L.E.K.

EXECUTIVE INSIGHTS

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Will ACOs Keep Hospitals and Insurers Out of Critical Care?

Much of the healthcare debate in the United States is focused on achieving the twin goals of improving patient care and reducing costs. While these objectives aren't mutually exclusive, success on both fronts will require the U.S. healthcare system to change radically from the current fee-for-service (FFS) model, which revolves around individual treatments, to a more holistic approach that measures patients' overall health, wellness and the quality of care. This marked shift in healthcare delivery will require better cohesion and coordination among providers, insurers and government agencies.

Although there is broad consensus about the need to adopt a more holistic patient care approach, there are a number of competing visions for actually implementing this new healthcare ecosystem. Among the various plans being debated, the Accountable Care Organization (ACO) model has been put forth with the promise of achieving these goals.

Simply stated, the ACO blueprint has payers (government or private insurers) establish financial incentives and risk-sharing with healthcare providers, who will be held accountable for improving overall patient health. ACO sustainability is predicated on hospitals and other providers having the appropriate financial incentives and infrastructure to treat patients across a continuum of care while also managing their costs more efficiently. This will be especially challenging because L.E.K. Consulting forecasts that healthcare reform will place added financial strain on hospitals, and drive many of them to operate in the red once new mandates take effect.

Hospital Operations: Weak Vital Signs

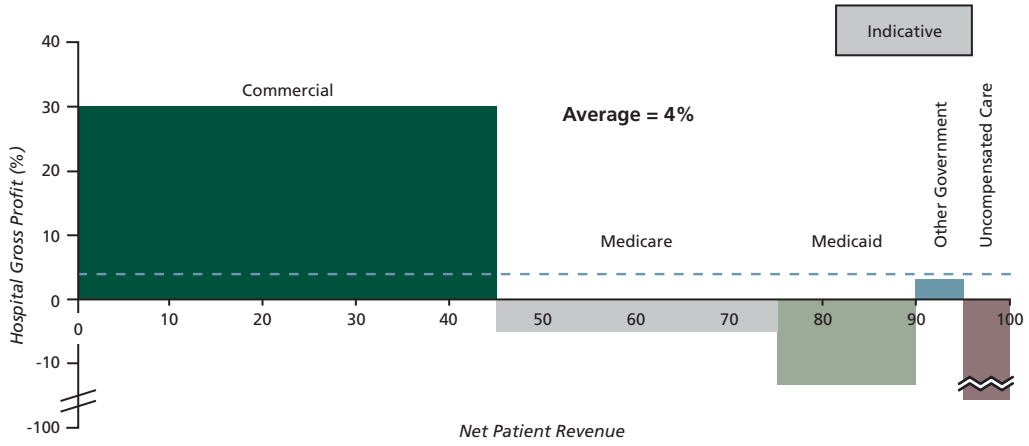
An American cultural truism is that hospitals and doctors apply the same standard of care to all patients regardless of their ability to pay. While this commitment is laudable, the marketplace has shown that it is difficult to sustain financially. Historically, the fiscal health of U.S. hospitals and health systems has been tenuous at best, and largely predicated on these institutions generating profits from commercial health insurance plans to cover losses assumed when caring for individuals who either don't have insurance or are covered by Medicare or Medicaid (see Figure 1).

To illustrate this point, commercial health insurance plans typically constitute approximately 45% of net patient revenues associated with hospital visits, procedures and related care conducted annually nationwide. Commercial health insurance plans also generally provide the majority of hospitals' gross profits because their reimbursement rates are significantly higher than those from federal agencies (e.g., 140% of Medicare rates). Conversely, hospitals are typically only reimbursed 92% of their care costs for typical Medicare patients and approximately 83% for Medicaid enrollees.

Will ACOs Keep Hospitals and Insurers Out of Critical Care? was written by the L.E.K. Consulting Healthcare Services Practice. Please contact L.E.K. at healthcare@lek.com for additional information.

Figure 1

Estimated Gross Profits for a Representative U.S. Hospital (2010-2011)



Source: L.E.K. Consulting

L.E.K. estimates that more than half of all U.S. hospitals and health centers are not structurally set up to provide care at costs that are within Medicare and Medicaid reimbursement rates. Clearly, these facilities are not financially viable serving these lower reimbursement populations. These two government programs serve a combined 105 million individuals (approximately 45 million Medicare patients and 60 million in Medicaid), which is approximately one-third of the U.S. population.

But enrollment numbers alone don't fully measure the impact that Medicare and Medicaid patients have on the healthcare system. Medicare provides approximately 30% of all reimbursements to hospitals – nearly five times the percentage of the American population that it insures.

Hospital Revenue Projections in the Era of Healthcare Reform

Despite the ongoing political wrangling and legal battles that may alter the final healthcare reform framework, some changes will likely take hold. Looking ahead to the next decade, L.E.K. predicts a pronounced shift in how the U.S. population will be covered, which will have significant ramifications for hospitals, health systems and providers.

The combination of reform and macro market dynamics may cause the following:

- Businesses May Drop Commercial Insurance Coverage: Many companies may discontinue their employer-sponsored coverage plans and instead subsidize employees' healthcare benefits on the health insurance exchanges (similar to that in Massachusetts or Utah), which are slated to come online nationally in 2014. In some cases employers may determine that it is cheaper to pay government penalties and not provide employee coverage at all. In either case, the commercial employer group market is likely to begin to unwind, which will add pressure to hospitals and providers by reducing the population of higher reimbursement, commercially insured patients.

- Insurance Exchanges Grow: The new health insurance exchanges will likely expand as employees who no longer have access to employer-sponsored plans will shop for coverage online. Previously uninsured individuals will also shop on exchanges with government subsidies to purchase individual coverage. Both of these dynamics will lead to significant growth in the individual insurance market and make exchanges the dominant distribution channel.

- The Aging Population: Baby Boomers reaching retirement age will cause the Medicare ranks to grow at a time when entitlement reform reduces Medicare reimbursements. For hospitals, this demographic shift will transition individuals from profitable, higher reimbursement commercial insurance coverage to Medicare as they age into the program (at a rate of roughly 3.1% per year).

• Increased Medicaid Enrollment: The healthcare reform legislation includes provisions that greatly expand Medicaid eligibility to help cover a portion of those who are currently uninsured. As part of this effort, the federal government will fully fund the expansion for individuals who meet the criteria between 2014-2017. Beginning in 2018, federal Medicaid funding will likely revert to lower historical levels – with the federal government paying roughly 65% of Medicaid costs and the states bearing the remainder. For the Medicaid program to remain financially viable post-expansion, the states will likely have to provide lower reimbursements to hospitals and providers. This means that Medicaid, which is commonly regarded as a "bad payer," will likely get worse.

• Hospital Bad Debt Shrinks: The healthcare reform legislation will provide coverage for the majority of previously uninsured individuals through expanded Medicaid coverage, or subsidized individual coverage through exchanges. Since a hospital's bad debt is largely driven by care for the uninsured, this reduction will significantly shrink the amount of bad debt that hospitals accrue. This is one of the few positive impacts of healthcare reform for hospitals and providers.

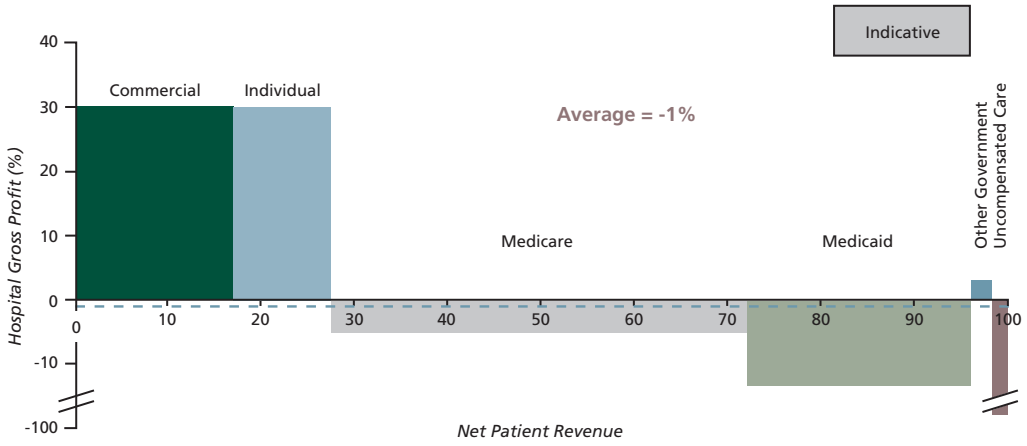
As a result of these marketplace changes, L.E.K.'s analysis indicates that the percentage of net hospital patient revenue from commercially insured plans will drop by more than half while Medicaid, the most unprofitable payer for most hospitals will expand 10% (see Figure 2). L.E.K. also forecasts that the percentage of total reimbursements from Medicare will grow approximately 15%, driven by seniors aging into the program. Based on this insight, L.E.K. projects that reform will place significant financial pressure on hospitals and health systems, transforming them from slightly profitable entities today to operating at annual net losses in the future.

The L.E.K. analysis addresses the shifting population mix and uses the relatively optimistic assumption that hospitals will continue to realize the same level of gross profit margins from commercial insurers and individuals in the post-reform era as they do today. For simplicity, the analysis also assumes no further margin erosion for either Medicare or Medicaid. In reality, reimbursement rates from commercial insurers, Medicare and Medicaid are likely to decrease in the wake of healthcare reform because of mounting financial pressure on both private payers and government entitlement programs. Hence the true outlook is likely worse than the picture painted here.

Changing the Hospital Mindset

So, how should hospitals address their financial pressures and revenue challenges while also continuing to deliver high-quality care? The answer requires a shift in the mindset of many hospital executives, and in some cases, a more nuanced patient care strategy.

Figure 2
Projected Gross Profits for a Representative U.S. Hospital
Post Healthcare Reform (2020F)



Source: L.E.K. Consulting

Historically, most hospitals and health systems have aspired to be "Centers of Excellence" (COE) for multiple conditions (e.g., cardiology, oncology, women's services, etc.). Consequently, hospitals have often overinvested in facilities, technology and equipment to develop "best-in-class" offerings for specific specialties or sub-specialties. Unfortunately, in many instances these new resources remain underutilized because the hospital's vision for all-around expertise is not aligned with market needs or competitive realities. Going forward, it is critical for hospital executives to map their strategies closely with the key populations that they serve.

For example, a mid-sized regional hospital system contacted L.E.K. with an idea to overcome its financial challenges by developing a broad suite of new services that would better target commercial health plan members. However, L.E.K.'s market analysis revealed that the population of commercially insured consumers in the hospital's service area was shrinking, while the number of Medicare-aged individuals and Medicaid members was large and growing faster than initially realized.

What's more, the hospital's primary competitor – a large, urban hospital system – had already established a significant regional presence in multiple specialties. Attacking this entrenched competitor would require a sustained and costly marketing campaign to attract consumers to the regional hospital system.

The new understanding of the region's changing demographics caused hospital leaders to rethink their path forward. L.E.K. worked closely with hospital executives to refocus their strategy around three key service lines. These included targeting cardiac services where they had a strong offering, developing low acuity services for lower reimbursement populations (alternatives to the emergency room) and enhancing targeted care for seniors. This multi-pronged strategy provided a sustainable and differentiated advantage for the hospital and improved financial performance by aligning core services with the needs of the area's primary populations.

Seven Steps to Establishing a Sustainable Model for Hospitals and ACOs

Based on our extensive research and work with hospitals, health systems and payers, L.E.K. has identified seven key considerations that hospitals and payers should address to create financially viable and sustainable care models, including ACOs.

1) Reassess Market Needs:

- Hospitals: The case study in the previous section illustrates why hospitals must realign their services and investments to meet evolving community requirements and develop strategies to provide care to growing populations efficiently and cost effectively.

- Payers: Use market insights and relationships with hospitals, providers and health systems to institute tailored programs (e.g., wellness) to better address specific populations. A shared view of population dynamics and collaboration with providers are keys to success.

2) Create and Administer the New Care Models:

- Hospitals: Providers should begin reorienting themselves to support a more holistic approach to patient care across all settings. This is especially important as hospitals establish their role in ACOs, and as the Medicare ACO compliance mandates come into effect in 2012.

- Payers: Experience working with a variety of providers makes insurers well equipped to establish a process of effective care choreography (e.g., coordinating health and wellness initiatives among hospitals, doctor practices, ancillary care providers, post-acute settings, etc). There are currently a number of pilots where payers are collaborating with providers to develop ACOs that demonstrate many of these attributes. (Please see the ACO successes sidebar for current market examples.)

3) Institute Incentives Focused on Holistic Patient Care:

- Hospitals: To serve the patient across the continuum of care efficiently, many hospital executives are considering acquisitions, joint ventures and alliances to create a more cohesive

health ecosystem that aligns hospitals, health centers, primary care and specialty physicians more closely. While doing this, they also need to consider risk/gain sharing models that establish appropriate financial motives among participants across the continuum of care.

- Payers: Given their experience as bearers of financial risk, payers can work with ACOs to develop and implement new risk management strategies as alternative payment models are introduced (e.g., revisiting capitation, gain sharing, bundled payments, etc.).

4) Integrate Clinical Data:

- Hospitals: Federal grants (such as ARRA HITECH funding) for modernization of information technology (IT) systems and meaningful-use implementations of electronic health records (EHR) systems will play key roles in accelerating the ability to share patient information securely among providers. Historically, changing the provider mindset regarding the value of clinically integrated data systems has proven difficult because most providers believe that payers (and patients to a lesser degree) are the primary beneficiaries of greater clinical transparency, simplified billing, etc. Despite claims to the contrary, technology has been available to achieve this goal, but the (often implicit) perceived lack of benefit to providers is largely why EHR's and other integrated information systems have been "five years away… for the past 20 years." Hospitals and providers must move past these perceptions and accept that clinical outcomes and quality measurement will be part of their financial equation going forward.

- Payers: Leverage IT infrastructure to support clinical data integration of hospitals and providers. This strategy extends the current "wiring" beyond basic revenue cycle management/claims payment applications to help enable information flows across care settings. Appropriately leveraging this infrastructure has the potential to accelerate the flow and access of clinical information while minimizing IT compatibility and accessibility roadblocks.

5) Ensure Seamless Transition of Care:

- Hospitals: Controlling care transitions (from hospital to post-acute provider, or hospital to home care) represents a key lever in addressing issues around hospital re-admits due to poor post-discharge planning and coordination in the next care setting. Given the focus on readmission reduction by the Centers for Medicare & Medicaid Services (CMS) and other payers, future reimbursements will be linked partially to a hospital's ability to reduce readmissions. This requires improvements in care transition and accountability for care outside the traditional hospital walls.

- Payers: By working with providers to deploy new and existing innovative care models, payers can help improve the quality of care and reduce costs linked to poor care transitions, which is often a driver of readmissions or complications post-discharge. As an example, several novel ACO pilots have pursued approaches that marry the efforts of payers and providers to transitional care model creation and coordination. (Please see the ACO successes sidebar for examples.)

6) Measure Performance:

- Hospitals: Given the impending linkage between quality, outcomes and reimbursement, hospitals have the opportunity to innovate by enhancing their ability to track quality and cost metrics across multiple patient populations. For example, provider quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS]) underpin the majority of metrics used to develop Medicare Advantage (MA) Star Quality ratings. Therefore, it is critical that hospitals track and work to improve the measures that will influence their reimbursements. This is an area where innovative hospitals could lead the revolution instead of being run over by it.

- Payers: As a leading indicator for the broader issue of healthcare quality, the Medicare Star Quality ratings for MA insurers provides an overall measure of a plan's quality and member satisfaction. Quality ratings such as MA Stars are a composite indicator of the quality of care, access to care, responsiveness and beneficiary satisfaction provided by the plan. However, because the majority of measures used to determine Stars are linked to provider performance, MA plans are using a variety of approaches to change provider behavior and drive improved quality. In the future, it is likely that the government and other payers will adopt measures similar to Medicare Star Quality ratings to gauge quality across all patient populations and reimburse providers accordingly.

Highlighting ACO Health Plan Pilots

There are a number of health plans that are piloting approaches to enhance holistic care for their members. Below, L.E.K. has spotlighted select insurers that are seeing early signs of success.

Health Plan and Date Initiated	ACO Pilot Program	Goals & Initial Results
Aetna (2007)	ACO partnership with 36 primary care physicians (PCP) practices to serve 20,000 Aetna Medicare Advantage members	• Managed Aetna MA members required 43% less acute (critical) hospital care than FFS in 2010 than in 2007
Blue Shield of California (California 2009)	Collaboration with Hill Physicians Medical Group and Catholic Healthcare West to form an ACO for the California Public Employees' Retirement System members	• ACO have saved more than $15 million • Program has reduced readmits and stays, eliminated some duplicative procedures, and increased use of generics • Patients are more compliant with in-network care
CIGNA (Georgia 2010)	Pilot of 10,000 individuals covered by CIGNA who receive care from Piedmont Physician Group	• CIGNA to evaluate results after program has been operational for at least one year • PCPs rewarded for improving outcomes and costs
Humana (Kentucky 2010)	Humana and Norton Healthcare coordinate care at Norton-owned patient-care sites, including four Louisville hospitals	• Improvements in preventive screenings • Better management of chronic illnesses • Appropriate utilization of generic drugs
UnitedHealthcare (Arizona 2009)	Collaboration with IBM and PCPs in Phoenix/Tucson on a PCMH	• PCMH focused on lowering costs by reducing ER visits and hospitalizations resulting from lack of immediate access to PCPs
WellPoint (2011)	ACO-like benchmarks for 1,500 hospitals in 14 states that serve WellPoint's 34 million Blue Cross Blue Shield members	• Insurer sets new requirements for hospitals to receive reimbursement increases • Measures for wellness include patient relapse after hospital stays and patient satisfaction

7) Educate Consumers About New Care Models:

- Hospitals and Payers: Changes in healthcare services can make consumers understandably concerned about how new programs will affect them. To overcome this, it is important to educate consumers about the advantages of new care delivery models such as ACOs and Patient-Centered Medical Homes (PCMH). And it is also important to stress how new programs, such as wellness incentives and services, can be tailored to address specific consumer needs. Emphasizing individuals' ability to help manage their care, and the benefits of new care models and approaches, will help personalize services and address misperceptions associated with reform.

Keys to Reengineering Care

Hospitals, providers and insurers need to reengineer the way they work together while transitioning to more coordinated models of care. This type of coordination can lead to greater use of alternative, low-cost care settings outside of hospitals – which can enable medical staff to treat relatively minor illnesses such as cold and flu quickly – and also serve lower reimbursement populations effectively.

Hospital executives need to maintain an open mind with respect to collaboration across the continuum of care while refocusing on the primary populations that they serve. This change in mindset is critical if hospitals are to succeed in this new environment that rewards better care at lower costs.

This fundamental change requires hospitals to explore ways to work with other providers, which will likely lead to hospital restructuring, mergers and joint-ventures, and hospital specialization (e.g., specialized facilities) to further optimize cost and care delivery for growing patient populations. As part of this ecosystem, insurers may also expand their strategies to own providers, hospitals and healthcare centers, and become more vertically integrated (as IDNs or ACOs).

Additionally, insurers can also draw from their expertise in managing risk and controlling costs to establish best practices and guidelines for integrated, choreographed patient care across a continuum of settings.

But getting the new care delivery business model right is only part of the process, as patient education and acceptance is essential to any new programs success. A clear, sustained outreach program will help consumers understand the benefits of coordinated care, wellness, and other approaches aimed at improving quality and outcomes while reducing costs. Informed patients will then be in a better position to work collaboratively with insurers and providers to follow their care regiments and take the steps necessary to maintain and improve their health.

L.E.K. Consulting is a global management consulting firm that uses deep industry expertise and analytical rigor to help clients solve their most critical business problems. Founded more than 25 years ago, L.E.K. employs more than 900 professionals in 20 offices across Europe, the Americas and Asia-Pacific. L.E.K. advises and supports global companies that are leaders in their industries – including the largest private and public sector organizations, private equity firms and emerging entrepreneurial businesses. L.E.K. helps business leaders consistently make better decisions, deliver improved business performance and create greater shareholder returns.

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