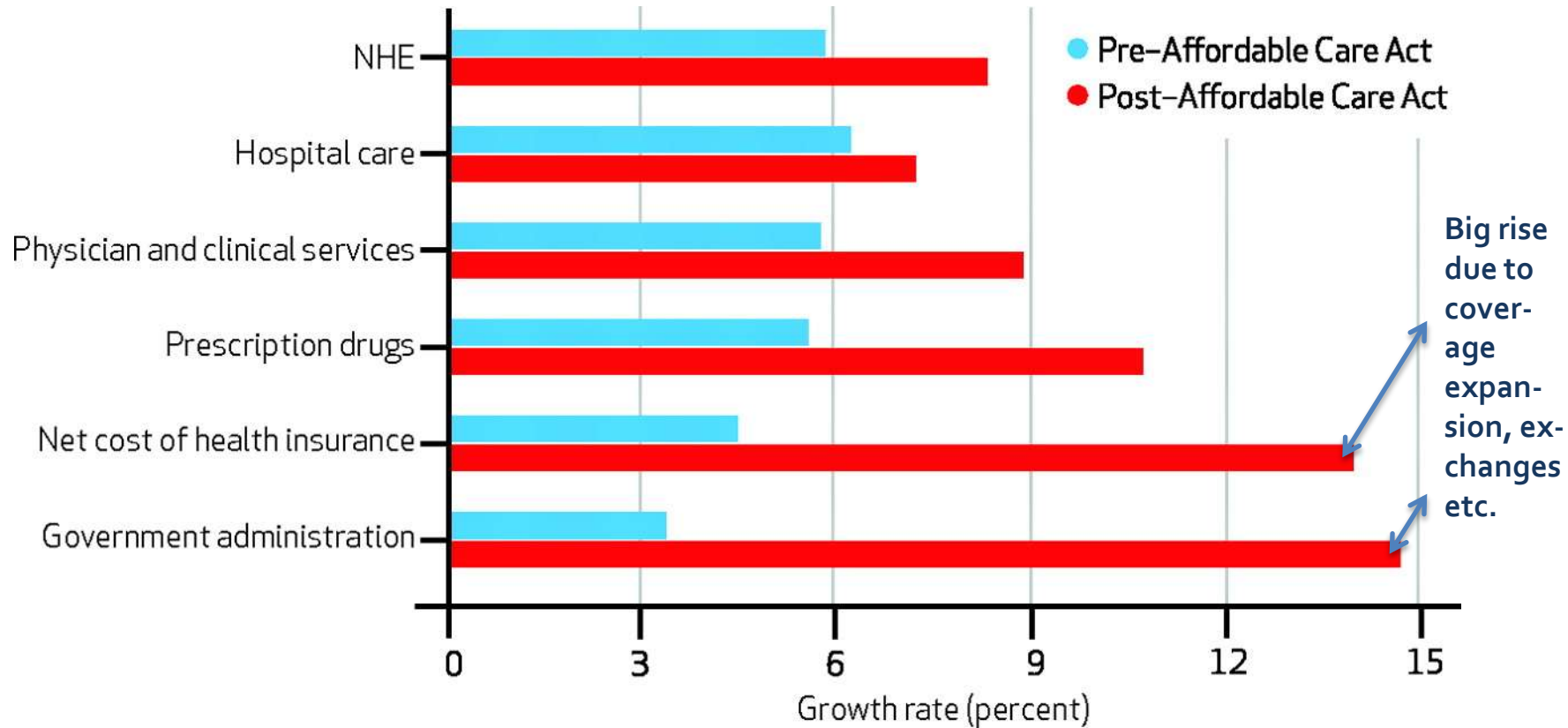
# Annual Growth Rates, Gross Domestic Product (GDP) And National Health Expenditures (NHE) Calendar Years 2009–20.



Keehan S P et al. Health Aff 2011;30:1594-1605

HealthAffairs

## 2014 Growth Rates By Selected Sector, Before And After The Impact Of The Affordable Care Act.

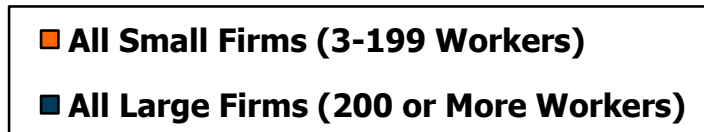
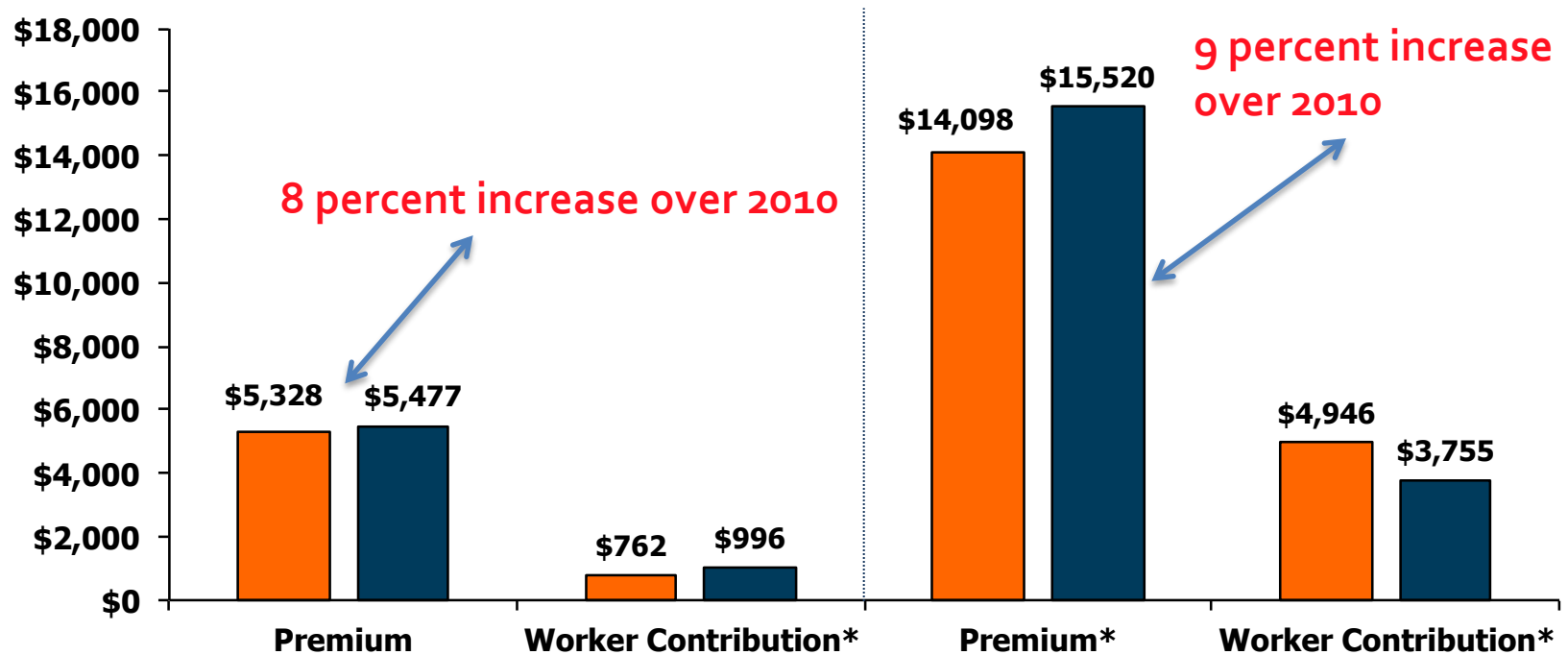


Keehan S P et al. Health Aff 2011;30:1594-1605  
CMS Office of the Actuary

HealthAffairs

# 2011 Kaiser-Health Research & Education Trust Survey

## Average Annual Worker Premium Contributions and Total Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2011



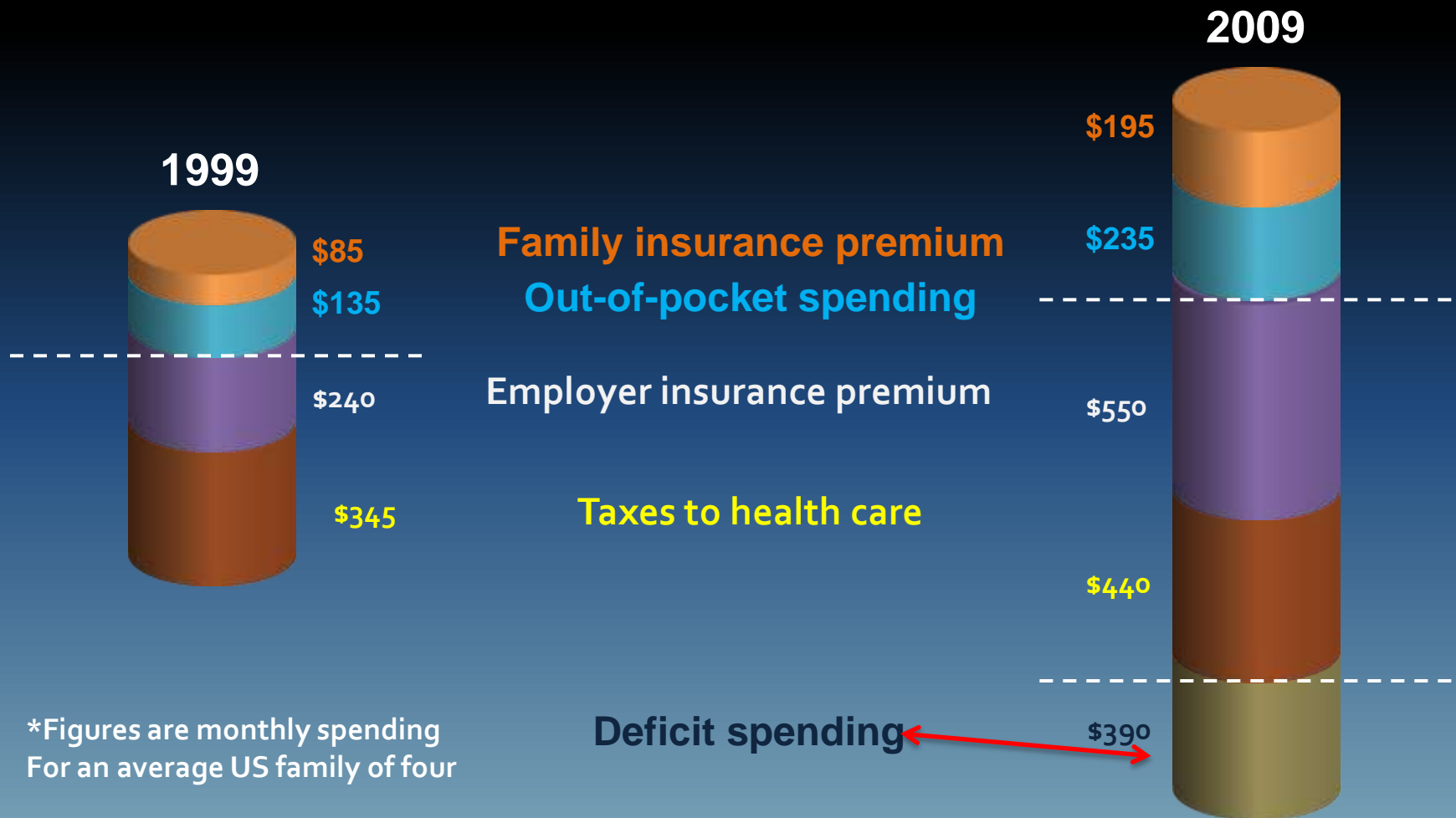
# The toll on American families

- For the decade that ended in 2009, an average American family of four saw its annual income increase from \$76,000 to \$99,000 – but **nearly all those income gains were erased by higher health spending**
- **The greatest burden** of national health spending has fallen on **families in the lowest one-fifth of the income distribution** -- those with average annual income in 2004 of \$13,450.



Sources: David Auerbach and Arthur Kellermann; Patricia Ketsche et al; forthcoming in *Health Affairs*, September 2011.

# Both visible and invisible health expenditures have grown



Forget "Occupy Wall Street"  
...How about "Occupy Health Care"?



# 2011 Census Bureau Estimates of Income, Poverty and Health Insurance Coverage

- In 2010, real median household income in the United States in 2010 was \$49,445
- A 2.3 percent decline from the 2009 median and lowest level since mid-1990s
- The number of people without health insurance coverage rose from 49.0 million in 2009 to 49.9 million in 2010
- The percentage without coverage –16.3 percent - was not statistically different from the rate in 2009.
- For children under 19, coverage grew, by roughly a half million

# The Bigger Problem Lies Ahead: National Commission on Fiscal Responsibility and Reform

- By 2025, federal tax revenue = interest on federal debt, Medicare, Medicaid, and Social Security
- Congressional Budget Office: Federal health care spending for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the health insurance exchange subsidies
- Projected to grow from nearly **6 percent of GDP in 2010 to about 10 percent in 2035**, and continue to grow



Commission  
Co-chairs  
Alan Simpson  
And Erskine  
Bowles (right)

# Joint Select Committee on Deficit Reduction (a/k/a Congressional “Supercommittee” )

- **Budget Control Act of 2011  
(August deficit-reduction deal)**
- **Earmarked \$2.1 trillion in savings over 10 years**
- **“Supercommittee” must now find an additional \$1.2 trillion in savings over 10 years, between 2012 and 2021**



Panel co-chairs  
Sen. Patty Murray  
(D-WA) and  
Rep. Jeb  
Hensarling  
(R-TX)



# Joint Select Committee on Deficit Reduction (a/k/a Congressional “Super Committee” )

- If no plan to produce \$1.2 trillion in across-the-board is enacted by January 15, 2012, automatic procedures for cutting both discretionary and mandatory spending will take effect



# Joint Select Committee on Deficit Reduction (a/k/a Congressional “Super committee” )

- Under Budget Control Act, much “mandatory” spending exempt from sequestration, including Medicaid
- Medicare cuts capped at 2 percent of payments to providers and plans per year
- = \$123 billion over 10 years
- In 2013, 2% of payments = \$10 billion
- However, this would be on top of Medicare cuts that will **drive Medicare hospital payments toward Medicaid rates by 2019 anyway.**

# Payment and Delivery System Transformation

# “Examination of Health Care Cost Trends and Cost Drivers”

- “We have only just begun to meet the challenge of addressing market dysfunction and promoting value-based purchasing and patient care coordination.
- “The market dysfunctions and inequities identified...cannot be corrected by any single policy reform or by any single group of stakeholders...
- “To control cost growth, we must shift how we purchase health care to align payments with value, measured by those factors the health care market should reward, such as better quality.”

# The Big Themes for Hospitals

- Emphasis on **care coordination** across multiple organizations – including ones you may not own or control
- **Systematization**; mergers, consolidation, acquisition of physician practices
- **Taking out** unnecessary costs
- Living on **Medicare rates**





**“You can’t be in the hospital business today and not be making money on Medicare – maybe Medicaid – because that’s where all the rates are going to go.”**

**--David Hunter, CEO,  
Hunter Partners,  
consultant to academic  
medical centers and turnaround specialist**

# Variations On A Theme

- “Every health system I’ve talked to recently has a ‘Medicare Break Even Project,’ which is, ‘how do we live under Medicare rates in 10 years’ time?’
- “Every one of them says, ‘We have to change the model of delivery. The mix of patients coming into our hospital will be unsustainable. We have to figure out how to deliver care differently to chronically ill older patients.’



Chas Roades, Chief Research Officer, Health Care, The Advisory Board Co.

# The Big Themes for Physicians

- Boosting **primary care** capacity and efficiency
- **Systematization**; mergers, consolidation, acquisition of physician practices
- **Rationalizing** use of specialists, who may be oversupplied by 50%
- Evidence-based medicine and performance metrics



# The Big Themes for Health Plans

- For those in individual and small group markets: **Survival**
- **Adapting to ACA changes: MLR, insurance exchanges**
- **For larger plans, forging new relationships with provider groups**
- **New roles: lending actuarial and other expertise**



# The Big Themes for Everybody -- Health Plans and Provider Partners

- Removing 25-30% of costs from the system
- How do we eliminate claims? Save on underlying costs of care and on processing
- Kaiser Permanente doesn't have "claims;" how can you make a health plan look as much like that arrangement as possible
- Bottom line: A health plan may look nothing like it does now For those in individual and small



# Strategy

- **Reform payment on public and private side to drive delivery system reform**
- **Government and private initiatives**



# Centers for Medicare and Medicaid Services Payment and Delivery Reform Efforts

- Readmissions program
- Comprehensive Primary Care Initiative: medical homes; all-payer national pilot; Medicaid “health homes”
- Community-based care transitions program
- Federal coordinated care office to better coordinate care of “dual eligibles” (Medicare + Medicaid)
- Bundled payment
- Value-based purchasing
- Accountable Care Organizations, including Medicare Shared Savings Program

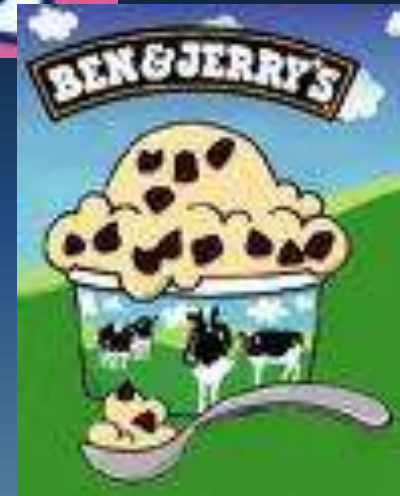
# Accountable Care Organizations

## ACO Principles

- Put the patient and family at the center
- Have a memory about patients over time and place
- Attend carefully to handoffs, especially as patients journey from one part of the care system to another.
- Manage resources carefully and respectfully
- Be proactive
- Be data-rich..
- Innovate in the service of the Triple Aim: better and better patient care, better population health, and lower cost through improvement.
- Continually invest in the development and pride of its own workforce, including affiliated clinicians.

# Accountable Care Organizations: Different “Stores,” Different “Flavors”

- 1. ACOs now forming in private sector – e.g., Empire Blue Cross Blue Shield and Montefiore Medical Center
- 2. ACOs that will be in Medicare Shared Savings Program
- 3. ACOs that will emerge under “Pioneer” and “Transitions” programs unveiled by Center for Medicare and Medicaid Innovation
- ACOs that may be a combination of 1 and 2 or 1 and 3

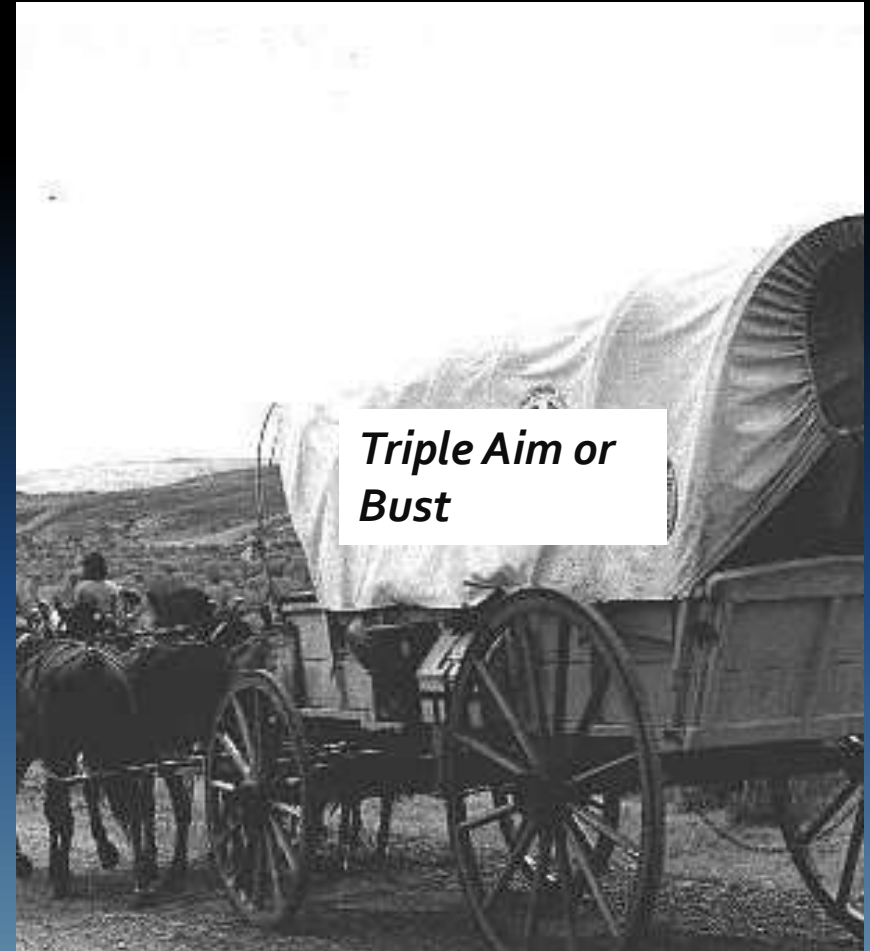


# Medicare Shared Savings Program

- **Final rule released October 20, 2011**
- **Many responses favorable**
- **Governance requirements more flexible; performance measures reduced from the original 65 to 33; assignment/attribution arrangements changed**
- **CMS expects 270 ACOs in program – realistic?**

# Other ACO options

- “Pioneer” program; 30 organizations to be selected; more aggressive quality/savings targets; providers accept more risk, move toward global payment
- Program oversubscribed
- Numbers of organizations have applied
- Partners Health Care/Massachusetts – case in point



# Other ACO options

- Transitions program
- for organizations formerly part of the Medicare Physician Group Practice Demonstration
- Include among others Dartmouth-Hitchcock, Mayo, Geisinger, Billings Clinic

# Other ACO models

- At least 12 states have passed legislation to support the transition toward ACO-like models for either their Medicaid programs or state employees.
- All major private health plans have started to implement payment reforms similar to the ACO model
- Brookings/Dartmouth and Premier Collaboratives
- New business lines – e.g., Aetna Accountable Care Solutions

# Aetna Accountable Care Solutions

- Move from: old payment system driven by **volume**
- Poor or missing **data** hindering performance
- System rewarded **inefficiencies**
- Care delivery disconnected from **accountability and quality**
- Fragmented system unable to address **true patient needs**
- Move to: **value-based** model focused on quality vs. quantity
- ~~New, relevant, and timely~~ **information streams**
- Payment system rewards **efficiency, continuity, and outcomes**
- Care delivery across the continuum, **integrated** across all providers
- System focused on provider **accountability and shared decision-making**

# Aetna Accountable Care Solutions

- Aetna is “replacing the valueless competition business model in the health care industry with synergistic collaborations in preparation for ACO operations”
- Deploying programs to improve quality, reduce supply sensitive care, and optimize care management process
- Source: Charles D. Kennedy, MD, head, Aetna Accountable Care Solutions, presentation to AHIP summit, October 18, 2011

# Aetna Accountable Care Solutions

- Aetna population based management approaches use Health Information Technology to apply evidence based medicine to care encounters
- Aetna collaborations “offer delivery systems the ability to prosper financially while reducing the cost of care to employers and improving the convenience and care quality for individual members”
- Source: Charles D. Kennedy, MD, head, Aetna Accountable Care Solutions, presentation to AHIP summit, October 18, 2011

# Health Insurance Exchanges

# Essential Benefits Package: Institute of Medicine Committee Recommendations

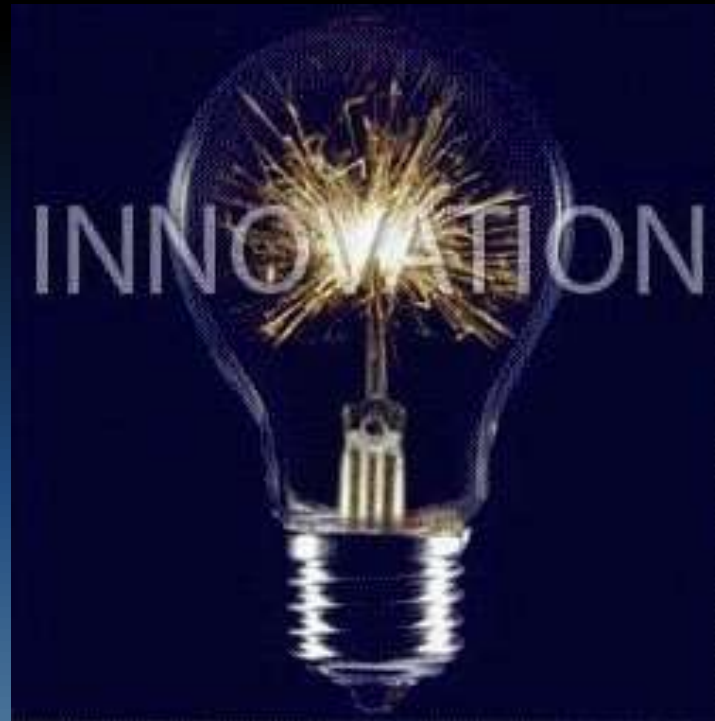
- Initial Essential Health Benefits package should be **a modification of what small employers are currently offering.**
- Package can be improved over time **“based on evidence of what improves health and that it promotes the appropriate use of limited resources.”**
- HHS should **“develop an initial package within a premium target.”**

Source: IOM report, *Essential Health Benefits: Balancing Coverage and Costs*, October 2011

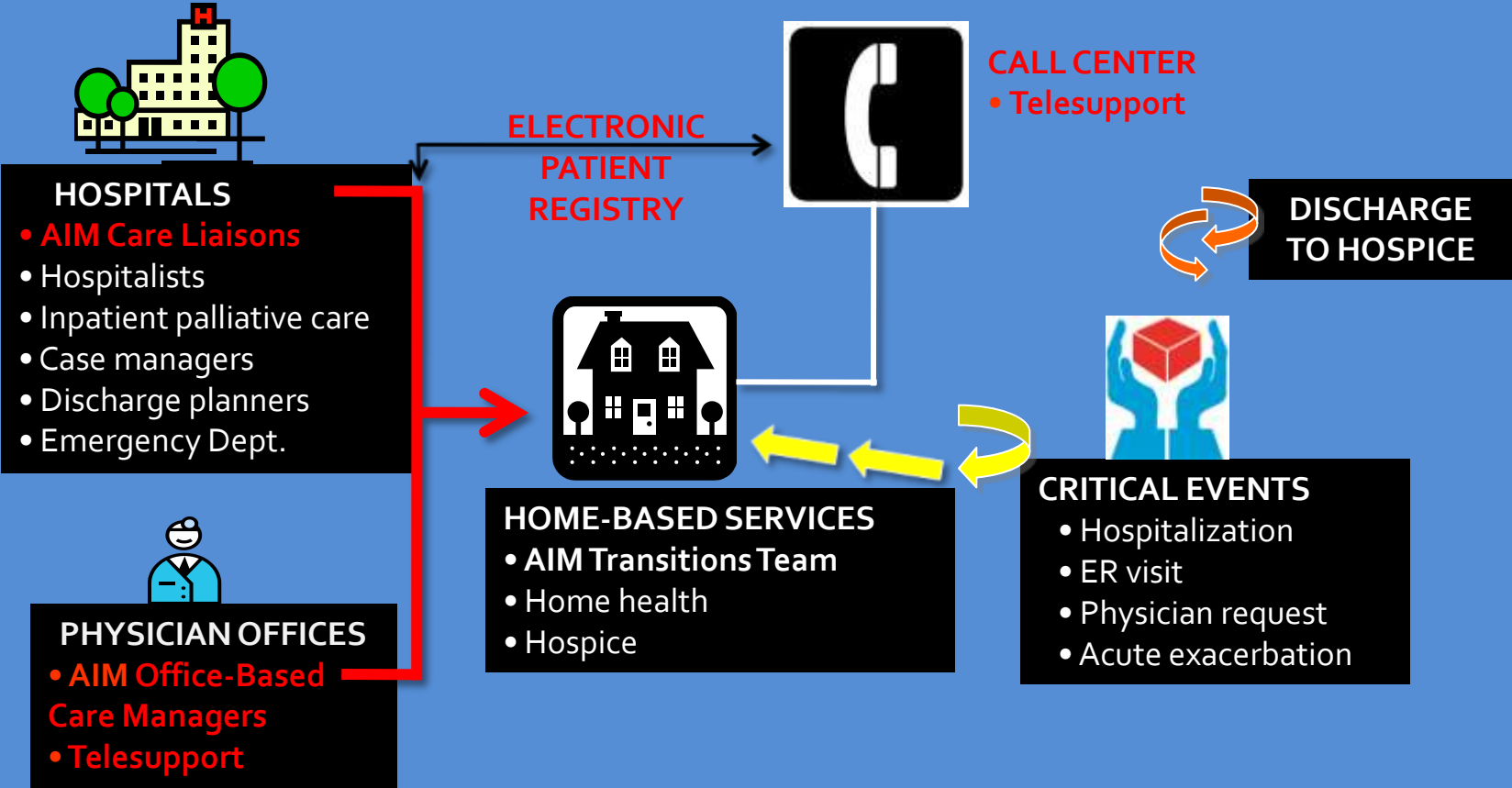
# Exchanges: Implementation Timeline

- January 2013: HHS secretary will verify whether each state will be ready to open its exchange on time
- If a state chooses not to run its own exchange, or is deemed unprepared, the secretary will take responsibility for its exchange functions (although now appears some leeway will be granted)
- January 1, 2014: exchanges are to be operational
- Questions: will timeline be met? By how many states? What then?

# Innovations Under Way Among Health Systems and Payers



# Sutter VNA & Hospice: Care Coordination

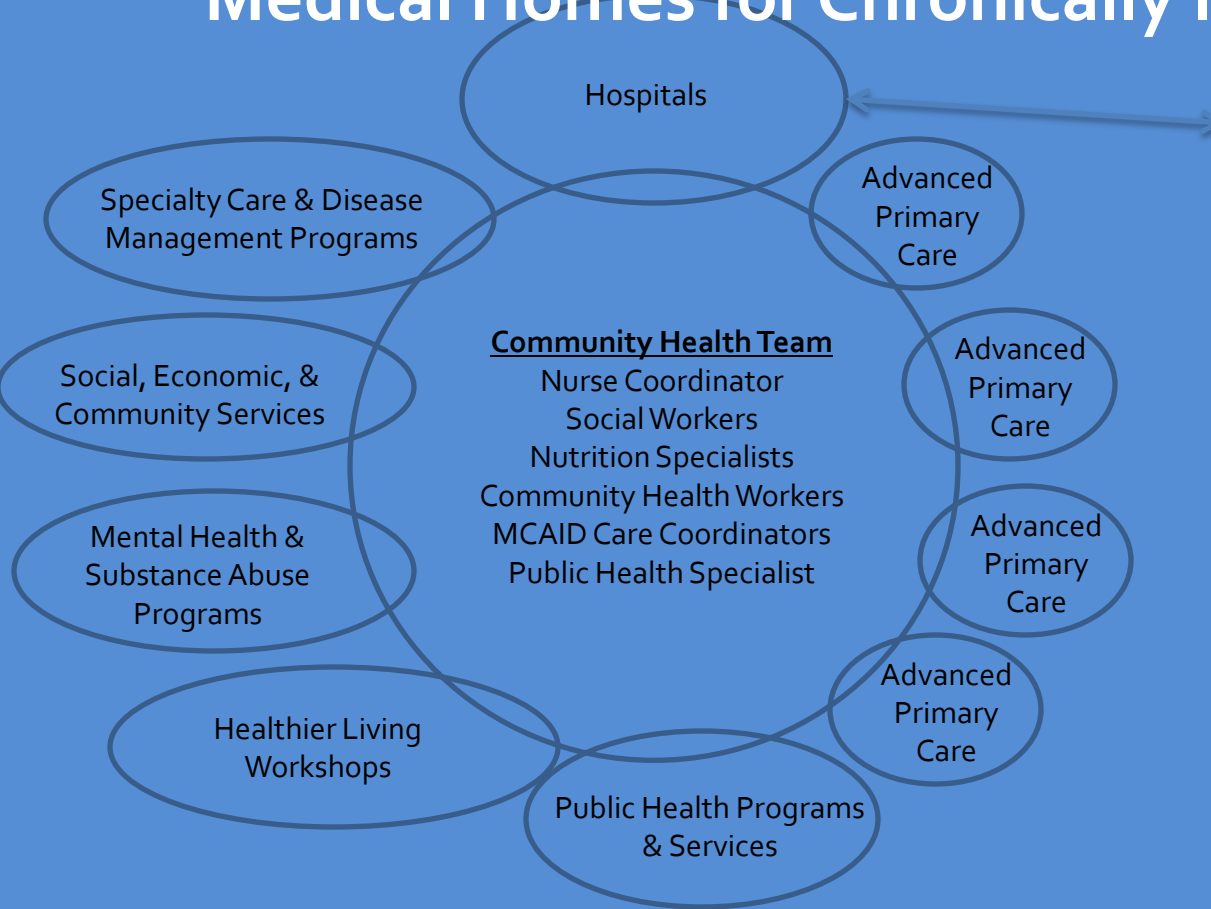


**Sutter VNA & Hospice:  
AIM 2.0 Preliminary Outcomes  
Sample period: 11/9/09-9/30/2010**

	<b>Days Pre/Post AIM Enrollment</b>		
	<b>30</b>	<b>60</b>	<b>90</b>
<b>N</b>	<b>185</b>	<b>121</b>	<b>96</b>
<b>Δ Hospitalizations</b>	<b>-68%</b>	<b>-59%</b>	<b>-63%</b>
<b>Total Direct Cost Savings*</b>	<b>\$394,326</b>	<b>\$475,305</b>	<b>\$573,581</b>
<b>Savings/Enrollee/Month*</b>	<b>\$2131</b>	<b>\$1964</b>	<b>\$1992</b>
<b>Excellent patient satisfaction</b>			
<b>Excellent physician satisfaction</b>			

\*Includes savings from reduction in Emergency Department and hospital-based outpatient services

# Vermont Blueprint for Health: New System of Medical Homes for Chronically Ill in State



Fletcher Allen Medical Center/  
University of Vermont;  
Dartmouth-Hitchcock Medical  
Center as tertiary care  
Facilities also providing  
Research support

State is also putting  
in place  
a new “single payer”  
health insurance  
system to ensure  
basic coverage  
for all

- Health IT Framework
- Evaluation Framework

# Reducing Costs and Improving Quality at Denver Health

- In 2010 Denver Health, Denver's major safety net system, ranked **first among US academic medical centers in terms of actual mortality observed relative to the national mortality rate**
- System has used "Lean" methods to identify "value streams" and extract costs, now exceeding \$70 million per year
- If a safety net system/academic medical center can do this, how about the rest of us?
- Sources: Patricia A. Gabow and Philip S. Mehler, "A Broad And Structured Approach To Improving Patient Safety And Quality: Lessons From Denver Health." *Health Affairs*, 30, no.4 (2011):612-618. Also, Harris Meyer, Life In The 'Lean' Lane: Performance Improvement At Denver Health. *Health Affairs*, 29, no.11 (2010):2054-2060

# Strategies Internal to Organizations

- Reduce utilization – e.g., unnecessary admissions and readmissions
- Reduce clinical resource consumption in care processes
- Take out steps; streamline care
- Look for best demonstrated practice in institutions and reduce variation among providers
- Reducing variation also increases quality

# Innovations In Integrated Care Management

- “Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers”
- Study identified 22 health plans with approximately 30 accountable care arrangements in place or underdevelopment; focused on 8 plans
- Aparna Higgins et al, *Health Affairs*, September 2011

# “Alternative Quality Contract,” Massachusetts

- All AQC groups met 2009 budget targets and earned surpluses
- Total BCBS payments to provider groups, including bonuses for quality, likely to have exceeded the estimated savings in year one (2009)
- BCBS Massachusetts and groups believe larger savings will result in 2010 and beyond
- Two major academic medical centers/systems have now joined – Partners Health Care (the Harvard institutions and affiliates) and Tufts Medical Center
- By 2012, 68 percent of in-state HMO membership will be enrolled
- Source: Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. Zirui Song, B.A., Dana Gelb Safran, Sc.D., Bruce E. Landon, M.D., M.B.A., Yulei He, Ph.D., Randall P. Ellis, Ph.D., Robert E. Mechanic, M.B.A., Matthew P. Day, F.S.A., M.A.A.A., and Michael E. Chernew, Ph.D.. July 13, 2011 (10.1056/NEJMSa1101416)

# New signatory to AQC: Partners Health Care

- Gary Gottlieb, President and CEO, Partners HealthCare
- IOM Health Policy Interest Group Meeting, October 16, 2011
- Partners' new model
- "Fewer units of care at less cost"
- Reduce trend by 50 percent
- "Become leading provider of population based care and a premier provider of episode-based care"



# Geisinger's "ProvenHealth Navigator" Advanced Medical Home

- **Chronic care management, Medical Home, and Patient-Centered Primary Care**
- **360-degree, 24/7 continuum of care**
- **System-wide EHR**
- **"Embedded" nurses in primary care practices**
- **Assured easy phone access**
- **Telephonic monitoring/case management**
- **Personalized tools (e.g., chronic disease report cards)**



Glenn Steele,  
CEO  
Geisinger



By Glenn D. Steele, Jean A. Haynes, Duane E. Davis, Janet Tomcavage, Walter F. Stewart,  
Tom R. Graf, Ronald A. Paulus, Karena Weikel, and Janet Shikles

**ANALYSIS & COMMENTARY**

## **How Geisinger's Advanced Medical Home Model Argues The Case For Rapid-Cycle Innovation**

**ABSTRACT** The Patient Protection and Affordable Care Act of 2010 provides for a number of major payment and delivery system initiatives. These potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services. We discuss lessons learned from our iterative tests of care reengineering at Geisinger—specifically, through our advanced medical home model, ProvenHealth Navigator™, and the way we continuously modified the model to improve quality and value. We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.

“We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and **the real-time feedback of data on the use of health services by the most complex patients.**”

Source:  
*Health Affairs*,  
2010 Nov; 29(11):2047-53.

## REENGINEERING THE DELIVERY SYSTEM

### EXHIBIT 2

Risk-Adjusted Acute Hospital Admission Rates Per 1,000 For Primary Care Patients In Geisinger Health System Clinics That Launched ProvenHealth Navigator™ In Different Years, By Year Before Or After The Intervention, 2006-9



SOURCE Geisinger Health System.

Geisinger  
Health  
System:  
Hospital  
Admission  
Rates  
For  
Patients in  
Medical Home

Source:  
*Health Affairs*,  
2010 Nov; 29(11):2047-53.

# Geisinger

- Will be part of Transitions program (extension of Medicare Group Practice Demonstration)
- Geisinger `s total cost of care increase in past year for attributed Medicare patient population was 1.4%

# **“A Model For Integrating Independent Physicians Into Accountable Care Organizations”**

- **Advocate Physician Partners, affiliated organization to Advocate Health System, largest hospital system in Illinois**
- **Organized independent physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results.**
- **Signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield**
- **Other commercial contracts to follow**
- **Source: Health Aff January 2011 30:1161172; published ahead of print December 16, 2010, 10.1377/hlthaff.2010.0824**

# Blue Shield of California, Catholic Healthcare West and Hill Physicians Medical Group

- In past decade, California HMO rates have increased an average of 11 percent a year
- With trend at 8 percent, by 2020, family rate for HMO coverage will be nearly \$39,000 per year
- Juan Davila, Senior Vice President, Network Management, Blue Shield: “We believe this will not happen; either the private sector will solve this issue or it will be solved for us.”

# Blue Shield of California, Catholic Healthcare West and Hill Physicians Medical Group

- 41,500 members of a Blue Shield HMO; coverage obtained through the California Public Employees' Retirement System
- Members served by Hill Physicians, whose doctors are affiliated with Catholic Healthcare West, the state's largest hospital chain
- Collaboration shaved more than \$20 million in costs in 2010 and prevented an insurance rate hike for public sector workers in Northern California

# Blue Shield of California, Catholic Healthcare West and Hill Physicians Medical Group

- Top 5 percent of patients account for 75 percent of pilot population spend
- Collaboration identified a few elective procedures — including knee and hip replacement and bariatric surgery — among the biggest cost drivers
- Overweight patients enrolled in a Hill Physicians weight-loss program, assisted by psychotherapists and dietitians
- Bariatric Surgeries reduced by 13% last year

# Blue Shield of California, Catholic Healthcare West and Hill Physicians Medical Group

- **Emergency patients taken to hospitals outside of Catholic Healthcare West stabilized and then directed back to the hospital system for in-network care**
- **Unnecessary readmissions reduced 15 percent; also 15 percent reduction in average length of stay**
- **On discharge, nurses reviewed patients' post-hospital instructions and then asked them to repeat it all back.**
- **Patients given appointments with doctors before going home.**

# What's ahead: The unforeseeable future



# Challenges for All

- **For Providers In Patient Care:**
  - ✓ **Very tough payment environment on Medicare and Medicaid, private pay**
  - ✓ **Need to live within Medicare – if not Medicaid – rates**
  - ✓ **Transition to new models – global payment; all-payer**
  - ✓ **Influx of patients as coverage expands in 2014; many may have serious health needs that have gone unaddressed for some time**
  - ✓ **Still large group of uninsured patients thereafter, many of them undocumented immigrants**

# Challenges for All

- **In Payers and Providers in Driving Delivery System Reform:**
  - ✓ **Forming collaborative relationships with other entities in system**
  - ✓ **Sharing risk with others in system**
  - ✓ **Forging new relationships with physicians and physician groups**
  - ✓ **Meeting wide variety of new goals and expectations of payers, especially in tight payment environment**
  - ✓ **Doing all this while implementing “meaningful use” and ICD-10**

# Challenges for All

- **For All In Improving Health**
  - ✓ Living in a time when social and economic determinants of health are worsening for millions of Americans, not improving
  - ✓ Dealing with issues related to human behavior
  - ✓ Gaining political consensus on needed changes – e.g., to food supply
  - ✓ Attaining needed funding for prevention

Where does this leave us?  
Summary Views



**“Prediction is very difficult, especially  
about the future.”**

-- Danish physicist and Nobel Prize Winner Niels Bohr



**“There has never been a better time to be an  
Innovator in health care.”**

**--Don Berwick, administrator, CMS  
Military Health System conference  
January 2011**



**“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”**

**--Bill Gates Jr.**



**“We always need to remember that behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time.”**

**– Gail Collins, *The New York Times*, August 13, 2010**



The End