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Cost Savings Opportunities for Provider-Led ACOs: Applying the "24-Lever Model"

By Tim Smith

As an actuary working with providers and accountable care organizations (ACOs), you may find yourself in the situation where you are asked to help find opportunities for cost savings. Like many actuaries working with providers today, I got my start in the health plan world within medical economics. A provider asking for ideas around care cost savings reminds me of health plan marketing and sales teams looking for additional premium savings on a new product.

The advantage in working with the provider directly is that many of the savings "levers" that we suggested on the health plan side were in some way going to take revenue away from the provider or benefits from the member. That made the ideas harder for the sales team to accept knowing this would lead to noise from the market. With the assumption for this article being that the provider created an ACO with an understanding of a future with potentially less volume and revenue, these initiatives are more realistic to attain. For example:

- **Network differentiation.** The preferred provider in the network is often the ACO owner or primary sponsor. They likely set their internal reimbursement levels for ACO products at a level that is best-in-network and lowest in their product portfolio.
- **Benefit alignment.** The ACO products should include differentiators to help the member "do the right thing," including staying in the preferred network and going to the right provider or setting for services.
- **Provider-led utilization and care management.** The product design encourages members to see ACO physicians on a regular basis to help manage their care. With care management now on the provider side instead of the insurer side, there is a direct path to help the insured only get the best, necessary care.

I dusted off the checklist that I used previously with health plan teams on various product features to achieve care cost savings. Applying this exercise of the "24-Lever Model" to the provider-led ACO proved fruitful. Over time, the use of the model grew to take a key role in the strategic planning for an early Integrated Delivery and Financing System (IDFS). The common-sense levers that made one product more affordable also created the blueprint for creating the low-cost product that they were designing for the future.

OVERCOMING TODAY'S MISALIGNED INCENTIVES

The 24-Lever Model works like this. If every health plan consumer made the right choice at every possible care decision point and there was a product effectively able to capture this behavior, the health plan or employer group customer should realize significant savings of up to 20 percent or even 25 percent.

So, if those savings are out there, why have we not achieved them already? Figure 1 shows the ways today's health care system works against the health care consumer, comparing the "Right Decision" to the way things often happen today.

Figure 1
How the Health Care System Works Against Consumers

The Right Decision	Working Against the Health Care Consumer
Consumers pay as little as possible for appropriate, high-quality care.	Very little or very hard to find price transparency on which facility or setting provides the lowest-cost care.
Consumers select the best physician for their specific health care needs.	Very little quality and outcome data to show whether one facility or physician is worth a premium price.
Consumers have a procedure or take a prescription only when necessary.	Even less available data to tell the consumer which providers perform in an efficient, low-cost manner, and which drugs are the best value.

Through the provider-led ACO, these incentives can be easily remedied. If the ACO is being built around a high-quality, low-cost preferred network, there is no need for the member to search for the lowest cost. By the provider leading the care management efforts, they can share quality and outcome data with patients that the insurer just does not have easy access to. Finally, by working to become as efficient as possible and keep

costs low for members, unnecessary care is removed from the equation.

THE PATH TO CARE COST SAVINGS: THE 24-LEVER MODEL

Here is the collection of ideas I refer to as the "24-Lever Model." If you have been around health care for a while, none of these ideas is perhaps "new." But there is value in seeing them all together as you are assessing the overall opportunities around care cost savings. This list is not comprehensive and could have been the 36-Lever Model, but I found that these ideas tackle many of the larger savings opportunities (see Figure 2 for a complete list).

Inpatient Surgical and Maternity Care: "Centers of Excellence"

Because surgeries and deliveries are often planned, they can follow the economics of supply and demand. The "Centers of Excellence" strategy focuses on identifying the most efficient, low-cost networks, with great outcomes, and strongly encouraging them in the benefit, perhaps even excluding some facilities. As an example, I have seen the cost of hip replacements

Figure 2
The 24-Lever Model

Inpatient Care
1. Surgical "Centers of Excellence"—the best-in-class for each service line, including moving care to outpatient
2. Maternity "Centers of Excellence"—preferred facility, with high-quality, low-cost bundles

Emergency and Urgent Care
3. Benefits to discourage unnecessary ER visits; appropriate escalation to Observation/Admission; "UM light"
4. Urgent care for breaks, strains and lacerations, but not for colds (encourage primary, retail, telehealth care)

Outpatient Care *Site of Service*
5. Lab, free at independent lab provider; large copay or coinsurance at hospital
6. Radiology, free at office-based imaging center; large copay or coinsurance at hospital
7. Surgery, free at ASC; large copay or coinsurance at hospital-based surgery center or hospital
8. Cardiac tests, free in office-based setting; copay or coinsurance in the hospital
9. Part B drug infusions, low-cost in office-based setting; significant copay at hospital-based infusion center
10. Clinic fees—reduced fee-schedule or zero-pay; member pressure

Professional Care
11. Tiered provider fee-schedules—lower reimbursement to non-preferred providers

Ancillary Care *Ultra-narrow networks*
12. PT site-of-service, preferred copays for office-based PT; value-based incentives on utilization
13. DME—ultra-narrow network for low-cost, high-quality DME providers
14. Home health—ultra-narrow network for low-cost, high-quality providers; incentives to reduce skilled stays
15. Skilled nursing and rehab—ultra-narrow network for low-cost, high-quality SNF and rehab

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Figure 2
The 24-Lever Model (continued)

16. Chiropractors—ultra-narrow network for low-cost, high-quality chiropractors
17. Dialysis—ultra-narrow network for low-cost, high-quality dialysis provider

Retail Pharmacy
18. Optimal formulary—encouraging generic and preferred brands; eliminating high-cost therapeutic equivalents
19. Utilization management programs—step therapy and prior authorization, encouraging use of preferred specialty pharmacy

Other Value-Based Provider and Benefit Levers
20. Narrowing the hospital network to exclude or "tier" expensive or inefficient facilities
21. Significantly lower copays to "efficient" specialists in top specialties (ortho/neuro) *Note: Simplest way to identify "efficient" are those specialists that refer to lower-cost settings and facilities*
22. Limiting PCP network to only "efficient" PCPs *Note: Simplest way to identify "efficient" PCPs are those with low overall cost, or refer to efficient specialists*
23. Cancer care preferred networks or even a "rider" to get high-priced network *Narrow-network if available; value-based programs if not available*
24. Targeting members that care for their conditions—medication adherence, etc.

performed in the outpatient setting at levels close to one-third of those in the inpatient setting.

As a provider-led ACO, they act as the "Center of Excellence." But there are even greater opportunities around care cost savings by the provider itself being able to highly scrutinize whether certain surgeries are even necessary, or whether a less intensive care path would be better. Examples here could be spine surgeries and cardiac catheterizations, which have shown to have high variability in utilization across health systems and regions.

Emergency Care: From Urgent Care to the ER to Observation to Admission

Unlike surgical care, emergencies are not planned. Often the consumer is in a position where they are not necessarily thinking about the cost of care and make a decision that is bad for both their pocketbook and their insurer. The benefit and network design needs to help these consumers make the right decision, from encouraging telehealth or physicians with weekend hours to finding an urgent care center (but not for a cold, please!).

In a provider-led ACO, they can have an even greater impact on ER utilization itself, and reducing escalation once a patient is admitted to the ER. Having primary-care physicians on call on the weekends can be one way of lowering admissions to the ER. And if an ER visit is needed, having the ACO hospitals that will treat efficiently, with no unnecessary escalation to observation or even a medical admission, can save the consumer a lot of money and lead to a better patient experience.

Outpatient Care: The Site-of-Service Dilemma

Think about your experience with a basic lab test. You may have visited an independent lab in a strip mall or perhaps a local community hospital. You may not be aware that the same test in these two settings could have as much as a tenfold difference in cost, and typically at least threefold. In a traditional insurance product without the benefit of an ACO, a benefit change of charging no copay for the independent lab can lead to significant cost savings.

But in the provider-led ACO, the hospital could instead "right price" shoppable services like this to match the lowest cost settings so that consumers do not get stuck in the middle of this cat-and-mouse game between providers and insurers. Many other outpatient services follow a similar pattern, including radiology, surgery, cardiac intervention, drug infusions and even physician visits.

Professional, Ancillary and Pharmacy Care: Encouraging Efficient Care

The professional and ancillary levers reference the savings achieved from narrowing a network of providers, where the

benefit either significantly incentivizes the member to use the preferred, most efficient network, or makes the nonpreferred provider out-of-network. It is important to stress that the preferred network is truly preferred—meaning providers of equal or higher quality, along with lower cost. These are the providers that understand care management and how to provide the least amount of care while still achieving the best outcomes. These providers are often lower-cost because they are referring to the appropriate setting or facility for their specialty care.

From a provider-led ACO perspective, ancillary care and prescription medications are often popular categories to go after for obvious reasons: savings here do not impact the bottom line of the provider! Other popular areas outside of the walls of the provider include durable medical equipment, dialysis providers, home health care and skilled nursing facilities.

These levers apply directly and easily within the provider-led ACO. Efficient care is the key to unlocking significant cost savings, but very difficult to achieve in today's world of broad networks with little benefit differentiation to encourage efficient systems. The provider-led ACO built around a low-cost, highly efficient system makes this reality easily achievable. Think about some of the most successful integrated delivery and finance systems across the country, and you will most likely find efficient care management of chronic conditions, lower inpatient utilization levels relative to the market and lengths of stay for admissions significantly under benchmark averages.

Value-Based Provider and Benefit Levers

With the recent focus on health care costs because of health care reform, value-based provider reimbursement and benefit designs are often mentioned as the bipartisan answer to all our health care cost problems. Just quoting "We will pay for outcomes and not the volume of services" makes everyone nod in agreement. Of course, the provider-led ACO becomes front and center in turning the rhetoric into reality.

Key to the role of the actuary is making sure that the savings and returns on investment are real. The measurement of which physicians and provider networks are efficient and low-cost is complicated and perhaps controversial ("My patients are sicker"), but I have seen it effectively accomplished. Ultimately, the primary care physician performing important preventive care, referring to the most efficient and effective specialists only when necessary, is how savings of 20–25 percent are achieved.

CONCLUSION

The 24-Lever Model for care cost savings, when applied to traditional health insurance products and benefits, was a road map for potentially lowering the premium of insurance products. But uptake of the ideas was often limited because of the unpopularity of the levers with both providers and insurance members.

By applying this same list of levers with the provider-led ACO, though, you can achieve the savings with less noise because the providers themselves have committed to the lower utilization and revenue through ownership of the ACO products. Also, members are only being encouraged to get all care coordinated and provided within the ACO, which is the ACO goal.

Ultimately, the 24-Lever Model describes how to create the optimal benefits wrapped around a highly efficient provider network. Such a product design is necessary to keep future premiums affordable. We see many of the incentives in the health care system today are misaligned, encouraging inefficient and costly care. Ultimately, health plans, IDFSs, employers and even individuals can have a significant impact on the overall cost of care if they follow the steps and ideas in this model. ■

Tim Smith, ASA, MAAA, is a partner and consulting actuary in the Pittsburgh office of Axene Health Partners. He can be reached at *tim.smith@axenehp.com*.