The Transformation of American Healthcare from Volume to Value

Spencer Berthelsen, M.D.
Chairman and Managing Director
Kelsey-Seybold Medical Group, PLLC
About Kelsey-Seybold

• 450 physician multispecialty group practice
• Founded in 1949
• 21 locations
• 1.3 million patient visits per year
• Advanced Accountable Care Organization
  – Own and operate KelseyCare Advantage
  – The KelseyCare health benefit plan is offered by 40 Houston area employers - 70,000 members
Kelsey-Seybold Multispecialty Care Centers

- 21 Locations
- 2,800 employees
- 450+ In-house physicians and allied providers
- 50 Specialties
- 5,000+ Contracted Specialists Available via Care Coordination
The Problem

- **Cost** – The US spends twice as much per capita as the average of other industrialized nations
- **Institute of Medicine** – 30% of healthcare dollars in the US are spent on unnecessary care
- **Maldistribution**
- **Uninsured** – crowding the “safety net”
- **Powerful economic forces**
The Present State

- Unit discounting without considering utilization
- Cost shifting to employees – barriers to early diagnosis and treatment
- Single disease management without management of co-morbid conditions
- Scientific evidence without application
- Consumerism without an informed consumer
- Enormous practice variability
- Differences in margin for different services creating oversupply and undersupply
U.S. Health Care Cost Increases

- 1950: Health care costs = 4.4% of GDP
- 1965: 6.1%
- 1970: 7.6%
- 1990: 12.0%
- 2000: 13.5%
- 2002: 14.9%
- 2007: 16.2%
- 2009: 17.3%
- 2015: 17.6%
Causes of High Cost

- Technological advances
- Misaligned incentives
- Lack of coordination at all levels
- Unrealistic expectations at the end of life
- Gaps in medical care
- Practice variation – Dartmouth Atlas
- Demographic shifts
- Defensive medicine
The Dartmouth Atlas of Health Care

www.dartmouthatlas.org

• Documents disparities in utilization of healthcare resources across the United States.
• Information & analysis of national, regional & local healthcare markets, local hospitals and physicians.
Medicare claims data demonstrates great variability in utilization

- Threefold difference in inpatient utilization for cancer, CHF or COPD
- Five to six fold variation in physician services
- The per capita Medicare rate in Minneapolis is about 50% of the amount spent in Miami or Orange County

“Current waste diverts resources; the committee estimates $750 billion in unnecessary health spending in 2009 alone.”

Source:
“Best Care at Lower Cost”
Institute of Medicine of the National Academies
Report Brief, September 2012
Relationship of Healthcare Spending to Benefit

- **Beneficial Care**: Greatest Benefit to Patient. Good Cost-to-Benefit Ratio.
- **Minimally Beneficial Care**: Cost begins to outweigh patient benefit. Leading towards patient harm.

Legend:
- **Beneficial**
- **Harmful**

Categories:
- Public Health
- Chronic Conditions
- Surgery
- Non-Evidence Based Care

Cost Levels:
- Lower Cost
- Higher Cost
• United States spends twice as much per capita as the average of seven industrialized countries surveyed
• UK, Netherlands, Canada, Australia, New Zealand, Germany, United States
• Scored last or next to last in 10 of 12 dimensions of quality
• Largely due to disparities in access to care
### Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00-2.33</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2.34-4.66</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4.67-7.00</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OVERALL RANKING (2010)</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Effective Care</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Safe Care</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Long, Healthy, Productive Lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2007</td>
<td>$3,357</td>
<td>$3,895</td>
<td>$3,588</td>
<td>$3,837*</td>
<td>$2,454</td>
<td>$2,992</td>
<td>$7,290</td>
</tr>
</tbody>
</table>

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).
US spends two-and-a-half times the OECD average

Total health expenditure per capita, public and private, 2010 (or nearest year)

1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.
Information on data for Israel: http://dx.doi.org/10.1787/888932215602.

Source: OECD Health Data 2012.
What Happened?

- PPACA Patient Protection and Affordable Care Act signed into law March 23, 2010
- Passed by the narrowest of margins with a partisan vote
- Voluminous legislation - 2,500 pages
- Drafted outside of public view
- The most sweeping social legislation since the passage of Medicare in 1965
• No pre-existing condition exclusions
• No rescissions – except for fraud
• No lifetime or unreasonable annual limits
• Dependent coverage through age 26
• Minimum medical loss ratios 80% or 85%
• Guaranteed issue with limited rating ratios
• Minimum benefits 60% to 90% coverage
• Preventive services covered
• State or federally operated insurance exchanges
• Individual and employer mandate with penalties
• Individual subsidies and small employer tax credits
Medicare and Medicaid

• Half of the 32 million uninsured would have been covered through Medicaid expansion up to 130% of FPL – paid mostly with federal tax dollars at least for ten years
• Medicaid reimbursement parity with Medicare for primary care
• Reductions in Medicare reimbursement to hospitals, nursing homes and home health care
• Pilots for bundled payments – Medicare Shared Savings ACOs
• Gradually closes the prescription benefit donut hole
• Reduces payments to hospitals related to readmission rate and preventable conditions
• Establishes a Medicare commission to make binding recommendations for cost reduction
Tax Provisions

• Cadillac plan tax in 2018 – postponed for two more years
• Medicare tax – 0.9% of income over $200K for individuals, $250K for couples
• Investment income taxed additional 3.8%
• Health Insurer’s fee – based on market share – suspended for 2017
• Drug manufacturers fee
• Device makers excise tax
• $500K cap on insurer executive compensation deductibility
• Opened October 1, 2013
• Coverage effective January 1, 2014
• Guaranteed issue
• Cannot consider health status
• Same rules apply outside the Marketplace
• Subsidies and tax credits
• Penalties if not insured – few exceptions
• Federal Data Hub
What Didn’t Happen?

• Single payer system – Medicare for all
• Public Option
• Elimination of Medicare Advantage
• Price controls
Insurance coverage expansion was a necessary first step

- Move away from rescue care for the indigent to prevention at a fraction of the cost
- Relief for local tax payers who fund safety net hospitals
- Loosen the tight coupling of healthcare and employment
What should be done next?  
Version 2.0

• Establish coordinated systems of care with medical management systems
• Convert from FFS payment to payment for the care of a population over time
• Invest in Information Technology
• Avoid catastrophic care
  – 5% spending -- 50% of cost
• Increase the supply of physicians
Two Paths to Cost Control

• Central control of the healthcare economy
  – Premium or fee control
  – Canadian example

• Accountable Care Organizations
  – American innovation
  – Best hope to avoid default of price controls
The ACO Movement

- Hospital Systems transforming into HealthCare Systems
- Insurance carriers establishing performance based payment arrangements
- Multispecialty group practices extending their models of coordinated care – managing total healthcare cost
- Government payors promoting systemic change through effectiveness research and modified payment for outcomes
Accountable Care Organizations

• Narrow concept – Medicare only
• Broad Concept – coordinated systems of care
  – Cleveland Clinic, Intermountain Healthcare, Geisinger Clinic, Mayo Clinic, Kelsey-Seybold Clinic many others
  – Proven model
  – Increased value ... quality/cost
  – Evidence based approach
  – Bundled payment
  – Not HMO redux
Essential Elements of an ACO

• Group commitment to raising quality and eliminating non-beneficial care
• Investment in Information Technology
• Management, measurement and reporting of quality and cost
• Reformed payment system away from Fee for Service to payment for maintaining the health of a population over time
What is Needed?

• Payment system reform
  – Incent value creation – not fee for service
  – Accountability for clinical outcomes and cost of care
  – Encourage investment in systems – information technology
    – medical management

• ACO competition

• Employers willing to discriminate among providers of care
Attention to total cost of care

- True measure of affordability
- Combination of unit cost, utilization, and administrative costs
- Requires clinical acumen
- Clinical efficiency vs. unit production
Medical Information Systems

- Information when and where it is needed
- Requires large initial investment
- Currently only possible in comprehensive systems of care
- Increases efficiency and safety
Prevent Medical Catastrophes

- Preparation for end of life
- Long term prevention – wellness
- Accurate portrayal of risk and benefit
- Use what we know
- Patient safety
- Greatest opportunity for improvement
Comprehensive Systems of Care

- Best opportunity to reduce practice variation around an evidence based norm ... standardization
- Beneficial competition ... not lowest unit rate
- Coordination ... not duplication or gaps in care
- Economies of scale
- Reduced administrative costs
Accountability for Resources

• Payment for health improvement not volume of services
• Efficient systems of care will produce more dollars for reinvestment
• All medical services should have the same margin through more precise FFS payments or bundled payment systems
Reason for Optimism

• There is enough money
• There is enough time
• Change is underway
• We know what care is effective
• Proven models of accountable care exist today
• The consequences of failure are clear
Implications for the Healthcare Industry

• Cost considerations will drive changes to payment methodology from FFS to prepayment for a population over time
• Coordination of care will reduce cost by eliminating duplication and ineffective care
• Physicians will be at the center of successful models
• Value creation – increasing quality while taking out cost – is the only sustainable model
• Employers will be more demanding and discriminating
• Networks will become efficient and more competitive