The Rise of High-Performance Health Care:

The Best Hope for Meaningful, Positive Health Care Change

AN E-BOOK BROUGHT TO YOU BY VALIDATION INSTITUTE, WRITTEN BY DR. BRIAN KLEPPER

ABOUT VALIDATION INSTITUTE

Validation Institute is a professional community that advocates for organizations and approaches that deliver better health value - stronger health outcomes at lower cost. We connect, train, and certify health care purchasers, and we validate and connect providers delivering superior results. Founded in 2014, the mission of the organization has consistently been to help provide transparency to buyers of healthcare.

To strengthen our offering and provide additional credibility around our service, the **Validation Institute** recently announced a Credibility Guarantee* that offers customers of validated solution providers up to a $25,000 guarantee. This guarantee confirms that a validated solution provider will, achieve what the validation language on a marketing claim says it will achieve.

ABOUT THE AUTHOR

Brian Klepper is a health care analyst, commentator and entrepreneur. He is a Principal of Healthcare Performance Inc., a health care strategy and business development practice, and CEO/Principal of Worksite Health Advisors, a benefits consultancy focused on linking high performance/high impact health care organizations with purchasers. He founded and moderates a popular professional health care listserv, Healthcare hackers, which is a discussion forum on health care high performance and value, and which has about 850 participating benefits managers, benefits advisors and innovative vendors.

As an active author and speaker, Dr. Klepper has provided health care commentary to CBS Evening News, the Wall Street Journal, the New York Times, and the Washington Post. He has published widely in health care trade and academic publications, and in newspapers nationally.

INTRODUCTION

The State of High-Performance Health Care in the U.S.

Objective:

- **Objective: Examine the value of high-performance health care as costs continue to rise**

You probably know that health care in the United States costs twice as much as care in other countries. But do you know why?

Six decades of fee-for-service medicine in the United States have led to a discipline of excess. The system has lost its way. To maintain high revenues and margins, health care doesn't just tolerate high prices and unnecessary services – it depends on them. There's little incentive to lower costs, improve efficiency, or eliminate services that have no impact on health outcomes.

What's more, the structures that support this system have become entrenched in policy that favors the incumbents, which makes policy reform very difficult to achieve.

That's where high-performance health care organizations enter the picture. These organizations manage cost and cost processes within high-value health care niches such as musculoskeletal care, a specialty in which up to 50% of medical procedures are unnecessary, inappropriate, or ineffective.

High-performance organizations have re-examined the conventional management processes within their niche, deconstructed the challenges, devised new approaches, and refined them over time. The end result is **significantly better health outcomes** and/or **much lower costs** than conventional care – so much so that these organizations are often willing to put their fees at financial risk against the performance targets they claim they can achieve.

Legacy health plans are rarely interested in working with these new vendors, since they represent a threat to the plans' grip on high revenues and margins. But employers, unions, and other organizations that are at financial risk for health care costs are increasingly interested – particularly as longstanding solution continue to show poor results. The major players may be the dominant players, but the market is receptive to high-performance organizations.

To heal American health care, we need to favor care and cost management patterns that deliver more predictable results, with better health outcomes at lower costs than today's conventional approaches. Said another way, we need to buy based on value.

This resource will help guide your understanding of the current state and future potential of high-performance health care. We will identify opportunities for employer health plans to significantly improve performance while at the same time affecting meaningful market reform. We will also discuss how to identify, vet, directly contract with, and ultimately favor high-performance vendors – helping you break the grip of the legacy health care industry.

Defining Opportunities for High-Performance Services

Objective:

- **Describe the key types of high-performance services and the main characteristics of vendors that sell them**
- **Learn what to look for when implementing high-performance services**
- **See which types of services deliver the most immediate yield for the lowest disruption**

1 Getting to Know High-Performance Services

A high-performance service typically evolves when health care professionals with deep subject matter expertise identify a problem, grapple with it, develop a solution, and refine that solution over time through well-informed, data-driven decision making.

Over time, the developers of these services often become so confident in their capabilities and outcomes that they themselves are willing to go at financial risk for the performance targets they claim they can achieve. These solution providers are willing to put their skin in the game – just like the employers, unions, and non-commercial health plans that are at financial risk for their own health care costs.

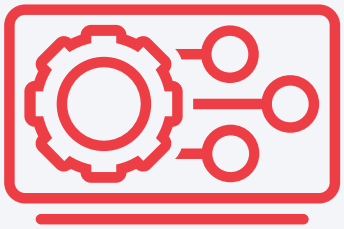
High-performance services typically fall into three major categories.

- **Everyday services** solve problems that occur frequently in a large percentage of the population. These services are clinical in nature and achieve the best outcomes when they are readily available in the community. Common examples include musculoskeletal care management, cardiometabolic care management, cancer management, and imaging.
- **Occasional services** are also clinical in nature but are required much less frequently. Surgery is the most common example. These services are typically offered through a Center of Excellence – sometimes at a nearby health care facility but occasionally at a near-shore destination where operating costs are a fraction of what they are in the United States.

- **Extreme-value services** are business and administrative services dedicated to managing and reducing the 2% to 3% of claims that represent the highest health care costs. Notable examples of these costs include specialty drugs and other treatments for rare diseases.

7 Characteristics of High-Performance Services

- Mission-driven and passionate
- Highly specialized expertise
- Deconstruct problem + devise unconventional solution
- Purpose-driven use of data and evidence
- Dedicated to continuous quality improvement
- Willing to financially guarantee results
- Strive to be distinctive in the marketplace



2 Effectively Deploying High-Performance Services

When considering high-performance services, it's important to weigh two factors:

- The potential **savings**, not just in dollars and cents but also in time and maintenance.
- The potential **disruption** to the health plan and its members.

In making the transition to a high-performance service, it is wise to lead with low-disruption, high-yield programs until enrollees and the plan sponsor buy in to the broader approach. As shown in the chart below, reference-based pricing may offer the greatest potential for savings – but depending on how it is structured and how likely it is for an employee or beneficiary to receive a balance bill, reference-based pricing also offers the greatest potential for disruption.

Example 1: Musculoskeletal Services

Orthopedics, the medical specialty that focuses on the body's musculoskeletal (MSK) system, is the largest health condition category in the United States. Orthopedics impacts 4% to 5% of gross domestic product (GDP) on an annual basis; it also represents 20% of group health spending and 80% of occupational health spending.

However, the diagnostic methodology for this specialty is unreliable, and half of orthopedic procedures are unnecessary. This means that inappropriate, wasteful orthopedic procedures comprise up to 2.5% of U.S. GDP every single year. That's unsustainable.

One high-performance service based in New Zealand approaches musculoskeletal services from the standpoint of physical therapy instead of costly and unnecessary procedures. This vendor is so confident in its service that it is willing to go at-risk and guarantee a 25% reduction in musculoskeletal spend on every patient it touches.

This guarantee translates to a 4% to 5% reduction in total health care spending – and actual savings have been more than twice that level. What's more, data from more than 750,000 patient encounters shows improved health outcomes – less pain, better range of motion, and shorter recovery time – at **half the cost of conventional orthopedic interventions.**

If one or more employers in the same community implemented this program, they would start to achieve critical mass – and fundamentally alter the practice of musculoskeletal care within their market.

Better MSK Care

THERAPY, NOT SURGERY

5% REDUCTION IN TOTAL SPEND LESS PAIN

25% REDUCTION IN MSK SPEND

SHORTER RECOVERY TIME

BETTER RANGE OF MOTION

Example 2: Medical Claims Review

About 17% to 25% of hospital payments include errors that can be traced back to the violation of a specific law or rule. Pursuing changes to these medical claims can lead to the recovery of up to 10% of an organization's health care spending.

It is important to note that reviewing the legality of a claim is different than reviewing its appropriateness. Appropriateness can get very murky very quickly – think of a medial claim that one party says is an intentional misrepresentation of the care that was provided. Legality, on the other hand, is concrete. It is based on whether or not a claim is in compliance with existing regulations.

Additionally, the process of legal review can be pursued out of sight, with no disruption to an organization. Benefits managers and the employees or members that they serve can continue to go about their day-to-day work.

Claims Review

ADDRESS SIGNIFICANT WASTE

CONCRETE PROCESS

RECOVER 10% OF TOTAL SPEND

NO DISRUPTION TO ORGANIZATION

Change Is Needed -- But How?

Objective:

- **Understand the role and responsibilities of vendors and purchasers**
- **Identify barriers to market acceptance for high-performance services**
- **Explore the actions needed to affect meaningful change**

1 The Challenge: Financial and Structural Barriers

Since high-performance services deliver better clinical and financial outcomes at lower costs, the health care industry should be embracing them with open arms, right? Think again.

High-performance services are neither favored by conventional, legacy health plans nor readily available to the marketplace.

In fact, employers and unions often must go around their existing health plans in order to gain access to these services.

To understand why, take a look at the stock price growth for the publicly traded health plans from May 2009, just after the Affordable Care Act was passed, to September 2018. In that period of just over nine years, every insurers' stock grew faster that the S&P 500 and Dow Jones Industrial Average. Humana's stock grew 1,072%, or three times the rate of the indexes. That averages 29% growth per quarter for 37 consecutive quarters.

Legacy health plans such as Humana find themselves in a financial box. They have been so profitable for so long by making excess the cornerstone of their business models. If they deliver care more efficiently, total expenditures will drop, to be sure – but so will earnings, stock prices, and market capitalizations. Buying into value would damage the financial fundamentals of the legacy plans.Adding to the challenge is three-way relationship among the health plan, the benefits advisor, and the benefits manager that strongly favors the status quo. This relationship presents a significant structural barrier to change.

The **health plan** and the **benefits advisor** both make money as a percentage of total health care spending. Any approach that is designed to make health care cost less presents an immediate conflict. The **benefits manager** does not want to update the relationship with the benefits advisor and also does not want to make choices that will increase workload, add complexity, or create a management burden.

2 The Opportunity: Adding Value With Administrative Simplicity

So how can high-performance services overcome these challenges? We offer two clear suggestions.

- A service much offer a **clear value proposition**. Make the offer so compelling that turning it down and missing an opportunity to achieve better health outcomes and substantial savings could cost a benefits manager their job.
- A service must favor administrative simplicity in its implementation, delivery, and management. A benefits manager must be able to roll out a new service without much heavy lifting. Otherwise, it becomes yet another contract to manage.

It is only inevitable that vendors will sign contractual arrangements through which they offer a range of integrated high-performance services. Like *The Godfather,* such bundles of integrated services can make benefits managers an offer they can't refuse: "Work with us and we'll guarantee better health outcomes with a reduction in total spend of 20% or more."

Program	% of total health care spend*	% savings within niche*	% savings from total health care spend**	PEPY savings
Reference-based reimbursement	36	35	12.6	$1,619
MSK disorder management	15	25	3.8	$482
Imaging	12.5	30	3.8	$482
Cancer	12	20	2.4	$308
Rx pricing optimization	16	15	2.4	$308
Rx formulary optimization	14	15	2.1	$270
Primary care***	10	15	1.5	$193
Specialty Rx management	4	35	1.4	$180
ACROSS OFFERINGS			**29.9**	**$3,842**

*** Solution results may interact and not be cumulative.**
**** Assumes a blended rate of $12,850 per employee per year health plan costs, per a 2018 Willis Towers Watson estimate.**
***** While primary care typically consumes about 10% of total health care spend, it influences care and cost throughout the full continuum, driving appropriate and disrupting inappropriate treatment practices.**

The table above shows the level of savings that are available from some of the most common high-performance modules, as well as the level of savings that could be available by deploying multiple modules. All told, it adds up to about 30% of current health care spending, or more than $3,800 per employee per year. And keep in mind: Since high-performance vendors willingly guarantee financial results, these savings projections are actually conservative.

This is the level of disruption that could fundamentally change how health care works in the United States.

CONCLUSION

What Will It Take to Make Change?

Objective:

- **Discover how a national community of benefits professionals and vendors can impacting change**

As we have discussed, not everyone is ready for high-performance services. Because of firmly entrenched business models that depend upon excess, legacy health plans simply are not interested.

To succeed, high-performance services need to appeal to employers and unions, which are at risk for their costs and can directly contract for their services. Already we see in the market a critical mass of frustrated large- and medium-sized employers and unions willing to supplant legacy health care approaches with high-performance, high-value approaches.

In addition, smaller groups that are capable of self-funding are coming together to leverage approaches that can provide meaningful relief from exorbitant cost and mediocre health outcomes.

Both purchasers and patients have embraced this new paradigm based on value – measurably safer care, better health outcomes, and lower costs. By embracing value, **benefits managers** at these employers and unions, forward-thinking **benefits advisors**, and **innovative vendors** are coming together to build a nationwide, value-focused community called the **Validation Institute**.

The **Validation Institute** is focused on driving improvement, efficiency, and savings. We see our community as a vital vehicle for information exchange, relationship development, collaboration, and performance improvement. Part of our work is to help the members of this community come together through platforms that support integrated modules of high-performance services for clinical, administrative, and financial risk management. These platforms could be TPAs, primary care clinics, or captives.

Our community of benefits managers, benefits advisors, and innovative vendors is already suited to manage quality and cost. As they create platforms and achieve substantial savings, it's possible that these structures will displace comprehensive health plans – or even become them.

Learn more about the Validation Institute today – visit our website, join us on LinkedIn, or send us an email. To request a conversation with us, please email our General Manager, Sue Morrell, or Executive Vice President of Sales, Bridget Kelly

We would love to hear from you and find a way to work together.

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