LEAN SOLUTIONS: IMO/ACO

Lean Applications: IMO/ACO

- For an IMO, ↑ health = ↓med expense = ↓MLR = ↑ Margin
- *Access* to Primary care = ↑ *access* for existing patients + new patients
- *Access* to Primary care = ↑ specialty FFS ($) = ↑ hospital FFS ($)
- *Access* to specialty care = *Access* to hospital = ↓Out of area/network (OOA) cost = ↓Med Expense = IMO margin (EBIT)
- Majority of *risk* agreements are in fact *no risk* at all: Risk Agreements = FFS ($) + pmpm ($) + core measures ($)+ Med expense ($)
- *For a 100,000 member health plan a 1% improvement in med expense = $5mm; a 5% improvement = $25mm*

LEAN SOLUTIONS: IMO & ACO

Overview: Integrated Medical Organizations (IMO) have a unique opportunity in the communities they serve. In operating *both* a health plan and a delivery system, IMOs are in a unique position to design, influence and manage the care delivery model/system used within their practices and health systems. Moreover, they can also provide the data, analytics and resources from the health plan to help guide care teams, coach providers and actively communicate across specialties, hospitals, primary care, home health, primary care, etc.

Similarly, this coordination of care delivery system and payor also provides a foundation to synchronize communications across case managers, population health teams, providers and social workers spanning all transitions of care.

IMOs are also in the unique position to be able to *see* the across the traditional boundaries that exists between the delivery system (where the patient, care team and care model work needs to be done to impact patients, communities and populations) and the health plan (where the majority of *financial benefit* of improved care will be realized). It is the building of these *crosswalks* across the delivery system and the health plan that is fundamental to helping leaders, providers and care teams see the real value in transforming from a FFS driven model of care to a population, patient and community health (i.e. shared risk) model of care.

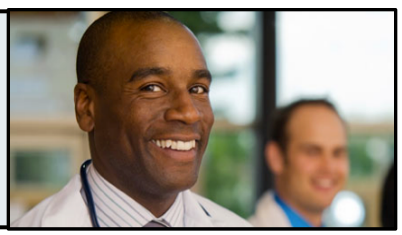
Population Health: IMO vs ACO

One of the biggest advantages (and challenges) of an IMO, extending beyond the benefits of an ACO, is that the *financial* returns associated with improved care, care models, coordination of care, etc are actually *not* realized by the delivery system (practice) P&L. The benefits (which easily equate to $millions) are *all* realized as *med expense* on the health plan P&L. IMOs who understand, support and look for this return have realized 2-8% improvements in med expense (e.g. $10mm → $50mm for a 125,000 member health plan) *as a direct result* of seemingly 'low' ROI activities at the practice level (as measured by traditional practice or medical group FFS financials). ACO's, although benefitting from *risk sharing* agreements for executing very similar work efforts, only see a small percentage of the actual savings (those savings 'shared' by the health plan).

For an IMO, when the right processes and systems are developed and implemented, every ED visit *prevented* not only converts a $1400 visit (plus lab costs, plus a 12-22% admission rate) into a 'series' of $86 *primary care* visits, but also creates the opportunity for the care team to begin to influence behaviors and build relationships (with their chronic disease patients, high utilization and large 'gap in care' patients). The type of PCP relationship that is imperative to an effective model of care.

IMO/ACO improvements

- Improved primary care access: time to third next (-38%)
- Increased primary care schedule utilization (71% → 91%; $4.6mm)
- Improved key specialty access (-62%); increased FFS specialty revenue
- Reduced Out of Area leakage (22%) for key specialties
- Reduced IMO med expense 4.8% ($31+mm)



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Access = FFS revenue (delivery system) = Med expense/margin (health plan) = IMO margin (EBIT)

As ACOs and IMOs focus on targeting and mobilizing around patient care, closing gaps in care, and population health, nearly all find that *access* becomes a key to improving nearly all clinical measures. *Access* to primary care is the driver to not only increasing patient panels (i.e. increased risk/capitated payments), but also to being able to improve population health, disease management and close gaps in care.

As an IMO, what also often emerges is the realization that *access* for existing patient panels is 25-40% *short* of where it needs to be to properly care for their patients (acuity adjusted). When analyzing the data, one also sees that it is through *access* to primary care that urgent care is converted to 'same day' primary care visits, and ED visits are converted to urgent care or preventative care visits. Without *access* all the things we know we should be doing are just words. *Access* provides the care delivery vehicle at all stages of the care continuum.

***Access* to specialty services** represents its own opportunity for an IMO. Nearly all health plans will speak to the *price premium* paid when a member goes *out of the network* (OON) or *out of the area* (OOA). For most health plans, OOA costs are often 50%-300% higher than in network costs. In addition, when a patient selects an out of area provider, not only do the specialty services travel out of area, but so too do all the associated ancillary, lab, imaging, therapies, hospitalization, etc. costs (also at premium pricing).

For an IMO, the impact of *losing* a patient to out of area providers is even more profound. When a patient selects an out of area provider, not only does the delivery system lose the specialty FFS revenues, the system also loses any hospital associated FFS revenues and any support/ancillary FFS revenues (imaging, lab, PT, OT, etc).

To go a step further, for an IMO, the financial impact does not stop with *lost revenue* to the delivery system. Since the IMO is also responsible for *payment of medical services*, not only does the IMO *lose* the various FFS revenues (medical group, ancillary and hospital), more importantly the *health plan* now must pay a 50-300% premium for nearly all services provided OOA. This premium price paid for medical services by the health plan *is* their med expense. For a health plan, med expense is 85-90% of their total cost. Once again, for an IMO, the opportunity associated with a 2%-8% improvement in med expense is significant (e.g. for a small health plan, a 1% improvement in med expense increases EBIT by 30% ($5mm), a 5% improvement in med expense increased EBIT from 3.2% to 8.0%). These financial improvements are *only* realized because of the unique payor/provider relationship of IMO's. ***Key Point: The work to create these results happens in the delivery system. The financial results show in the health plan***

Do IMOs need risk based contracts/payments to be successful? Not necessarily. Whether the health plan chooses to encourage certain behavior within their delivery system is a choice. In theory, if the health plan could engage and activate their providers, care teams and practices *without* sharing the gains, the need for shared savings agreements would not exist. The important realization is that the *doorway* to these types of medical expense improvements comes through the clinical relationships provided through the *primary care provider* and their *care team.*

In a FFS model, too often, PCPs, their care teams and primary care practices are under funded, under utilized and under valued. Their revenue *generation* is not big enough. Their opportunity to create health system revenues is not recognized (to the degree that specialists are recognized). The emergence of risk/shared savings contracts, the changing payor models (highly driven by CMS/Medicare), and the connections made by IMOs between prevention (primary care) and preventable medical expense has created the interest. The results achieved by IMOs who have targeted and focused *Lean* improvements efforts are gaining rapid interest. IMOs, who *are* the epitome of a shared savings model, have realized they have the most to gain by *focusing on the right end of the care continuum (i.e. value stream)* are beginning to understand the opportunities associated with this perfect storm.

A new vision of care: A situation where *health* is the goal, and rewards are given to those that actively support, promote and enable it. Clinical, social and community *work* designed to encourage health, recover health and/or prevent/slow deterioration of chronic conditions is *valued*. An environment, where payor *views* and more importantly *values* those that *prevent* illness, *engage* risk prone patients, and create/utilize *access* to key health services is the norm. Even with only touching the tip of the iceberg, our IMO and ACO clients are witnessing 2-8% improvements in med expense by focusing on the fundamentals.

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