IMA Insights

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Direct Contracting for Surgery

To Our Healthcare Clients and Friends:

A little-noticed announcement in February may be a watershed event affecting who, what and how complex surgery is provided throughout the United States. In this edition of *Insights* we explore the announcement between Lowe's, the nation's second-largest home improvement retailer, and the Cleveland Clinic to direct all heart surgeries for Lowe's employees and dependents to the Clinic. Coupled with this announcement there is an emergence of "Personal Health Assistance" (PHA) firms. These firms seek to reduce health benefit cost for large self-insured companies by managing the care provided through many avenues, some of which may be direct contracting between the employer and provider for complex surgery based on outcomes and cost. We will note some of the implications to hospitals and health systems, and offer some suggestions on how hospitals should prepare themselves to succeed.

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BACKGROUND

On February 16, 2010, Lowe's and Cleveland Clinic announced a three-year deal to provide heart surgery to all Lowe's employees and dependents. Of the estimated 200,000 Lowe's employees and their dependents, Lowe's expects to have approximately 125 patients per year go to the Cleveland Clinic for heart surgery. Lowe's is prepared to pay for the travel of the patient and one family member and to discount the employee's copay and deductible as an incentive. It is unclear if the employee must go to the Cleveland Clinic. For the Cleveland Clinic, the approximately 125 patients will be just a blip on the radar to the over 40,000 cardiac surgeries they perform. If all of the top-50 companies by size in the United States, which represents 12.3 million employees and add to that another 12.3 million dependents, were to send their cardiac surgery business to the Cleveland Clinic or any single health provider, then another 15,000 cardiac surgeries would be siphoned away from community hospitals. If other types of surgery like orthopedics would find similar favor with large self-insured companies the numbers could be staggering. Possibly too much of an extrapolation, but what if insurance companies started doing the same thing and directed surgery to those providers who are the least expensive and have the best outcomes? The role of the community hospital would change drastically.

Aiding self-insured companies is the emergence of PHA firms. These firms seek to contract with large self-insured companies with the goal of reducing their health care benefit dollars by attempting to manage costs and outcomes of employees and their dependents. PHAs have staff available to employees who can assist to coordinate care throughout the health care system including preventive care, pre and post care, and episodic care. It is not inconceivable that these PHAs will begin to represent self-insured companies to contract with providers for disease management. With proper information, technology, and clinical expertise the PHA can contract with the lowest overall cost providers. Overall cost is defined as those providers' best suited to manage the diagnosis not the procedure.

Properly structured PHA firms are in an excellent position to become Accountable Care Organizations (ACO), a common theme of many health reform legislative proposals. The firms will have the infrastructure built to act as an intermediary on behalf of large firms, insurers, providers, and individuals. They will have the experience to direct care to participating providers.

CHALLENGES

If more self-insured companies, insurance companies, PHA firms, or ACOs have the mechanisms to steer complex surgeries to those providers with the lowest cost and best outcomes this creates significant challenges for hospitals. Among those challenges are:

- Steerage of "lucrative" surgery business from community based providers;
- An outdated reimbursement system that rewards physicians and hospitals on volume;
- Inadequate quality and cost measurement; and
- Inadequate contracting capabilities to contract with multiple, large self-insured multi-nationals.

Hospitals that perform few complex surgery cases per year, and rely on these high margin surgeries to make up for losses in community based services like Obstetrics, will feel the greatest loss. Over the last decade many hospitals have made investments in equipment, physicians, and infrastructure to grab some market share on high margin complex surgeries. These services have significant fixed costs that require a minimum volume to achieve a return on that investment. But because these volumes remain somewhat low the weighted average cost tends to be higher than in high volume settings, like the Cleveland Clinic. Although this *Insights* does not present quality outcomes, many studies have shown that higher repetition of a particular procedure results in proficiency and better quality outcomes.

Our current reimbursement system rewards hospitals and physicians for volume. Although CMS and some private payers are piloting quality and outcome payments, in most cases the reimbursement system is still volume oriented. Also, because with relatively few exceptions like the Cleveland Clinic, Mayo Clinic, Geisinger, etc. hospitals and

physicians are paid separately. This archaic payment system based on separate payments and volume provide little incentive to manage disease. The self-insured companies, PHAs, and ACOs will contract with those hospitals and physicians that seek to manage the disease and provide the lowest cost.

Many hospitals across the country have limited capabilities to truly measure their cost and quality outcomes. Information technology in hospitals is typically purchased based on “Best of Breed”. This leads to disparate systems for each of the departments within the hospital and rarely do they all talk to each other. When statistics are matched against billing systems and accounting systems, the variances are eye-popping. Further, when all of this data is supposed to be funneled into a hospitals’ decision support, the standards for cost are often never updated or if updated only every several years. With limited cost data the hospital is at a significant disadvantage to contract in a bid process without knowing that they may be putting themselves in a bigger hole by winning the contract.

Another big challenge for providers is their capacity to bid on request for proposals (RFPs) to the self-insured companies, PHAs, or ACOs. Hospitals are well positioned to negotiate with insurance companies. Many of these negotiations are reactionary. After an insurance company provides a payment scheme, the Hospital or physician counters with a proposal. The lack of expertise and information presents healthcare providers with a distinct disadvantage.

INSIGHTS

Hospitals and physicians can do several things to prepare for possible changes including:

- Affiliate with a large integrated delivery systems for the disease management including pre and post surgical care;
- Determine one disease that your hospital can manage better than others;
- Use the idea of contracting within your own health system as a basis for improvement; and/or
- Measure and manage your true costs and develop a contracting arm if the resources are available.

One solution for hospitals and health systems is to develop an affiliation agreement with a large integrated delivery system. With access to peer review, clinical protocols, and possibly technology, a hospital, even in a disparate geographic region than the IDN, may play a role in the care of the patient. If a Hospital in the Mid Atlantic is affiliated with the Cleveland Clinic then maybe the Lowe’s employee or dependent who has cardiac related issues from that same geographic area is provided care by the affiliated hospital including pre-admission testing, post-surgical visits, and ongoing disease management. For those affiliated hospitals that can match the outcomes and cost of the IDN then possibly they can contract with the IDN to provide the surgery as well.

If your hospital has a true proficiency in managing a particular disease then use that strength in leveraging contracting agencies to encourage patients (through reductions in copay and deductibles) to your hospital. The proficiency has to be measurable against your peers. While information from such organizations as Healthgrades and Leapfrog may provide starting points, the hospital must include more specific information to differentiate itself from competitors. Indicators should include better quality outcomes, lower readmission rates, lower cost, and better pre and post care follow-up. The strength is not in providing a great surgery with no follow-up or preventive care. The hospital has to build a core competency that includes physicians in that specialty, after care, and education. The culture has to switch from one of creating volume and move to one of managing the disease.

For the large health systems, many of which are already self-insured, take the next 12 months and challenge your hospitals to bring down their costs and improve outcomes. Let them know that you are going to put out for bid that all employees in your health system will go to ABC hospital for cardiac surgery. Most health systems have access to data that can monitor costs and outcomes centrally to ensure that none of the hospitals game the system. After 12 months, select the hospital with the best outcomes and lowest cost. The win for the health system is the prospect of hospitals improving to gain the business and lowering overall employee health benefit expense.

Lastly, begin measuring and managing your costs and outcomes. Too often, hospitals and physicians go after revenue without consideration for costs or outcomes because that is how they have been historically paid. Costs and outcomes are imperative for the future. Although access to care seems to gain the biggest sound bite in healthcare reform it is only a matter of time before cost and outcomes are the centerpiece of government payment. For now, we have the self-insured companies looking at managing their rising health costs. It’s only a matter of time before all payments are managed this way.

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SUMMARY

Whether the agreement between Lowe's and the Cleveland Clinic becomes the norm or an isolated event, health benefit costs cannot rise unabated. The people who pay the premiums will create mechanisms either directly or through other means like the PHA firms. The government will seek avenues to continue to rein in spending through ACOs, pay for performance, payment bundling, or yet to be determined payment mechanisms. Whatever form health care takes in the coming years, hospitals and physicians must be prepared to manage and measure cost and quality outcomes instead of chasing every procedure and test.

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We are pleased to present this edition of *Insights*. Should you have any questions or comments please feel free to email rsutton@ima-consulting.com or call toll free at (866) 840-0151.

Truly yours,

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