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Association of Internal Management Consultants

2010 AIMC Conference
Health Care Workshop

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Healthcare Workshop -- Agenda

- Overview of Key Issues & Trends in Healthcare
- Group Discussion on Implications for Payers, Providers, and Other Players (e.g., Pharmas)
- Role of Internal Consulting in Addressing Issues
  - Mayo Clinic
  - Elmhurst Memorial
  - Blue Cross Blue Shield of MA
- Group Discussion and Information Sharing
  - Positioning IC Groups to Provide Maximum Value

Outline of Key Issues and Trends Presentation

- Emerging governmental policies and economics
- Legal/regulatory implications and risk assessment
- Impact of new technology, including personal health records and electronic medical records
- Trend toward aligned/integrated delivery systems and value-adding networks
- Evolving business models, including:
  - Structural integration
  - Process coordination, and
  - Technological enablement

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Healthcare Reform Bill -- Highlights

- Largely maintains employee-based system
- No new government-run plan
- ERISA protections maintained
- Maintains State regulation under Federal framework of rules for insured business
- Reduces Medicare Advantage payments (2012) and reduces the “doughnut hole”
- Adults and children with pre-existing conditions will have insurance coverage with caps on spending
- Children up to age 26 can remain on parents’ insurance (2011+)

Healthcare Reform Bill – Highlights – cont'd

2014+

- Individual mandate:
  - All individuals must purchase minimum coverage
- Employers:
  - >50 FTEs must offer minimum coverage
- Will give more than 30 million people access to healthcare starting in 2014

Severe Challenges of the Current Healthcare Environment

The current political and economic environment has created a "perfect storm" for the healthcare industry. Just some of the key factors include:

- National/global economic uncertainty is causing cutbacks in healthcare spending by both consumers and governments.
- Increasing incentives/disincentives by government to hospital/physicians based on quality considerations, and if they do not work together, both will suffer.
- Medicare will no longer pay for mistakes (if problems occur due to mistakes, the hospital/and or physicians cannot bill for the added services).
- Due to the lack of continuity of care, rework can occur because of the inability to access medical histories.

Severe Challenges of the Current Healthcare Environment -- continued

- Increasing regulation will dictate a change in attitude in relationships between hospitals/physicians/patient
- Government stimulus spending in healthcare information technology provides incentives for conversion to electronic medical records, and reimbursement penalties for not completing the conversion by a future date certain.
- The sources of revenue are shifting and the ability to sustain a profit margin is decreasing dramatically.
- The government is likely to go to a “global fee” approach to force cooperation relative to reimbursement.
- Medicare physicians face a 20-40% pay cut next year

Pressures of Turbulent Times on Key Stakeholders

Hospitals

- Compliance and compensation concerns
- Information technology upgrade requirements
- Pressure for greater operational efficiencies and coordination of care

Physicians (medical physicians vs surgeons and groups vs individual practitioners)

- Declining compensation
- Limited access to capital
- Increasing paperwork and hassle
- Accelerating trend to group practice

Pressures of Turbulent Times on Key Stakeholders -- continued

Payers

- Government mandates (including national healthcare reform & State imposed rate caps)
- Eroding financial position
- Pricing challenges & prospect of interstate competition

Patients/Consumers

- Greater access to healthcare information
- Desire for improved convenience & service
- Pressure for quality improvement and clinical outcomes measurement
- Push for affordability of coverage
- Greater control over healthcare decision-making

Pressures of Turbulent Times on Key Stakeholders -- continued

Pharmas

- Biologics will receive a 12-year data exclusivity
- Mandated discounts to Medicaid increase from 15% to 23%
- Contributing a 50% discount to close the “doughnut hole” in prescription coverage
- Payers will experience increased pressure on their margins resulting in increased cost control for Pharmas

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Impact of New Technology

- Electronic Medical/Health Records (EMRs) (Impact of evolving functionality):
  - Data Display: greater access to patient data
  - Information Retrieval: enhanced ability to work with patient data
  - Work Flow Improvement: integrating processes around patient services
  - Enhanced Decision Support: Integrating data from multiple sources into decision templates
  - Predictive Modeling: Integrating data from multiple sources and multiple patients over time to establish patterns

Impact of New Technology--continued

- Personal Health Records (PHRs)
  - Personal health history, patient controlled
  - Contains any health information deemed important by that individual (not meaningful use compliant)
- Healthcare Information Technology/Systems (HIS)
  - Computerized physician order entry
  - Tele-health connectivity/networks

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Health Information Technology Discussion

Goals of Health Care Reform

- ✓ Provide Health Care Coverage to All
- ✓ Improve Quality, Safety, Efficiency
- ✓ Engage Patients and Families
- ✓ Improve Care Coordination
- ✓ Improve Population and Public Health
- ✓ Ensure Privacy and Security Protections
- ✓ Provide Quality Health Care to the Under-served
- ✓ Reduce the Overall Cost of Health Care

Which Drives

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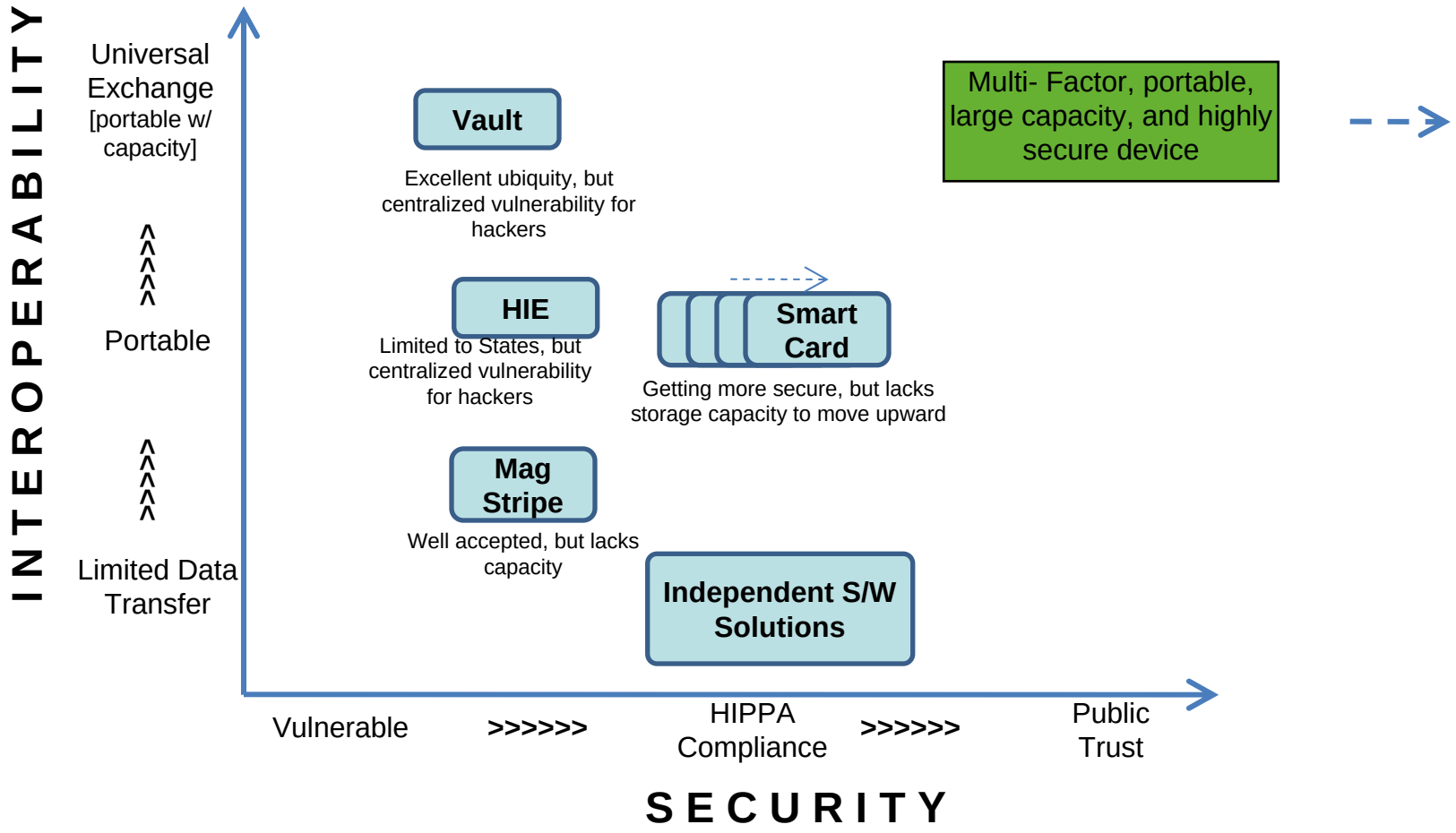
- Electronic Medical Record - EMR
  -Driven by “Meaningful Criteria”-
- Personal Health Record - PHR
- Health Information Exchange -HIE

a Portable Medical Record - PMR

A Portable Medical Record is the Secure Bridge between Diverse Heath Care Systems



The Problem

Five Tall Hurdles to Developing a Meaningful Electronic Medical Record (EMR) and Personal Health Record (PHR) Systems

1. The landscape of electronic medical information is fragmented between multiple enterprises.

2. Not many doctors use electronic health records.

3. Doctors only trust accurate medical information.

4. Technical standards vary, as do the use of medical terms for different data.

5 Who controls the data, and how can we protect patients' privacy?

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The Real Problem

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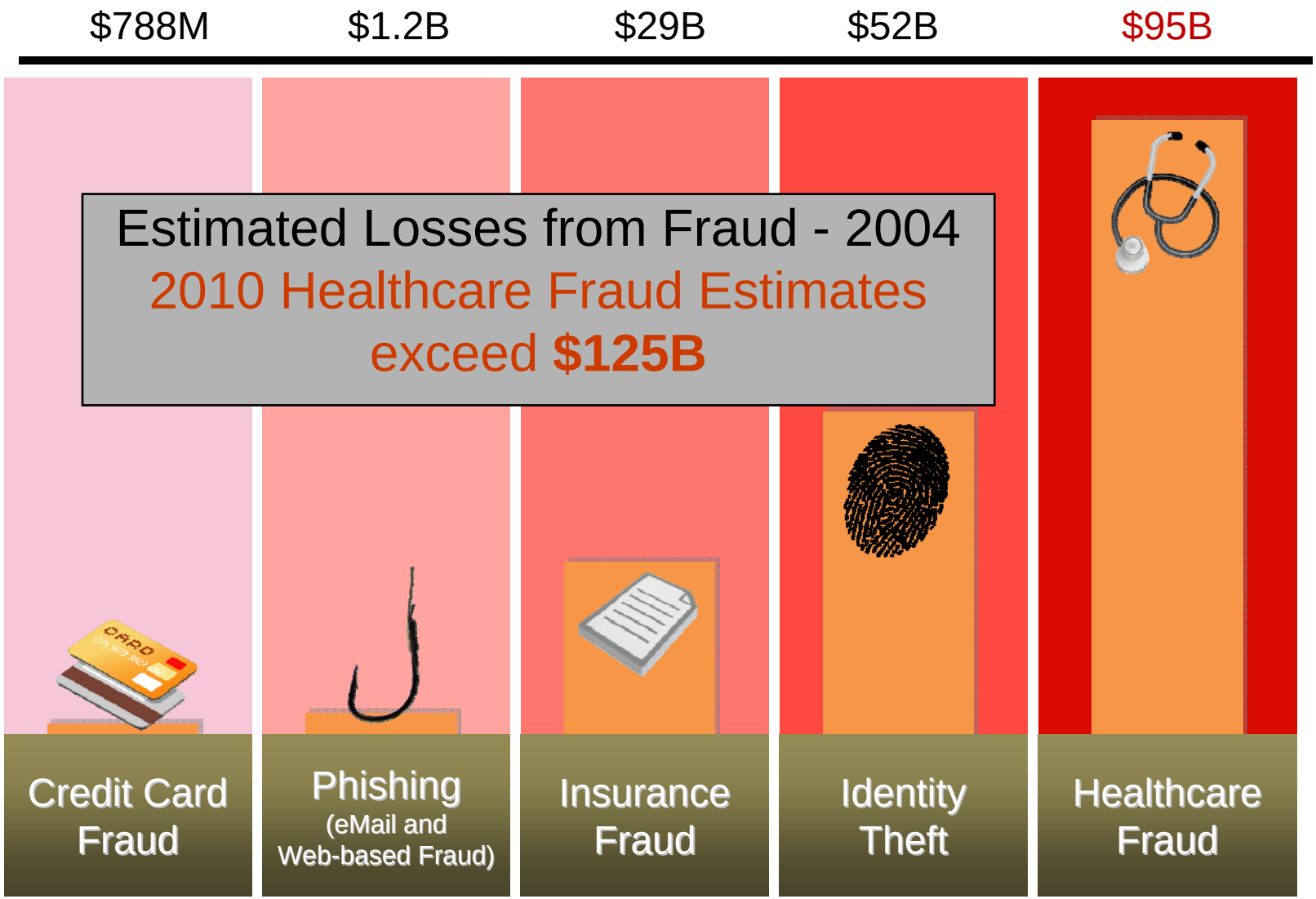

Fair Isaac Fraud Estimates for 2004 Based on Data from Various Sources

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Where We Should Focus

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Focus Group
Cost Savings Areas of Analysis

- ✓ Identify Fraud Reduction
- ✓ Provider Fraud and Error Reduction
- ✓ Reduction of Duplicate Services
- ✓ Billing Efficiency Improvement
- ✓ Savings from Medical Directive Access

The Financial Impact on the U.S. Medicaid Program

This analysis methodology was developed in conjunction with a large Medicaid Managed Care Organization.

Assumption Inputs in Yellow Cells

	yr 1	yr 2	yr 3	yr 4	yr 5
CARD ADOPTION ASSUMPTIONS					
Adoption % (assumes 1.7 M Medicaid recipients)	10%	25%	50%	75%	95%
Card Participants	5.8 million	14.5 million	29.0 million	43.5 million	55.1 million
Avg. Annual $ Claim Amount / Medicaid Participant	$5,517	$5,517	$5,517	$5,517	$5,517
Medicaid Claim $'s from Card Participants [1]	$32.0 billion	$80.0 billion	$160.0 billion	$240.0 billion	$304.0 billion
IDENTITY FRAUD REDUCTION					
% Impact on Medicaid Claims Base [2]	2.50%	2.50%	2.50%	2.50%	2.50%
$ Impact from Card	$0,800 M	$2,000 M	$4,000 M	$6,000 M	$7,600 M
PROVIDER FRAUD & ERROR REDUCTION					
% Impact on Medicaid Claims Base	2.00%	2.00%	2.00%	2.00%	2.00%
$ Impact from Card	$0,640 M	$1,600 M	$3,200 M	$4,800 M	$6,080 M
REDUCTION OF DUPLICATE SERVICES					
% Impact on Medicaid Claims Base	4.50%	4.50%	4.50%	4.50%	4.50%
$ Impact from Card	$1,440 M	$3,600 M	$7,200 M	$10,800 M	$13,679 M
PRESCRIPTION FRAUD & ERROR REDUCTION					
% of Claim Dollars related to Prescriptions	20.00%	20.00%	20.00%	20.00%	20.00%
Participating Claim Dollars from Prescriptions	$6,400 M	$15,999 M	$31,999 M	$47,998 M	$60,797 M
% Impact on Card Prescription Claims	3.00%	3.00%	3.00%	3.00%	3.00%
$ Impact from Card	$0,192 M	$0,480 M	$0,960 M	$1,440 M	$1,824 M
BILLING EFFICIENCY IMPROVEMENT					
Avg. # of Claims / Card Participant / Yr.	15	15	15	15	15
Aggregate # of Claims from Card Participants	87 million	218 million	435 million	653 million	827 million
Avg. % Participants Not Previously Utilizing EDI [3]	75%	75%	75%	75%	75%
# of Claims Migrating to EDI due to Card	65 million	163 million	326 million	489 million	620 million
$ Value Increment / Converted EDI Claim	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00
$ Impact from Card	$0,196 M	$0,489 M	$0,979 M	$1,468 M	$1,860 M
SAVINGS FROM MEDICAL DIRECTIVES ACCESS					
% Claim Dollars -- Unaccessible Medical Directives	1.00%	1.00%	1.00%	1.00%	1.00%
Participating Claim Dollars	$320.0 M	$800.0 M	$1599.9 M	$2399.9 M	$3039.9 M
% Impact on Card Claims [4]	50.00%	50.00%	50.00%	50.00%	50.00%
$ Impact from Card	$0,160 M	$0,400 M	$0,800 M	$1,200 M	$1,520 M
TOTAL $ IMPACT FROM CARD	$ 3,428	$ 8,969	$ 17,138	$ 25,707	$ 32,562

[1] Assumes approximately $320 billion in Medicaid claims (FY2007, from www.statehealthfacts.org) for all Medicaid members (and remains constant thru year 5).
[2] CityJournal (Spring 2006): Steven Malanga estimates Medicaid identity fraud to be 10% of total Medicaid fraud.
[3] This input declines over time to capture the reality that there would be some migration to EDI even without the Card.
[4] UHC anecdotally stated that not having immediate access to medical directives increases their claims by over 1%.

$32.5 Billion in projected annual savings

States' Portion (~43%)
$14 Billion in annual savings

Medicare & Private Insurance Savings *Not Included*

MEDICARE - The Bigger Problem

- Medicare, the government insurance program, provides health care to 46 million elderly and disabled Americans.
  - Medicare fraud is estimated now to total about $60 to $90 billion a year.
- Medicare fraud has become one of the of the most profitable crimes in America.
- Resulting in the American people questioning the government's ability to manage the medical bureaucracy.

AND NOTHING IS BEING DONE ABOUT IT - JUST LIP SERVICE

The Growth of “Hospitalists”

- Few hundred existed in mid 1990’s
- Over 25,000 employed in 2020
- The exclusive domain of large and teaching hospitals
- Now being employed by small and rural hospitals
- Primarily benefits medical doctors –little impact on Surgeons
- Mixed reaction from patients –still want their ”own” Physician

Emphasis on Quality

- 98,000 patients die each year from preventable mistakes
- Only 50-60% of patients receive recommended evidence based medicine
- Initiatives from JCAHO
  - 2010 National Patient safety Goals
- Initiatives from CMS
  - Over 4,000 U. S. acute care hospitals reported on quality of care and patient experiences in the "National Hospital Voluntary
- Reporting Initiative" sponsored by the Centers for Medicare and Medicaid Services (CMS)
- No payment for mistakes, falls and readmissions

What is Alignment?

"Hospital physician alignment may be defined as a close working relationship In which a hospital and physicians place a priority on working toward shared, quality/patient – centered and economic goals, and they each avoid conduct that damages the other"

Foundation: Legal/Statutory Basis for Scrutiny of Hospital/Physician Alignment

- Stark Law
- Federal Anti-Kickback Statute
- Tax-Exempt Organization Regulations
- False Claims Act
- Civil Monetary Penalties Law
- Health Insurance Portability and Accountability Act (HIPAA)
- Emergency Medical Treatment and Labor Act (EMTALA)
- The Sherman Act and other Federal Anti-Trust Laws

Environmental Factors Influencing Hospital/Physician Alignment

- Increasing numbers of facilities are paying for call
- Rising dollar amounts are paid for on-call compensation
- From 2006 to 2008, median expenditures by trauma centers for physician on-call compensation increased by 88 percent
- From 2007 to 2008, median expenditures by non-trauma centers for on-call coverage increased by 114 percent

Traditional Medical Staff Model Vs. New Reality – Historically

- Physicians voluntarily served on the medical staff
- Compliance with active medical staff by-laws related to emergency department ("ED") on-call
- Coverage was considered necessary to build a practice and was a physician's community service

Hospital-Physician Integration

What Drives Hospitals to Consider Issue

- Elimination of competition for outpatient services
  - Outpatient surgeries 1980 -15% of all surgeries
  - Outpatient surgeries 2000 – 70% of all surgeries
- Expansion of services and service area
- Improved market share
- Community service and indigent care
- Physician supply/demand management
- Improved leverage with payers
- Access to clinical leadership
- Addressing the pay-for-call dilemma
- Alignment of quality objectives

Hospital-Physician Integration

What Drives Hospitals to Consider Issue -- continued

- Shortage of physician residents exists, particularly in certain subspecialties
- The number of sub-specialists who limit patients, injuries, and illnesses treated is increasing
- A growing number physicians drop out of call rotation
- Smaller supplies of on-call doctors increase the difficulty and stress for those who remain in the rotation
- Fewer emergency departments and increasing utilization
- Nationwide ED closures and other problems in access to care
- Create an over-utilization of EDs, resulting in:
  - Increased intensity and risk in on-call coverage, and
  - Negative impacts on payer mix and physician reimbursement

Hospital-Physician Integration

What Drives Physicians to Consider Issue

- **Tort climate**
  - A slight decrease in malpractice premiums is occurring on a national scope
  - Malpractice risk is higher for patients first seen in emergency department
  - Estimates of the annual cost of defensive medicine range from $50 billion to $100 billion
- **Uncompensated care**
  - Forty-five (45) million non-elderly persons are uninsured
  - Access to care is affected for the uninsured
  - Half of uninsured adults are four times more likely to delay or forego care
- **Quality-of-life for physicians**
  - Call rotation causes a disruption of private practice or other professional and personal activities

Hospital-Physician Integration

What Drives Physicians to Consider Issue -- continued

- Relief from administrative burden
- Improved leverage with payers
- Partial or perceived insulation from reimbursement and overhead pressures, including subsidized arrangements
- Malpractice premium cost control
- Access to capital for facilities, equipment and services
- Information systems and EMR
- Stability of earnings
- Other reasons
  - "It's not my responsibility"
  - Resentment for not being paid for call
  - Difficulty in enforcing medical staff by-law requirements to take Call

EVOLVING BUSINESS MODELS
Delivery System Collaboration & Alignment Model

Not Integrated

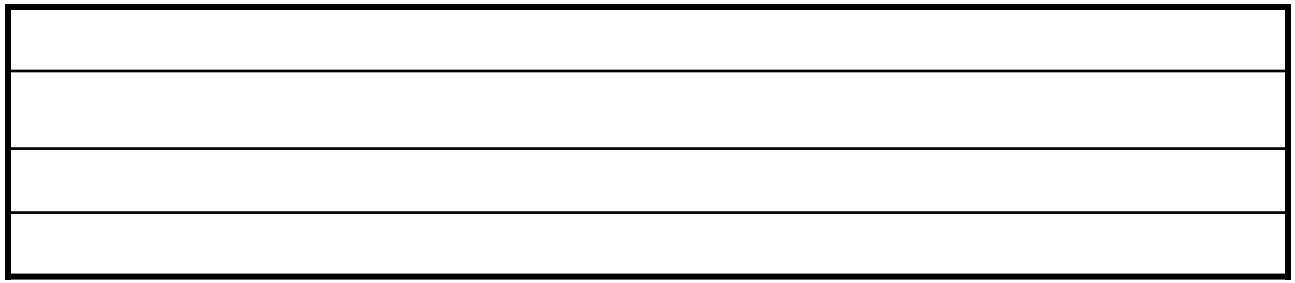
Structural Integration

Highly Integrated

Not Coordinated

Process Coordination

Highly Coordinated



Not Enabled

Technological Enablement

Highly Enabled

Delivery System Collaboration & Alignment Model – cont'd

	Not Integrated	Structural Integration	Highly Integrated
Physician Alignment	• Independent Practice		• Unified Practice • Multi-specialty Medical Group
Physician-Hospital Integration	• MD As Customer • Totally Independent Medical Staff -- Privileges Only		• Physicians As Agents of MD Enterprise • Captive Employment Model Medical Group/Foundation
Reimbursement Optimization	• More Conflict		• Less Conflict if Mutual Agreement

Delivery System Collaboration & Alignment Model – cont'd

	Not Coordinated	Process Coordination	Highly Coordinated
Patient Safety	• Significant Level of Prescription and Medical Error		• Dramatic Reduction in Errors
Quality Improvement	• Repeated Unnecessary Diagnostic Procedures • Unnecessary Re-admissions Not Paid for by Reimbursement		• Dramatic Reduction in Repeated Procedures • Virtually No Reimbursement Problems Due to Re-admission
Clinical Efficiency	• Higher Length of Stay • Lower Case Mix Index (CMI)		• Patients Processed in Less Time – Lower Length of Stay • Higher CMI Leading to Higher Reimbursement
Service Line Development	• Surgeons & Medical Physicians Operate Independently		• Combining of Medical and Surgical Physicians • All Specialties in a Broad Area of Service Integrated Into Overall Service Offering / Delivery System
Community Health	• Encounter-centered Approach		• Patient-centered Beyond Individual Encounter

Delivery System Collaboration & Alignment Model – cont'd

	Not Enabled	Technological Enablement	Highly Enabled
Access to Patient Data	• Limited Access and Largely Paper Records		• Easy Access and Ability to Work With Patient Data Within the Health System in Electronic Format
Workflow Improvement	• Little Integration of Processes Facilitated by Electronic Media		• Significant Integration of Processes Around Patient Service Facilitated by EMRs, Including: Electronic Medication Management, Health Management and Practice Management
Decision Support	• No Ability to Utilize Data Sources Beyond Individual Patient Information		• Integrating Data from Multiple Sources into Decision Templates and Establishing Patterns Over Time

HCDS Strategy Development Methodology

- Situation Assessment
  - Including Stakeholder Input Gathering
    - Key success factor ranking
- Positioning Analysis
  - Mapping to HCDS Strategic Framework
  - Comparison to Best Practice Approaches
  - S/W/O/T Analysis
- Alignment Strategy Recommendation
  - Benefits Identification
  - Gap Closing Measures
  - Transition Plan