The Development of Physician ACOs

Grass Roots Development in the Delivery of Health Care by Medical Teams Through Accountable Care Organizations (ACOs)

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Preface

Twenty years ago, Memphis, Tennessee and Birmingham, Alabama were economically depressed, but had two very rich enterprises: medical businesses and pawn shops. Pain and suffering had built the medical businesses and need served by usury had built the pawn shops. As the health care system continues to decline in value and performance more cities may look like Birmingham and Memphis.

A declining system can be avoided, but staving off decline will require grassroots organization and cooperation between patients and physicians. First, everyone must see the health care system as it really is. Second, everyone must support changes in the way the money is collected and distributed so that both physicians and the patients get what they want and need.

Reforming and recreating the health care delivery system in the United States requires many basic changes in patient and physician education. It requires that health care be the primary goal and that payment for the services be understood clearly by everyone. If profit taking is a part of the system then it should be limited within normal to moderate ranges for the type of services provided.

If the system improves through grassroots organization and satisfying the needs and wants of both patients and physicians, then the cost of care will fall to the levels seen in other developed countries. Quality of care should be better too. The transformation will be the job of more than one generation, but not starting now would be a mistake.

Health Care System is Unnatural

The health care financing systems in the United States do not enable people and patients to choose what they want, when they want it, and from whom they get advice, care and treatments. This system does not follow nature in having multiple pathways for communication and protection. It was not born of the step-by-step building of a living system, but out of convenience for the U.S. economy that was under the stress of depression followed by war. Development of the system was built on the premise that adults had enough information and education to make intelligent decisions about the values of the products and services they chose. Further, the products and services were deemed to be affordable and readily available, but the measure of that was the profit of the enterprise and not the health outcomes of the patients. The consideration that these systems were about the preservation of life, the complex interconnections between people, their labor, and their dedication to each other was set aside in favor of monetary exchange. The consequence has been poor economy, poor health, and unnecessary loss of life. While other nations have given health problems more attention in the last five generations for reasons of economy they have done only slightly better in health outcomes. The main problem is about how to live and not about how to trade representations of goods and services for health advice and treatment.

Top-Down Management System has not worked

Regardless of the outcry about high cost and bad outcomes in health care from the most knowledgeable people in our society, a top-down solution to the problems has not and will not work. The solution, if there is to be one, will come from the bottom-up, from the patients, their
interconnections with each other and the inclusion of knowledgeable caregivers in guild driven self-directed small communities. People will need to be nudged into organizations that raise their level of understanding of medicine and leave them empowered to act in their best interest and economy. Health care providers are the likely class of people in this kind of guild/community to have a positive impact. However, these providers will be a small subset of physicians and other non-physicians providers; those who deal with both health and disease, acute and functional disorders and have a strong desire to teach medicine and health maintenance to people in a comprehensive and reproducible way.

**Life Sustaining Systems arise from the direct participants**

The organization of guilds and communities into life sustaining networks begins with the providers of care and not with other agencies regardless of how well informed or well-meaning these agencies may be. Enrolling patients into Medicare, Medicaid, or private insurance plans does not solve health care delivery and cost problems. Good health is about understanding health and health care problems and their solutions within a community of other people who share similar knowledge and concerns, some of whom are expert advisors and care givers. Paying for all of this is a commitment made by each individual drawing on the resources they have available from their labor, their entitlements, and the gift circles to which they belong. In the words of Abraham Lincoln, “labor is prior to, and independent of, capital.”

**The Imposition of Structure by government may reduce cost but it does not restore health**

In most other industrialized nations, the organizational structures necessary are imposed by law and the elite classes of administrators and medical care providers tend to have less opportunity for financial gain, but the general population suffers less expense and seems to have slightly better health outcomes. However, this top-down approach has not created a medical knowledge base that would allow the patient population to win against the relentless march of chronic illnesses that make us all old before our times. We seem to be wholly dependent on radical changes in the environment to get at the causes of our problems not addressed by acute care medicine. The interconnections characteristic of living ecological systems in which harmful elements are excluded and healthy nutrients created and supplied are not in the current medical/financial systems. In the case of the current systems, knowledge is not power but simply a fire alarm to which we have become accustomed to ignoring.

**Bottom-up Organizational Structure imitates nature and creates trust**

It is time to take a step back and put into place through mutual help what we need and want as people and patients. The paradox is that the organizers and care givers are patients too and can be properly empathic if empowered by their patients acting in concert. The nudge to physicians to act as teams and to embrace the solutions to both good health care and cost controls has been given through several programs from the government and the private sector. The programs presume that the people and patients are already organized into plans of insurance through which physicians must just become “accountable” by proper financial incentives, positive and negative. The financial incentives that are positive seem only to manifest about 20% of the time and only partially for the health care providers and not at all for the patients. However, the “nudge” has made a window where there was a wall and the possibility that the wall will fall as health care providers bring their patients through it. This is the paradigm shift that was needed. Prohibitions against voluntary association and mutual support seem to be few, but there are barriers to overcome in shifting trusteeship (a needed service within the guild) to new platforms.
Step by Step reorganization leads to Open Systems

Assume that the existing Physician Associations that contract with Medicare, Medicaid, HMOs and Commercial Health Plans are open to contracts between providers and their individual patients to carry the “nudge” physicians have gotten from government into the general marketplace. The physicians’ goals would be to: (1) determine the health status and profile of each patient and (2) personalize care and treatment so that most of it can be managed by the individual patients. The main barrier to that goal is: **time spent between the patient and the health care provider is compressed so much that the patient cannot learn and the provider cannot teach.** The next barrier is that communications within the community are restricted in silos that retard learning and stifle healing.

Financial and Medical Education of people and patients are the keys to reform

As a comparison, people think that language and math literacy is a benefit for the whole population. A few hundred years ago that was not the case. Medical literacy must catch up with language and math literacy and just paying for services does not accomplish that goal. **So, step one is to let the patient pay directly for their basic care so that the patient and their chosen provider can act freely in the quest to restore health.** Physicians and patients are already enabled by the established practice of “Concierge” medicine and medical saving accounts. We have not addressed the possibility that a patient could fail financially in their agreement with the provider, but a gift circle within the community is an easy remedy for that problem. It is done all of the time in catastrophes and there is no good reason why it cannot be done routinely in self-organized groups.

The Accountable Care Act is a nudge to reform but is not a natural solution

Government assistance in an overall health care program in which the patient’s saving account is driving their access to health care and in which there is price control and insurance against large expenses **is needed, but it is not the substance of the Accountable Care Act.** This type of system, if a top down approach were used, is like what was done in Singapore at \( \frac{1}{4} \) of the cost in the U.S.A. with better health outcomes. Singapore is a society in which people see community responsibilities as a prior condition for free enterprise. The U.S. is not yet that kind of society. However, we need not await political change to have such a high performing system, we can use the “nudges” we have gotten to “seize the day” and make our own patient-centered system.

Labor is cheap

In spite of the very high cost of health care in the U.S., the cost of primary care is a small part of it. Consequently, an individual patient can pay a physician for primary care services, laboratory, imaging, health education and care coordination for less than 6% of a minimum wage or 2.5% of an average wage. The Singapore model set their saving rate at 3% of wages. Perhaps the difference between the 2.5% we need and the 3% they collect is a surplus to assure that all of the people in Singapore have basic health care. In the U.S. that surplus would be our gift circles within individual cooperatives.

Paying a little more for Labor stimulates the changes that produce better health and economy

The peculiar thing about our proposal for the primary care physicians is that the “concierge plan” pays the practice more than they usually collect from insurance of all types. This includes the patients’ copayments and deductibles they may add to the money from the insurers. The concierge payment is 35% more that the Medicare rates. Yet, the access to care issues are eliminated and so
are the frequency of acute care episodes. The utilization of hospitals and emergency facilities drops and so does the attendant costs.

**Patient and Physician Friendships create Medical Homes**

The incentive for maintenance of the patient’s health works best when the patients know the bill has been paid in advance and the provider they need is ready and available to use. The incentive for the provider is the established patient relationship and the knowledge that the patient regards them as his or her Medical Home. With these conditions in place any bonuses earned by the provider because of good care coordination and reduced spending on other medical and hospital services is the seal for continued participation as a “concierge” Medical Home.

**State Regulations are imposed on natural systems**

An organized a patient–centered health care system requires an association of patients and physicians that is approved by the various state departments of insurance as a purchasing group. In some cases the states license these entities as Discount Medical Plan Organizations. One such group, Senior Patient Association, dba Patient Physician Cooperatives (PPC) was started in Texas in 2004. The members of PPC made “concierge” payment agreements between the individual patient member and the individual or group practice provider. Additionally, PPC, as a qualified Association, purchased group health insurance for its members that was as limited or comprehensive as they required. The purpose of the group health policy was to fund the specialty and hospital costs that were beyond the funds available in the “concierge” payment plan. The result was to have all of the resources needed to get health care without exclusions and for a price that was below the usual market prices.

**Existing Insurance Pools can use the natural systems of cooperatives**

Patients who are beneficiaries of Medicare, Medicaid, Employer Sponsored Trusts or private insurance can combine the PPC Group Association Plans with the patients’ “concierge” payment plans and the result is better access to care and lower medical loss ratios. Physician Associations can also form their own HMOs in order to contract with Medicare, Medicaid, and Employer Sponsored Trusts as plans through which the patients will have coverage and service advantages. These service plans should be able to have a lower administrative burden than the 15% usually charged by the currently competing HMOs. At least, if there is an administrative profit margin it can be shared with the patients and physicians.

**Focus on Education, Trusteeship, and Physician Incentives to make improvements**

The fundamental changes needed in the health care system are in the areas of education, trusteeship, and proper incentives for physicians who advise and treat patients. An educated patient’s point-of-view about his or her health care could be a desire for help when needed and avoidance of harm at each encounter. The knowledge and skill of the physician is the main concern even if their personality does not match well with that of the patient. Since physicians are trained in many different types of practices the patient, for reasons of economy, should pick a primary physician within the type of practice that suits the patient’s needs and wants. Since the patient is paying directly for these services in a private agreement with the physician that choice has little or no impact on the financing through insurance of the other types of care needed episodically. The way in which the system will maintain health is by the diversity of its interconnections and the capacity to of its members to share information and labor. The costs of care for any particular group will be
commensurate with their needs. The greater the carrying capacity of the organization the more likely they will be to maintain health and control their economy.

**Rapid Change is possible**

Healthcare costs in the U.S. are double that of almost every other industrialized nation because of patient ignorance, corporate greed, bad laws and regulatory policies. Oddly enough, patients can fix these kinds of problems rather quickly by **joining together locally and teaching each other medicine, finance, and good trusteeship.** As an example, should an educated old person subject themselves to extreme medical care and surgeries in the last few weeks of their life? And what guardians would allow that to happen? At such times a helpful person can show their love to dying relatives and friends by attending them, holding them and thanking them for who they were and what they did for others. These acts are superior to extreme medical care and surgeries. It is unfortunate that sometimes the decisions about medical care are vested in those whose lives are not seen in the context of their time and condition but in the imaginary time of their care givers and their younger relatives. The saying, “First do no harm” begs repeating. Yet, doing nothing is contrary to nature, even when it is right. The record of more than 400,000 people per year killed by medical care in hospitals is the mark of our wrong notions about the needs of infirm patients. People want to live as long as possible but in good health, free of pain, and independently. So, good medical care is advice and treatment leading to those conditions. Measures of quality from people other than patients are checks on the skills of the physicians by his or her peers and they may or may not be important.

**Cooperation between the patients within a practice is the first step**

Financing healthcare requires cooperation: first, between the physician and all of the patients who regard him or her as their primary care provider; second, between the all of the patients and primary care physicians in a particular community. In the first case, the patients of a physician support the practice and the physician makes time for all of them. This does not rise to the level of needing to be shared in a larger population to be affordable to each patient. In the second case, the patients need to pool their money to be able to pay catastrophic costs. They need a qualified non-profit Association so as to purchase group insurance that would be all inclusive of their needs. If their group were large enough they could probably form their own company for this insurance, but in most cases that is unnecessary and more expensive.

**Restore Trusteeship**

Within cooperatives, trusteeship of the money is the central issue. The predominate system in the U.S. is broken because the trusteeship is poorly structured and corrupted by a transfer of ownership of the trust funds to third parties. This transfer allows the money that was intended for health care expenses to be converted into inflated administrative expenses or corporate profits. The Medicare trust funds could be an exception to that transfer except the payment system in Medicare is based on fee for services or derivatives of that, such as bundled payments or capitation. The consequence of this faulty payment system is that the trust funds are simply plundered by frequency of use of unnecessary services that are very difficult to challenge by regulators. Also, the distribution of the Medicare funds is handled by contractors who benefit from the volume of transactions they process. So, the Medicare trust funds are not really in the hands of the trustees in a practical way. In the case of premiums paid to commercial insurers by individuals, businesses, Medicare and Medicaid, those funds become the property of the private company and what they have left from the premiums belongs to that company as an underwriting profit. The new health care law (PPACA) has attempted to address the unfairness of this by limiting the Medical Loss Ratio (MLR) to 85% of
group business and 80% of individual business. It is not universally applied and it can be manipulated by the companies. 15-20% is a large percentage of the premium for administration and marketing when compared to other financial management, especially when compared to the 2-3% paid by self-insured large employer groups. The solution is for the funds of the patients that can’t be budgeted and paid directly to their providers, to be pooled in a trust fund that pays the lowest of administrative fees and returns the balances from claims to the Trust. Those funds can be returned to patients and shared with their physicians as an incentive to get better care and to not waste any money on unnecessary services and supplies.

**Carpe Diem**

This is the best of times for taking control of the healthcare system because it is inflated and the wasted money can be applied to correct both services and distribution of funds. There are few if any barriers to correcting the payment and delivery systems when it is being done for self-identified groups of patients and physicians. The shrinkage of the funds will affect unneeded medical services and overpriced administration. The potential financial gain for the patients and physicians is to substantially lower the cost for patients and increase the revenue for their chosen physicians.
Introduction

Patients pay for medical care. They pay out-of-pocket and from benefits they earn through work or through entitlements like Medicare, Medicaid, CHAMPUS or Patient Protection and Affordable Care Act, (PPACA) Health Exchanges. Insurers are usually the trustees of the benefits and entitlements money. However, in our current system of health care, the insurers take ownership of the patient’s money before they distribute it to those medical providers who accept assignment of benefits. The Medicare Trust Fund is an exception to the transfer of ownership, but the way it is managed does not result in any funds returning to the beneficiaries in lower taxes or increased benefits. This process of transfer of ownership of the patient’s money to the insurers creates an incentive for the insurers to deny claims and for the patients to ignore the details of the claims and payment processes. The failure of Medicare to control its costs causes the same kind of claims denial and patient behavior.

The consequence of this transfer of ownership and abandonment of trusteeship is that each active party in the system is an adversary, and the cost of the medical and administrative services are much more than they would be if the transfer of ownership did not happen. Based on audited reports from managed care plans for the last fifteen years, the distribution of funds that have been paid for health care premiums to insurers are as follows:

<table>
<thead>
<tr>
<th>Portion of Premiums</th>
<th>Insurers</th>
<th>Hospitals</th>
<th>Primary Care Physicians</th>
<th>Specialists</th>
<th>Ancillary</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>40%</td>
<td>11%</td>
<td>11%</td>
<td>9%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The insurer’s 25% includes their expenses and profits; in turn, the profits represent 10% - 15% of the gross premiums in the plans. About one third of these profits were paid back to the physicians as performance bonuses.

There is an alternative to this poorly performing health insurance system that does not require new laws or regulations but does require cooperation between patients, physicians and sponsors of Employer Group Health and Welfare Trusts. This book is about that alternative.
The report from the Commonwealth Fund in June of 2010 was the wakeup call for all of us. On a scale of 1-7 the U.S.A. ranked last overall and costs were twice as much.

<table>
<thead>
<tr>
<th>Category and Rank</th>
<th>Aus</th>
<th>Can</th>
<th>Ger</th>
<th>Neth</th>
<th>NZ</th>
<th>UK</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</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>Quality</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Effective 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>Safe 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>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</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>4</td>
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<tr>
<td>Access</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Cost-related Prob</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</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>
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<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Long, Health Life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

**Health Expenditures**

- $3,350
- $3,895
- $3,588
- $3,837
- $2,454
- $2,292
- **$7,290** *

*These costs have increased to $9,100 in the U.S.A. since 2010*

*Source: Survey by the Commonwealth Fund*

The new health care law, “Patient Protection and Affordable Care Act, (PPACA)” was an attempt to solve many of the problems in our current system. However, it has not made insurance more affordable for most people nor does it apply to all patients for whom care must be provided. It does not change the ownership of premiums from the insurers to the patients (the condition that seems to be at the root of the problem), and it does not fix prices for medical services, administration or claims. The law, however, does require that the medical loss ratio be 80% for individual plans and 85% for large group plans; this rule means that more may be distributed to the health care providers or rebated to the premium payers.
Premiums have increased each year since the passage of PPACA and it is likely the premiums will continue to be above the rate of inflation. During the last year, there have been two rounds of 16% increases from the major insurers. Some large employer groups have told their employees that they will pay the government fines rather than provide the health benefits as they are required to do under the Act. The consequence of this new law may create larger numbers of uninsured patients and make less money available for the entitlement plans.

Hopefully, the future is not as dim as it appears to be after the first experiences under PPACA. Physician organizations should not let this Act negatively impact them or their patients. Contracts with Medicare Advantage Plans and ACOs will pay physicians more than traditional Medicare through profit-sharing agreements and provide their patients with greater benefits than they can get with Medicare and supplemental insurance.

Contracts with commercially insured patients through Cooperatives controlled by the physicians and patients will restore the trusteeship that has been lost in the current system. The COOP (Consumer Owned and Operated Plans) that are recognized under PPACA and the insurance policies under which they can operate economically are exempt from the regulations. However, these organizations are actually mutual insurance companies under the State Insurance Codes and not Cooperatives as they are understood by most people in such businesses and in communities throughout the world. The PPACA version of a COOP does not restore trusteeship to physicians and patients as can be done in true cooperative organizations by the following types of agreements:

1. Agreeing on the prices between the patients and physicians based on a comprehensive list similar to the current Medicare RBRVS.

2. Making common-sense written payment agreements between:
   a. patients and physicians
   b. patients and hospitals
   c. physicians and insurers
   d. facilities and insurers

3. Being sure that the agreements with insurers have the least load for administrative services and have provisions to return the profits from the medical and hospital funds to the medical care provider group and their patients (“Insurers” here include the COOPs created under PPACA and other companies that are part of the Insurance Exchanges, nationally and in the various states).

4. Assuring that patients and physicians know all of the costs of health care, thereby dispelling the mysteries of the administrative loads and complexities in paying claims.

This book contains comprehensive and practical information that will make organizing physician groups easier. It should also help physicians and patients control cost and quality of health care.
Chapter 1  First Step: Organization of the Physicians into Local Teams

In creating ACOs it is imperative to find physicians that other physicians trust and respect. They have to be as intelligent, articulate, and caring as the best teacher you ever knew. The primary goal of the team is to relieve suffering, so the physician has to be dedicated to that goal while at the same time having the attributes of a good teacher. It is possible to find such physicians.

Regardless of your experience and knowledge in the administration of ACOs or similar types of organizations the job cannot be done without the help of physicians like those described. Undervaluing the role of the physician is the road to the demise of the Local Physician Team. However, this undervaluing of the physician’s role is the road most often taken by those in power who want to organize a network of physicians to serve the budget of the Health Plan and the pocketbooks of the key investors. Leadership based on business models often results in the failure of the health care system.

The clearest evidence of the failure of our current health care system is that it costs twice as much as health care purchased in other developed countries. In the USA, most medical delivery systems run by managers, hired nurses, and medical directors have as their unavowed primary goal the generation of money for elaborate business structures feeding corporate needs and profits for capital investors. If, however, the main goal of an ACO is the alleviation of suffering, (1) the persons in charge must have an in-depth knowledge of diagnosing and treating sicknesses and injuries, (2) the managers must have a profound respect for peer relationships and sound economics. [A lay organizer who is outside the medical team (the core of the ACO) is a peer only in a nominal sense and will not necessarily have the respect of the medical group.]

There have been great physician leaders directing IPAs over the last twenty years. Our company has worked with many of them in managed care plans, in quality assurance committees, and in the direct care of patients. There are still many such people available to direct ACOs today. Find them in your groups.

A hierarchical structure in business is the usual operational model. In this model, leaders actually direct and perform important roles. But that is not the practical model followed by most physicians because they have small staffs and do not need middle managers. Consequently, when physicians participate in a large organizational structure like an ACO they often overlook the role of middle management and run their ACO organization much like they run their practices; It is often a struggle to build a practical structure around physician teams because it is counter-intuitive to the physician leaders.

In spite of the organizational difficulties, leaders of some ACOs have been able to reform the medical delivery and finance system from the grassroots. Such leaders have been able to bring from fifty to one-hundred of their fellow physicians to form the ACOs, with 438 ACOs so far in the United States. In order to win over the initial group, promoters followed-up with personal visits to each of the physicians to explain the ACO, the plan for
qualification, and the part of each doctor on the medical team. It takes about six months to organize and about three years to produce an operational team of providers. Pioneers in the formations of these teams remain convinced of the pivotal nature of the physician leader’s role.

Past physician leaders that have spoken the truth and did their best to relieve the suffering of everyone around them have built good teams. Sometimes they have incorrectly assumed that the primary care physicians would be budget-watchers and gatekeepers in the use of specialty and hospital services. They have also erred in assuming that the contracted specialists would behave as a group in the care of patients. It has taken several years to finally realize that it is not money that controls the costs or the quality of care—money is not even a real incentive in patient care. The incentive seems to be pride and fear—pride in what physicians do and fear that they will make mistakes. Therefore, the system for communicating what is happening everyday with every patient that is referred to a hospital or to a diagnostic facility is the controlling factor. The frequency of patient contact with the primary care physicians and their management of chronic illnesses also has had dramatic impacts on outcomes and costs. When the primary care physicians see patients frequently and monitor their care there are fewer crises and fewer hospitalizations.

Physician leaders must know all of the team members, the roles they play, and how they practice medicine. Furthermore, the team physician members must be reminded constantly that they are in an ACO and not in a traditional practice. Some doctors are habituated to referring patients to a very large circle of specialists—as many as fifty—whom they know from their contacts at the hospitals and at medical conventions. This number is far too large for a team that serves a small patient population. The reform of the present system must begin with a specific population of patients served by a specific ACO. There can be as many ACOs as needed to serve a whole community and patients can change teams periodically as needed, but open systems and lone wolf physicians and patients will not contribute to any improvement in health care, except to make it more costly and less effective.

Some ACOs have been diligent in avoiding contracting with too many specialists and in knowing that the team members must limit their referrals to team members only. Further, all members of the ACO must get the point—they must take care of their patients as they would take care of members of their own families.

There is an example of four physicians who put together ACOs with some ease. They all had a clear idea of the nature of an ACO. Each recruited from 50 the 100 physicians in about sixty days and then turned to the ACO management company to build the organization and get it into the market.

What made it possible to organize the ACO so rapidly and what does it take to get business for the ACO? If you want to slug it out with the big companies that control the health care funding, including the government, you have to have capital, and the ACO can’t scrimp on initial investment monies. Most of the organizers have invested about $1.5 million in the development of their ACO. Usually, the physicians own the majority of the interest in the
business. They recognize that there must be insured business for the ACO and there must be willingness to move patients to the ACO’s contracted health plans.

Medicare has entered this ACO arena and they assign patients to these ACO physician organizations. They contract to share savings with the ACO. They followed the model of the Medicare Advantage Plans by sharing between 50% and 60% of the savings.

The elements necessary for further development of successful ACOs are:

1. physician leaders who are well-respected, articulate, and caring
2. member physicians who put the patient first and treat her or him like “family”
3. creation of the right-sized teams
4. adequate capital for the operation
5. patience
Chapter 2  Contracts with The Medical Practices

How do the physicians organize their ACO and their medical teams?

*The first step is having enough primary care physicians who are willing to influence their patients to buy Health Plans that contract with the ACO they control.*

A typical PCP practice has from 1500 to 2000 patients. (That patient load must be shared with physician extenders who can attend to the health screening of well people and the worried-well people in order for the physician to have enough time to attend to acute and chronically ill patients.) Over three years, it should be possible for a doctor to convince about 800 of his or her patients to move to the ACO contracted health plans. It is not possible, however, for insurers to add new patients to his or her practice in such a way that it does not simultaneously reduce the quality of care. The patient/physician relationship will be disrupted. To get the enrollment numbers needed for the ACO to be profitable, the physicians need to direct their patients to the ACO’s best contracted health plans. About 400 of 800 potential patients will be seniors who choose Medicare Advantage Plans (200) and Traditional Medicare (200); The rest will choose commercial health plans through their employers or associations. The ACO needs 30 PCP practices to have a large enough population to enlist the support of a specialist team and a local hospital.

If the current insurance system changes dramatically and ACOs, Medicare Advantage Plans, and employer based plans reduce payments, then the plans will still need to perform under budget to earn “performance bonuses.” Care co-ordination, peer review, and quality assurance will have to be done better than is being done now for less money. In a zero sum game it is a question of who will get less, physicians or facilities?

*The second step is to recruit two specialists in each of the following twelve categories:*  

<table>
<thead>
<tr>
<th>Cardiology</th>
<th>Diagnostic Radiology</th>
<th>Gastroenterology</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Hospitalist</td>
<td>Neurology</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>Orthopedic Surgery</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Pulmonology</td>
<td>Urology</td>
</tr>
</tbody>
</table>

Cardiovascular Surgery, Neuro-Surgery, Oncology and other sub-specialists are special teams in themselves and are usually available in only a few tertiary hospitals. They form their own teams and ACOs contract with them to be more effective in the of care critically ill and chronically ill patients.

Part of this second step is in knowing the referral patterns of PCPs as they exist currently and then changing those patterns to enable the group to operate as a team. The example below is a graphic analysis of what referral patterns look like before organized into teams and after team organization. The disorder in the existing system is apparent and it leads to higher cost and lower quality care. The example was taken from a newly formed ACO and the analysis was done using Doc-Graph from CareSet.
The third step is contracting. Contracts between an ACO and a physician are long and written in technical language. Over many years contracts have gotten longer because of new laws and regulations governing commercial insurance, Medicare and Medicaid.

Some states have introduced a standardized “Physician Credentialing Application.” This has helped by saving physicians the need to complete a different form for every insurer. The standardized applications are about twenty pages long and require thirteen additional documents:

1. current resume, including work history (no gaps)
2. list of continuing medical education credits
3. copy of State Medical License
4. copy of current DEA certificate
5. copy of current DPS certificate
6. copy of current liability insurance face sheet
7. copy of current liability claims history
8. copy of medical board certification or eligibility
9. copy of medical school diploma
10. copy of residency certificate
11. copy of ECFME (if applicable)
12. copy of CLIA (if applicable)
13. completed and signed W-9 Form

Most physicians keep an electronic version of their completed standardized application and the thirteen supporting documents on file so that they can easily respond to new contracts. This process makes the job of ACOs much easier when they are required to verify each physician’s credentials for all of the contracted insurers.

The cost to each insurance company or hospital to collect the information and to verify the credentials is approximately $250 per year per physician. Sometimes insurers transfer this cost to the physicians or to the ACO.
The contract between the Physician and the ACO can be made easier to read and credentialing easier to complete. The template shown in our attachments contains the wording necessary to comply with current State and Federal laws and regulations. The declarations page of the contract has the basic terms of the agreement and the signature line.

The full agreement, including the required attachments, can be put into booklet form. It is the same for every member. The physician keeps the booklet for his or her files and returns to the ACO only the signed declarations page, the standardized application, and the thirteen supporting documents. Changes to the agreement with individual physicians never happen. If it were otherwise, then the ACOs would be unable to easily get agreements with health plans.

If a practice has a hundred or more patients from an insurer then that insurer will expect to spend less than 80% of the premium for hospital and professional services. If more is spent, the insurer will consider that practice a loss and will decide that either the patient population is too sick or the physician is the cause of the overuse of services. If a problem is not solved in a short period of time, the insurer sometimes terminates the agreement with the practice. The physician is afforded some protection from this action by the ACO, but if the situation is the same with the majority of the ACO member physicians then the plan will terminate the ACO. The consequence of termination of a physician is the patient might not move to another new provider and will drop the Plan. Or, if the problem is the physician, then moving the patients to a new physician that has a “good” bottom line will accomplish even more for a profit-driven insurer.

ACOs that are completely independent from the Health Plans and from the hospitals stand the best chance of avoiding the cancellations. A reformed health care system must eliminate this practice and perhaps can do this by judging the physician within his or her team and based on patient outcomes and not just the bottom line. Sometimes patient populations are really unhealthy and the premium does not match the real costs. There is currently enough fat in the non-professional portions of the Medicare Advantage Health Plans and Medicare to offset most of the possible losses until real solutions are worked out. Under the new health care law, PPACA, the plans will have to pay 80% to 85% for the medical and hospital services or rebate to the patients. This means that the ACO should be able to increase provider reimbursement and performance bonuses.

The addendum contains a sample “provider agreement” as mentioned above. In reading and understanding the agreement one gains respect for the lawyers who are trying to describe the duties and responsibilities of the Health Plans, the physicians and their ACO organizations.
Chapter 3  Organization of the Physicians within the ACO

Having made a roster of medical teams, ACO organizers could think that the ACO is in good shape. However, they will not know the true condition until really sick patients show up in the utilization reports. It is only then that the physician and nurse reviewers discover who did or did not do what was needed for the patients. The organizers may think they have picked the right Hospitalists, but the hospital system may have put patients into the care of someone not on the ACO team. Even if the ACO team has extensive experience controlling hospital admissions, the team has to develop enough activity to correct the admission errors that are likely.

Teams from the past may do their work without interference from the hospital’s case managers, who are often motivated to maximize the hospital’s revenue. The ACO’s Hospitalist should see the patient to determine what is wrong before an admission. They absolutely must not admit a patient to the hospital unless there is no other alternative because of the risk of disease and injury in any hospital setting.

ACO Hospitalists must have good relationships with the ER doctors. They must have all of their consultants on the spot within hours, especially for Cardiology, Neurology, Gastroenterology, and Orthopedics. The Hospitalists should not admit patients to ICU who will not survive; such preemptive transfer places an unnecessary financial burden on the hospital when Hospice is the viable alternative. They should continue to observe the patients in order to improve and update diagnosis. When they do admit a patient, they should keep him or her until the problems are resolved and hospitalization is no longer required. The Hospitalist should prefer a Skilled Nursing Facility (SNF), in most cases, instead of the Long Term Acute Care facility (LTAC). The Hospitalist must plan the discharge of the patients and get them back to their Primary Care Physician as soon as possible. Team physicians cannot have a financial interest in the hospital, the SNF, or the LTAC.

The key to the team having good outcomes is attention to detail and a profound respect for team members who are helping the patient. The work is about mitigation of suffering in others. It is not a performance seeking an award.

Some ACO teams have shown an extraordinary sense of responsibility in the care of their patients. This is a primary characteristic of people who mean to relieve suffering. Outside motivations in caring for patients, like money and fame, are bad character traits. The physicians who are “all about the money” or “all about recognition” should not be on any teams. They destroy the team and everyone on the team knows it as soon as you try to include them.

An insight into the right understanding of the practice of medicine has been written by Dr. Nassir Ghaemi, MD, who said the following about himself and his peers:
“We doctors are not gods. Nor should we wish to be. The concept of medical godhead reflects a mistaken notion of medicine, in my view; I call it Galenic, because it stems from the medical theory of Galen, which has seeped into our profession and our culture after two millennium of wide acceptance. This is the view that nature causes disease, and that the doctor fights nature to cure the disease. The doctor provides the cure: only a step is left to godhead.

The other view, long lost but deeply correct, I think, is the Hippocratic view of medicine: The idea here is that nature heals disease, as well as causes it, and the role of the doctor is to help nature in the healing process. The doctor is the not the central hero, but the handmaiden to nature. This does not mean that cure does not occur, but it occurs less than we think, and nature deserves the credit, not any human being. There is no room for doctor as god, and our purposes are more humble: To cure sometimes, to heal often, to console always.

Medicine is a complex affair; we frequently do not do justice to what our patients suffer and what they need. Pretending to know more than we do only makes matters worse. But being honest about what we do not know is not a sign of weakness….”

The ACO can find the physicians that understand the true nature of their practice and they can become a team. It is to serve the needs of patients and to operate within a budget dictated by government and businesses.
Chapter 4  Contracting with the Insurance Companies

Most major insurance companies contract directly with individual practices to provide medical services for their policyholders. They have “Preferred Provider Plans,” or “HMO Plans” and very few “open access indemnity plans.” They expect to spend 80% to 85% of premiums on hospital and medical services, 10% on overhead, and 5% to 10% for their shareholders or for dividends for their policyholders if they are a mutual company. Many times they fail to reach their budget goals, but in the last five years under the Medicare and Medicaid Plans, they have been able to match the targeted percentages in each category. Under the new law, they will have to reduce marketing and sales costs and profits to reach their 80% to 85% medical loss ratio. Reducing or holding the line on payments to the health care providers will not give them more profits, but will lower the prices to the government and to the patients.

Contracting with individual practices is the safe way for insurance companies to limit the fees they will pay to physicians and to retain any of the surpluses they might accumulate. The companies fix fees by using Medicare-approved rates as a basis, paying some percentage more or less than the Medicare rate. The range is from 80% of Medicare for diagnostic and surgical specialties to as much as 125% of Medicare for primary care.

The large employer plans and the Medicare and Medicaid Plans cannot exclude individual patient members but can limit coverage through higher deductibles and coinsurance. If these deductibles and coinsurance amounts are high enough they can transfer bad debt to the practices too. However, insurance companies usually manage financial risk by terminating physicians who have high risk patients or who are not taking part in the “utilization management” program of the company.

Having an individual contract between an insurance company and a medical practice is not physician-friendly. In fact, many physicians have overcome this obstacle for years by forming associations to do the contracting. This practice has worked to the advantage of the physicians in some cases but not in others. When an Association is very large and connected to a hospital system, or inspired by a medical association, it looks very much like a union to the insurance companies and to the Federal Trade Commission. Since “big insurance” influences government, the “union-looking” Associations have had many days in court for de facto price fixing. These Associations have usually lost in courts and been told that they must be “at risk” with the insurance company; therefore, fees are not fixed but vary as utilization rises and falls. Usually, large Associations do not operate well as teams. To work well they would have to be broken up into in small groups that would exclude many of the member physicians from particular plans. In large-group mode, the providers have their fees reduced, withholds retained, and administrative costs increased.

What actually works is a physician team serving a specific patient population that is no greater than the team can actually manage at one or two hospitals. Some ACOs have decided that this is the kind of organization they want and have made contracts with insurance companies that are fair to both parties.
There is a temptation for physician ACOs to want to be a capital stock insurance company and “have it all.” This has been tried by some large group medical practices already, but seldom, if ever, by an ACO. The capital requirements of operating even a modest HMO health plan are astronomical. As an example, the ACO incorporating 40 PCPs, each of them having 250 Medicare Patients would have 10,000 Medicare Patients:

- **Average premium:** $120,000,000 a year
- **Reserve required:** $30,000,000
- **Development Cost:** $2,000,000
- **Minimum Capital and Surplus:** $2,000,000

This means that a group needs at least $34,000,000 to get into the game in a meaningful way. Missing the target budget by more than 5% may impair the ACO and lead to asking shareholders for a bailout or closing its doors.

A better strategy is for the well-organized medical team to contract to share the profits with the insurance company. The insurance company should be well-capitalized and willing to manage the ACO’s financial risk. Such an insurance company needs the ACO’s help to make profits for their shareholders.

The costs mentioned are not peculiar to the health insurance business; they are typical of other types of casualty insurance. The target margins for marketing, sales, administration and profits are from 25% to 40% of the premiums. The contract must call for full disclosure of all of the income and expenses in detail at every level. Individual physicians rarely get to see that detail; thus, most associations of physicians, large and small, don’t get to look at the 15% to 20% that is taken from the top of the premiums and called “administration and marketing expenses.”
Chapter 5 Enrollement of Patients

Much misinformation surrounds the enrollment of patients into Medical Advantage Plans, (MAPs). In spite of the fact that the benefits for enrollment in MAPs are greater than those in Medicare or supplementary insurance alone, the Center for Medicare and Medicaid Services (CMS) restricts the time for enrollment in MAPs. CMS also scares both physicians and agents from telling eligible patients about alternative plans. The open enrollment period is currently three months less than allowed by past rules (exceptions: individuals just becoming eligible for Medicare, those enrolling in CMS-rated five-star plans, those in special needs programs, and those who are also eligible for Medicaid). Ninety percent (90%) of the eligible population has only the “open enrollment” during which to change to MAPs.

A comparison between a Medicare Advantage Plan with prescription drug coverage and Medicare with a supplemental drug and Medi-gap coverage is as follows:

<table>
<thead>
<tr>
<th>Medicare Advantage w/ Drugs</th>
<th>Medicare</th>
<th>Medicare Drugs</th>
<th>Medigap</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium</strong></td>
<td>$0</td>
<td>104.90</td>
<td>26.50</td>
</tr>
<tr>
<td><strong>Hospital: Part A Deductible</strong></td>
<td>450</td>
<td>1,260.00</td>
<td>0</td>
</tr>
<tr>
<td><strong>Part B deductible</strong></td>
<td>0</td>
<td>147.00</td>
<td></td>
</tr>
<tr>
<td><strong>Part B Coinsurance</strong></td>
<td>none</td>
<td>20%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Annual Deductible Drugs</strong></td>
<td>0</td>
<td></td>
<td>295.00</td>
</tr>
<tr>
<td><strong>Coinsurance Drugs</strong></td>
<td>none</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td><strong>Copay Drugs</strong></td>
<td>0</td>
<td></td>
<td>58.00</td>
</tr>
<tr>
<td><strong>Gap Coverage Drugs</strong></td>
<td>generic</td>
<td></td>
<td>none</td>
</tr>
</tbody>
</table>

An all-inclusive chart would demonstrate that Medicare can be even more expensive. The private insurance industry that sells prescription drug plans and Medicare supplement plans is protected through non-exposure. Most MAPs are HMO’s that have the freedom to choose any doctor or hospital that accepts Medicare within their restricted HMO-contracted networks.

A way to expose the differences between the MAPs and the Medicare plus a Medicare Supplement and PD Plans is to embed trained staff as patient advocates in the practices. Such staff could be taught to read and to understand contracts between physicians and insurance companies. The same staff could learn “right speech” and “right actions” in
relationships between physicians, insurance company representatives, and patients. They would also know and be able to teach operators to use Electronic Medical Record, Medical Billing and Appointment, and Internet Communications Systems.

Finally, that same staff member could also learn the ACO Plan from Medicare, the Medicare Advantage Plans, and the Commercial Insurance Plans in order to connect patients to the licensed representatives of selected companies that the physician wants to have under contract. Then, this carefully-selected and fully-trained individual could become the consultant—a Patient/Physician Advocate—for several physician’s offices. He or she would spend one day a week in each physician’s office handling all contracts with insurance companies, all contacts with their provider relations and sales representatives, and all training for the EMR, Medical Billing, and Internet Communications system. Each physician would commit to paying a portion of the consultant’s salary per month, but whatever the consultant earned from the ACO administrative fees would be credited against the guaranteed payment. If physicians were truly committed to having patients in the contracted plans, the cost to the physician for the consultant would be zero dollars.

Such a system could yield 250 patient enrollments per year per physician, or 1,250 enrollments linked to the consultant’s services and influence. It also has the advantage of leading to a better plan for patient care. The assumption here is that the Patient/Physician Advocate will help the physician to contract with the best plans for both the physician and his or her patients.

I have no expectation that the present and future Congresses and Administrations will do much to change the way people are insured or not insured. Payments for medical services under Medicare or Medicare Advantage Plans will not increase more than the rate of inflation. Congress is paralyzed by its relationship to big financial institutions whether they are failures or successes. The game is to protect the activities that make money and transfer the losses to the government.

Patients and physicians need to enroll into managed care plans if the health care delivery system is to work. The agency system used to enroll patients into managed care plans has not worked very well. Sales agents who are not known to the patients nor to the physicians sell a host of different policies to people they contact through every way they can imagine. Sometimes, the companies they represent send them lead cards gotten through advertising.

Regardless of the way contacts are made, the productivity is on the average, very low; About one sale a day for those agents who actually make a living selling insurance. This is bad news for the health care system because the patients and the agents must discover whether the patient’s physician is with a particular plan that has the best benefits for the patient and the best commission for the agent and is available when the parties meet. The probability of that happening is very low, so sales aren’t made and patients get plans that have the best commissions but have to change doctors. Alternatively, patients end up getting enrolled in bad plans because that is where their doctor has a contract.
As expected, these agents have to have a license, professional liability insurance, appointment with each company they represent, and must complete continuing education classes each year. Yet, if they sell Medicare Advantage Plans, they must take added examinations, must be retrained on each plan each year. They may not contact potential enrollees through door to door sales, nor by mass calling, nor by means that is not a direct referral from someone both parties know. They can respond to written requests from the potential enrollees who attend an advertised meeting or from literature displayed in the physician’s office. Physicians are prohibited from selling the Plans in their offices and from sharing patient information with either the companies or the agents. However, physicians can tell patients they have contracted with an MA plan as well as how to reach an agent. Additionally, the practitioner can get permission from that patient to have the agent contact them by phone. Physicians have little or no motivation to help in marketing in any way.

Since agents can sell all other types of insurance, including Medicare Supplements and PD Plans without this long list of contact rules, it is easy to see why productivity is low for the Medicare Advantage product. There are thousands of agents in every city, yet not many are willing to go through extra nonsense to get a better deal for seniors and their physicians. So, I think that the usual agency system is not the best way to enroll people in Medicare Advantage Plans or any kind of reformed health care system. The embedded Patient-Physician Advocate is a better solution to the problem if the managed care system is to be used effectively.

The PPACA has taken a different approach to the enrollments. The regulators reached out to all agents and almost anyone who will go through a day of training to get as many people enrolled as possible. Suddenly, it is no longer important that agents be educated, trained and retrained as in Medicare Advantage. In fact, they don’t even have to be licensed agents, just warm bodies who can say; “… please, sign here, there’s a subsidy. It’s almost free. You won’t be fined. Oh, if you are wrong about your subsidy, you won’t be fined until later.”

All of this is a problem because it is an employer driven and mismanaged non-health care system that a large percentage of the people cannot use even if they wanted to use it. All that ever happens when I think about this mess is that the Ricky Nelson song lyric plays in my head over and again; “You can’t please everyone, you just have to please yourself.” Consequently, solutions are limited to natural networks of providers and voluntary associations of patients.

When Medicare Advantage Plans began, some physicians told their patients they were not going to take Medicare. If the patient wanted to continue to be seen, he or she had to join a Medicare Advantage Plan that contracted with the practice. (Kelsey-Seybold Clinic in Houston formed their own HMO MA-PD Plan in 2008 and they use this tactic now.) It was and still is a very effective enrollment method. Often, the HMO does not use agents, but enrolls patients using salaried staff.
When the numbers of physicians were few, and there was a risk-sharing agreement between the plan and the physician, the programs worked okay. As the ambitions of the Health Plans and the physicians grew, the numbers of physicians listed for the plans became huge and the costs grew both administratively and medically. The bigger the network the looser the controls on administrative, hospital and diagnostic costs.

The plans tried to solve this utilization control problem by more automation and more detailed reporting of encounters between patients and medical and hospital providers. The doctors that moved their patients wholesale into a particular plan found that instead of making a profit they were paying the Health Plan for hospital and specialist costs beyond any network or facility they personally would have approved. All of this was before the 2003 rate increases and the change in reimbursement based on morbidity, but the experience among physicians was widespread and negative. Now, it is almost impossible to get one of those physicians to move all of his or her patients to a particular plan and take the risk of paying for the care.

Both CMS payment amounts and risk bearing agreements have changed. Risk has been spread among more physicians, financed by the Health Plans and budgeted over longer time frames with stronger reserves set aside for potentially large claims. Also, risk taking is not done unless there is a whole team of physicians working for a particular patient population and the patient’s services can be kept within the team.

The intention is about caring for patients. This requires resources that match tasks. People should avoid needless help in the delivery of health care, in the enrollment of patients, and in the use of equipment and facilities. It is communication from a trained staff to physicians and their patients that sets up all of the member enrollments.
Chapter 6  Home Visits with Each of the Patients

Suppose patients enroll in plans that are economical and beneficial for both the patients and the physicians. Further suppose that all of the people in your organization get to know patients well and really want to relieve suffering and stress. You can’t get to this idyllic relationship solely through mail or phone. You can’t sit quietly at your computer and crank out memos to members with full-color pamphlets that have generalizations about the most common chronic diseases. The most likely scenario for developing a good doctor/patient/staff rapport will be through a comprehensive physical exam—after which the patient can get the advice and care they seek. For the 20% of the population who don’t go to the doctor, the in-office visit is “not the best medicine.” The office visit does not relieve suffering and stress to the same extent as does a home visit.

A home visit by a nurse did not seem very important until our company contracted with XLHealth for our IPAs in Texas. XLHealth was a special needs program that was assigned 15,000 Medicare patients who had one or more of the following chronic diseases: diabetes, COPD, heart disease, or end stage renal disease. Their program was designed to see if frequent contact with such patients and close attention to their care and instructions would make a difference in the cost of their care and medical outcomes. Since CMS changed the way Plans were reimbursed to a morbidity model, XLHealth decided to form an HMO called “Care Improvement Plus,” and to become a special Needs Medicare Advantage Plan. They contracted with our IPAs for physician services, and in October of 2006 they began contracting with agents to enroll patients into their new plan.

XLHealth had a list of 15,000 patients from their pilot project to convert to their Medicare Advantage Plan. I had the opportunity to go with three agents on sixty of these patient conversion visits. The patients were very happy to see a nurse in their homes several times during the prior year, and they still had continued to go to their doctors’ offices routinely for examinations and treatments. The agents actually signed up more people for the new Special Needs Plan than were on the list of XLHealth. The spouse or other family members would also join as soon as they realized they could get the same care as their family member had been getting under the pilot program. The nurse’s home visit and the attention of the company to the patient’s particular problem was more important to them than their relationship with their primary care doctors. Patients were willing to join the program even if their specific doctors were not listed in the directory of the Plan.

XLHealth was so confident of their own medical delivery system that they did not pay much attention to which doctor the patient consulted. They still have an open panel approach to their delivery system, but they have now outgrown their ability to see every patient at home several times a year. They are becoming an insurance company instead of a medical care provider. However, the start for them showed that personal contact with the patient in the home does something positive that no other kind of contact can do. Relieving suffering, stress, and loneliness seems to help people to get well.
A summary of the Nurse Home Visit Program:

I. Goals

- Get in front of the hospitalizations with every patient
- Determine who is at risk
- What the risk is
- What the PCP and consultants have done so far
- What the PCPs and consultants want to do
- How the company can use its medical and administrative capacities to assist the PCPs and consultants
- Contact every patient in the home to get baseline information about her own health and family support systems and do a comprehensive physical examination.
- Get the information gathered back to the PCPs, Consultants, and Health Plan in a pure form with as much relevant medical data and professional analysis as possible to assure that all coding of medical history is completed and up-to-date. The completed medical record and encounter data is sent electronically to the Health Plan, the PCP, and consultants. Anyone unable to receive the data electronically will get it in a standard printed format.
- Connect the PCP’s staff to this project for positive feedback and support.
- Eliminate the social and economic barriers that are discovered that may negatively impact health outcomes.

II. Structure and Process

- Use the Nurse as a field contact with both patients and PCPs and Consultants.
- Support the Nurse with the Medical Director in the field and in the Clinic office to get expert guidance on the patient care and the proper analysis of the data gathered from patients and physicians.

III. Use the comprehensive health risk assessment form.

Our company has only used NPs in this program while other programs (like the one done by XLHealth) have employed both RNs and LVNs in home visits. In our case, the Health Plans wanted a higher level of care and wanted to be able to use the diagnostic information gathered by the NPs in their reports.

Our company provided the Nurses with MEDICs software to gather the patient examination and demographic information. We used the Open EMR system (certified in 2011 and 2015) to transmit that information to the physicians and insurers. Both systems are HIPAA-compliant, and details about them are in the supporting document section of this book.
Chapter 7  Delivery of Health Care Services

In the countries where access to medical and hospital services is easy, the population is healthier and lives longer. Since American is not yet among those countries that patients have easy access to health care, this country ranks low in the first world in health and longevity. That is a bitter pill for a proud people. However, these statistics include the whole population—not only those who are fully insured. Physicians may or may not be willing to serve people who are uninsured; in fact, they are often not willing to serve people who are insured by Medicaid. This problem seems to stem from class prejudice, but it may also derive from difficulties in verifying eligibility or receiving payment for services. Of the 520 physicians in our IPAs, about 350 are willing to take Medicaid; Far fewer will take the uninsured on any terms other than cash up front for full billed charges. Some physicians are always open to everyone regardless of the ability to pay. Frequently, patients who can’t pay are difficult to serve and physicians get discouraged.

The problem in the delivery of health care services for a new organization is the establishment of relationships between the physicians on newly-formed teams and the patients’ desire to seek care and advice from the professional team members. Relationship-building begins with the home visit program because it gives the patient a sense of trust in people and specific directions about physician contacts. The patients over age 65 should see the physician an average of five times a year. Younger patients need to be seen fewer times. These statistics are based on current practices in Europe, Japan, and the United States.

In seeking medical care, there is some risk that patients will be hurt rather than helped. That risk is greater if the patient receives invasive procedures or is hospitalized. The statistics on this are appalling, and reporting of them is avoided as much as possible in the press. However, physicians and medical researchers have reported it in detail. It was even reported in USA Today in October of 2011. Gary Null, Ph.D., Carolyn Dean, M.D. N.D., Martin Feldman, M.D., Debora Rasio, M.D., and Dorothy Smith, Ph.D. had this to say in an essay about the American medical system:

“A definitive review and close reading of medical peer-review journals and

Government health statistics shows that American medicine frequently

causes more harm than good. The number of people having in-hospital

adverse drug reactions (ADR) to prescribed Medicine is 2.2 million.

Dr. Richard Besser, of the CDC, in 1995 said the number of unneces-
sary antibiotics prescribed annually for viral infections was 20 million.

Dr. Besser, in 2003, now refers to tens of millions of unnecessary antibiotics.
The number of unnecessary medical and surgical procedures performed annually is 7.5 million. The number of people exposed to unnecessary hospitalization annually is 8.9 million. The total number of iatrogenic [induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures] deaths is 783,936.

The 2001 heart disease annual death rate is 699,697; the annual cancer Death rate is 553,251. It is evident that the American system is the leading cause of death and injury in the United States.”

Several model health care delivery systems have been developed in the United States and they have inspired laws such as the HMO Act in 1973 (PL93-222) and the current PPACA which everyone loves to call “Obamacare.” The largest of these models is the Kaiser-Permamente (KP) that now serves 10.1 million members. It is a non-profit organization in which Kaiser is the health plan and Permamente are multi-specialty physician medical groups for the delivery of care. They have five star ratings in both senior and commercial health plans. They are prepaid by their clients for the health care of the beneficiaries and the cost is well below the national average and the quality of care is superior to their competitors.

KP reported in their annual statement:

**KP BY THE NUMBERS IN 2013**

- $53.1 billion operating revenue
- $1.8 billion operating income
- $2.7 billion net income
- 9.1 million members
- 174,415 employees
- 17,425 physicians
- 48,285 nurses
- 38 hospitals
- 608 medical offices and other facilities
- 93,675 babies delivered
- 4.4 million members using My Health Manager
- 34.4 million lab test results viewed online
- 14.7 million secure emails sent
- 3.6 million online requests for appointments
- 455,512 Kaiser Permanente mobile app downloads
- 14.8 million online prescription refills
- 36.5 million doctor office visits
- 221,660 inpatient surgeries
- 962,852 mammograms
- 1.7 million colorectal cancer screenings

Community Investments

Approximately $1.9 billion invested in our community

- $175.4 million in grants and donations
- $49.8 million to safety-net clinics, hospitals and health departments
- $29.6 million invested in medical research development
- 558,461 children and adults enrolled in care and coverage programs
- 4,184 studies undertaken by Kaiser Permanente
- 1,169 articles published in peer-reviewed journals
- 970,994 people reached by Educational Theatre Program
- 54 farmers markets

When KP results are compared with the performance reported by Medicare and Commercial Insurance KP is far better. Their charges per person per year averaged $5,835 when the average in the U.S. was $9,100. KP also gave back $209 of their premiums to improve the community health programs. Their system has not reached the lower levels of expenses reported from other countries but is it so far ahead of every other plan in this county that it can be a proper model.
Chapter 8  Reporting Health Care Encounters

Reporting health care encounters might seem to infringe on a patient’s liberty; however, there are others who regard such cooperation as necessary to proper treatment of patients. For example, such detailed record-keeping enabled Dr. Paul Farmer in Haiti to help relieve the suffering of others. The run-of-the-mill practice of encounter reporting in order to be paid by the insurance company can be corrupting. A doctor cannot codify diagnosis and treatments without reducing the information discovered even if the ICDA10 codes are used. Further, reports made on the basis of payment can be tainted by greed or sloth. In sum, records can be unwittingly corrupted, and the greater the number of these reports, the more corrupt the collection becomes. A simple test is to ask a doctor who needs to see the medical records of a particular patient if the encounter reports submitted to the insurance companies for claims will do. He or she will most likely just laugh at the question.

Disconnect compensation from reporting, as in Dr. Farmer’s case, and you could get valuable information to an epidemiologist. That is exactly what must be done in an ACO—real medical records recorded in a real medical records system. While codification makes the record easier to sort and compare, it does not improve it. Since most of the new electronic medical records and billing systems enable the physician to know exactly which diagnosis and procedure codes will be paid by the insurers at the highest rates, the physician can use a pick list to improve his presentation of the patient’s problems and the coded services. Such a system tends to corruption.

There are thousands of medical records systems, and so far, only hospitals and large group practices have been able to make sharing and maintenance of records somewhat useful and practical. This move forward has been very slow and done at great expense. It is unlikely that ACOs—unless rebuilt on a group practice model—will be able to harness the beast. Nevertheless, they should make the attempt.

Lately, there has been a push to Open Source Systems that include Open EMR. Open EMR is a robust system that was certified in 2011 and again in 2015. It is free only in the sense that a person does not pay a proprietor a license fee to use it. However, you have to learn it, and most of us have to pay someone to install, support it, and train other people to use it. The hope of the thousands of doctors and geeks who use such a system is that it will become a standard—like Linux. If it does, then our physicians in the ACO might be well-served. There are physicians like Ignacio Valdez, in Houston, who are working hard to promote Open Systems and who have expert knowledge of the technology. His white paper on the subject is available online. Altogether, there are approximately two thousand people working to improve and support this software.

Because the record-keeping side of medicine is understood and managed dynamically, it is difficult to convert people to a wholly-computerized system. I have had computerized record-keeping systems since the late 1960’s, and the only thing that has lasted over that fifty-year period has been the printed copies of the records—and not even all of them. At the level of operation of a physician’s office, the maintenance and storage of the medical records electronically is very risky. Natural catastrophes happen frequently, and they do
damage to our machine support systems. Just being without electricity for a week suspends these systems and you are left with hand recorded paper records. Even the NSA is not able to keep its system up all of the time. The saving grace in medicine is that the human body is a record of its health and a physician can recreate a copy of that record for a patient by physical examination and questioning. Sometimes what has been recorded in the past is not so helpful and not as important as people think.

It is not the medical record per se that drives the perceived need for automation. It is the third party payer system that drives it. There are no individual physicians or patients who would not survive a complete melt down of the electronic records - medical or claims. But, there are no insurers that can do cost predictions and policy determinations without a claims database supported by medical records. This would be true even if the data collected was not true, which is the case in all of the current claims databases, and the records were either up-coded or down-coded. Corrupt or not it is tied to the money and the budget and the policies, so, for the sake of the insurers, they think it must not melt down. They own the government, so I guess it will be protected in any state in which it exists. A reformed health care system would dump all past histories from those corrupted databases and start clean and not connect the medical records to payments.

A strong desire to see the world as it is should keep the ACO and its members from becoming delusional and following the instinctual path of regarding encounter reports as a bit of a joke. Some physicians have picked a few codes and a few basic charges and that is all they report. To them it is an uncomplicated way to report claims and get paid. About five years ago Medicare decided to pay the Health Plans based on the morbidity of their patients. In order to establish morbidity one must report all of the diagnosis and procedures done and re-establish diagnosis every year.

At first, it seemed that CMS had a perverse sense of humor. It must have known that a large percentage of the physicians would not go to so much trouble in reporting their claims to the Health Plans and other insurers. I assume someone thought the reimbursements would fall because of lack of reporting. Eventually the joke would be on CMS because the Health Plans and the physicians went to school about this and the reporting became more robust than the real lives of their patients. As mentioned in an earlier example, physicians will buy computer software systems that make up-coding much easier and harder to detect. It took about a year for that to happen in our community. HCC coding raised the profits about 30% for the dominate health plans.

There may be a point in time when medical records are recorded perfectly and stored electronically to be shared quickly with all of the providers needed to attend a patient. However, providers must be able to report exactly what is discovered in the encounter with the patient. There can be no understatement or overstatement. It must be done in a timely manner and through the channels available for those communications. Using EMRs and electronic claims transmissions will make it easier to report the findings.
Chapter 9  Reports to the ACO from the Insurance Companies

Enrollment and claims data are about the only information the insurance companies report to the ACOs. Financial data that shows the details of administrative costs are usually only available in the reports to the state and it is general rather than specific to the ACO. In the ACO reports these costs are assumed to be 15% to 20%. There may be equity in that assumed percentage. When compared with the public reports our company found that about 1/3 of the assumed cost (5% to 7%) was equity. Sometimes the insurance companies will form a separate claims and administrative company and the equity in the assumed administrative charge will disappear into that black hole.

There are some advocates of the single payer system that say the administrative load should be about 3% to 5%, but in those cases they are only focused on the claims processing and accounting services. The cost of enrollments, medical utilization management and administration of the medical groups and investor profits are not included and assumed to be unnecessary. Those are real elements in the whole health care system and I think their cost may add another 3% to 5% to the costs, ignoring profits, if that is part of the private system. If it is a public system they could automatically enroll everyone and avoid the marketing and sales costs altogether, but it is likely they will have some complex enrollment system like they do for Medicaid so as to continue as much unnecessary expense as possible.

Communications about hospital and emergency room encounters are kept in note files at the Utilization Review Department level and are shared with the ACO on a daily basis. Companies that do not do this are not depending on the ACO’s Hospitalists and Medical Director to control costs. Consequently, they usually don’t control costs but depend on the nurse communications between their staff and the hospital’s case managers.

The reports that are produced by the companies show the (1) enrollments, (2) premium income, (3) assumed administrative expenses, (4) incurred but not reported claims (declining percentage based on the age of the enrollments), (5) hospital claims, (6) other facilities claims, (7) professional claims, (8) capitation for other medical services such as mental health, dental and vision, pharmacy claims, and transportation. These reports can be sorted from the level of the individual patient to the primary care provider, to the local ACO, to the regional ACO, to the company. You can also sort the data by diagnosis, procedure, and location. These sort options allow you to see what variations there are in the practices of the individual providers. Physicians who code more elaborately and those who code moderately stand out from the mean average. The prevalence of certain diseases becomes apparent.

Despite comments previously about the corruption of the underlying data because it is driven by billing and collections it is still interesting from a financial perspective. No physician would depend on the data in these reports to treat a patient. The patient and his or her real medical record would be needed to make valid judgments about a medical problem. But, in general, the medical conditions and their costs which are derived from these database sorts point the Medical Directors to the physicians and patients they should
question. Of course, the more accurate the claims reporting is, when compared to the medical record, the better the system will work.

If the companies give the raw claims data to the ACO in a flat file, then other kinds of reports can be produced which further define what is happening between all of the physicians and patients. An example would be a report that showed how many unique patients were seen by each physician both in the ACO and outside of it and how many times they were seen and how much money was paid per patient and per encounter. That kind of information is important in the distribution of performance bonuses. It causes you to distribute the surplus money based on labor rather than just ownership.

There is sometimes an assumption that the ACO organizers, Medical Directors and Hospitalists have more to do with the creation of surpluses than the care given through routine encounters with patients. It is not true. The more you are able to report from the raw data the more democratic and fair your organization looks. Routine work by PCPs is about equal to the specialist’s contributions in more dramatic encounters with patients.
Chapter 10 Performance Bonuses

“A performance bonus” is Orwellian for, “The workers should have some of the profits, but selectively, of course, so that they do not attack the established order.” The fight between the companies and the ACO is about who will make the distribution decisions. The ACO can win that fight but must prove that they will not violate CMS’s or Insurer’s rules about “performance bonuses.”

Naturally, in what is assumed to be a capitalist republican democracy, everyone concedes that the investors get “first-count.” They often use borrowed money to create the ACO and must pay it back at usurious rates of interest. Their share is not a “performance bonus,” but a return on investment. Those selected for bonuses are the providers of care, usually Primary Care Physicians and some key Specialty Groups. The general rule from CMS is that the bonus should not exceed 1/3 of their compensation during the year. Further, bonuses should be tied to some preventive measures that are thought to be useful in maintaining good health, such as: Annual physical examinations, cancer screening, flu shots, prescriptions that control blood pressure, cholesterol levels, heart disease, diabetes, and glaucoma. It is possible to glean this information from the claims database and use the report to support your distribution of bonuses to the selected providers of care.

Medical Groups, by necessity in this culture, operate within an economic system that requires capital in order to function at the most basic level. Certain members of the group and their managers invest that needed capital. In most cases, the investments come from borrowed money or from savings and, over time, have an interest cost as well as a requirement to pay back the principle. Our ACOs, which are a network of three local groups, have invested $2,000,000 in capital during their development phases. Our company had to organize the individual practices into teams, contract with insurance companies for enrollment of patients, and establish our general administration, legal and accounting services. Debt service and restoration of the capital cost of our owners and managers is $15,000 per month and the only source of repayment is from the bonuses paid by our contracted insurers. In the past our company has received as much as $4,000,000 per year in bonuses on a population of 6,000 patients so that restoration of capital and distribution of incentive money to member providers was easy. The ACOs in many cases have a similar level of attributed patients but getting Shared Savings from the CMS programs has been impossible for 80% of the ACOs and slow to collect for the other 20%. It is not like the Medicare Advantage plans that pay a global capitation which includes administrative fees. It is more like a rigged roulette wheel guarded by the casino’s police.

Consequently, the ACO cannot afford to depend only on attributed patients from CMS to survive financially. So, many who did rely on just the Shared Savings bonus quit when they did not receive it and ran out of capital.

The right solution for an ACO is to use the ACO program as stimulus to influence patients to be part of better programs in which health care is first, but in which the financial arrangements are acceptable to both the provider and the patient. The ACO becomes the contracting agency for the practices for all of the health plans their patients use. The
practice and their total patient population becomes a collective bargaining unit to create a system in which health care is first, is fairly compensated, there are no wasted services or supplies and the third party administration is minimal and cheap.

The amount paid for medical services is dictated by the rates set by CMS whether paid on the basis of fee-for-service or capitation. Capitation is just a derivative of fee-for-service experience that is adjusted at the annual budget cycle. The medical group usually agrees to capitation if the amount paid is slightly more than they would have received on a fee-for-service basis. The CMS rate is not viewed as adequate compared to commercial insurer’s reimbursement rates and direct payments from patients, so the bonus system is a needed participation incentive. It is probably not an incentive for patient care or coordination of that care, but it is necessary, unless you change to a non-profit public system in which the government pays fairly and has popular support, whatever that means.

Special attention to hospitalizations, preventive care by the PCPs, and treatment of chronic medical conditions are the activities that result in better outcomes and lower costs. Physicians do these things if they are working together as a team and have the information about the patients in a timely manner, usually without any idea about the bonus money.

Since the budget established by CMS in their prescribed rate structure was built on an uncoordinated system of care, a coordinated system of care results in lower costs and better outcomes. The savings creates a surplus from which the Health Plan can pay bonuses. The budget most often used by the Health Plan is to assign 85% of the premiums to the Hospital, Pharmacy, and Medical Pools. Based on audited reports, the 15% assigned to the Health Plan has about one-third surplus. The hospital and professional pool 85% portion may have a surplus that can be used to fund bonuses for the provider groups.

The following is the usual distribution after final accounting:

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<th>%</th>
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<tbody>
<tr>
<td>Health Plan Administration and Marketing (includes equity) 15</td>
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<tr>
<td>Hospital, Pharmacy, and Medical Professional Pools 85</td>
</tr>
<tr>
<td>Expected Pool Expenses</td>
</tr>
<tr>
<td>Hospital 40</td>
</tr>
<tr>
<td>Pharmacy 5</td>
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<tr>
<td>Medical Professional 30</td>
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<tr>
<td>Potential Surplus 10</td>
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<tr>
<td>Division of the Surplus</td>
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<tr>
<td>Withhold for reserves 5</td>
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<td>IBNR 5</td>
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<tr>
<td>Plan profits 15</td>
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<tr>
<td>ACO Management 10</td>
</tr>
<tr>
<td>Capital restoration for ACO 20</td>
</tr>
<tr>
<td>Specialists 20</td>
</tr>
<tr>
<td>Hospitalists 5</td>
</tr>
<tr>
<td>PCPs 20</td>
</tr>
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</table>
The division among the member providers is based on patient contacts, records of preventive care, and management of chronic care cases.

In 2003 Congress began increasing reimbursement to Medicare Advantage Plans in order to pass on more benefits to patients in the forms of prescription drugs and lower out of pocket costs. At the same time, Congress also passed many more profits to the participating insurers. The benefits of the former rate increases began to end in 2010 as a 2% decrease was followed by 3.5% for the next four years. These decreases took away the administrative surplus and any other fat that may have been in the MA system. As a result, IPAs in the MA plans that survive will need hospital admission rates of 250 per 1000 people per year or less, and the management of chronic diseases will have to vastly improve. Business as usual is over.

Bonuses will have to be earned the hard way by eliminating unnecessary administration costs while improving patient outcomes. Under the new law, PPACA, the plan’s profits in the example above will have to come from its administrative share (15%) and not from the Medical and Hospital pools (85%). The latter will have to be distributed to the medical care providers as fees and bonuses or returned to the government or patients. Because the ACOs no longer have to bear the marketing and sales costs, they may have gained an advantage over the MA plans. If an ACO can maintain hospital admission rates below the 250 target it can make better bonuses because it does not have the higher marketing, sales and administrative loads.
Chapter 11  Accounting within the IPA and ACO

In the seventies, eighties and early nineties many IPAs had contracts to do delegated claims and delegated credentialing. They were the administrative office of the insurers with which they held contracts. They bought computer systems that tracked eligibility and claims and the data from that fed their general accounting programs. In the nineties there were many failures of these types of IPAs and the insurers stopped delegating claims. They did not like paying the IPA a lump sum of 85% of the premium and then having to pay the hospitals and physician again after the IPA failed. The transfer of risk did not work very well. The realization by the insurers and their regulators that claims were going to have to be handled by the insurer meant the IPA contracting and accounting was going to become less complex and less risky.

As expected, greed is usually why systems collapse under stress. In the case of why insurers entered into risk agreements and delegated claims to the IPAs, it was because they did not want to get into details of how an “at risk” medical group has to operate as compared with an indemnity insurer. They reasoned that if the IPA put up a substantial letter of credit, had a claims payment system, and accepted a gross capitation payment for provision of medical and hospital services, the insurer could have a profit regardless of the losses the IPA might suffer. (This is the same kind of thinking that is manifest by CMS in the ACO programs in which they push risk contracts.) That was greed and it did not work. You might say that it was stupid as well, but the people who were doing it were not stupid and had made substantial profits in the same kinds of contracts in the past. It is a little like our current mortgage failure; Greed followed by relaxation of standard underwriting, followed by business changes focused on more profits and not on the service that supported the enterprise.

Fortunately, the insurers had the capacity to take over the claims handling and the physicians had the ability to form new IPAs that did not do claims processing and accepted less financial risk. Consequently, the IPA and the ACO has been left with its general accounting and tax reporting to the owners as its only accounting functions. It is a CPA job and not too complicated. The cost of doing it is about $.25 per member per month when the population being served is more than 3,000. Independent audits cost about $10,000 per year, but can cost more depending on which CPA firm you choose and whether the IPA and ACO owners are contentious.
Chapter 12  Legal Support for the ACO

It is possible to do business without the advice and support of a lawyer, however a lawyer is indispensable to an ACO. ACOs contract with corporations and physicians that are much stronger financially than the ACO. The weakest party at the table must have good legal advice and support. Will Durant once said, “Animals consume each other without qualm, human beings do it through due process of law.” The amounts of money involved in funding an ACO can bring out the vultures in times of stress.

The appendix to this document points out the number of complex documents needed to conduct this kind of business. All of the documents appended have been written and rewritten several times by lawyers working for very large insurance companies and ACOs. Further, the contents must be reviewed and approved by both CMS and the insurance departments of the states in which the companies operate. Even though your lawyer must be your word-smith, do not be passive about what needs to be explained and whether or not it is necessary. Too many physicians simply give up when they read detailed contracts, some team leaders must have a thorough grasp of the contracts. The contracts are the full expression of the business the group intends to undertake and which the ACO might need to defend.

The fear that an attorney will charge too much is the same as the fear that a doctor or a CPA will charge too much. All such professionals require about $300 per hour to pay themselves and their overhead. They don’t always get that much, but it is a common rate. Doctors arrive at their rates through piecework billing (the CPT codes), but lawyers and CPAs automate their time tracking and bill you for the time they are awake and thinking about the job. An alternative way to pay both lawyers and CPAs is “capitation.” Several years ago a large law firm in Austin, Texas contracted with a dental HMO. The firm accepted $1.00 per member per month. Over time, as the plan grew in membership. The $1.00 was far more than the hourly rate for their routine work. Our company contracted with a law firm for $.75 per member per month and it worked to the advantage of the ACO in several ways. Over a twelve-year period of caring for 4,000 - 10,000 members with various companies we experienced four cases where the companies left the market or failed, putting our deposits or accounts receivable at risk of being lost. Having an attorney who was on retainer and who had a vested interest in preserving our income saved us more money than our company ever paid him. In cases where the companies went out of business, the attorney was able to reduce our settlement with one company by $100,000. From another company he was able to get a judgment in bankruptcy court for $150,000 when one of the officers of the company failed in a fiduciary accounting role with us. The officer knowingly approved a payment from reserves that was not due from us. In cases involving companies that had left the market, our attorney was able to get new contracts done and approved with new carriers so that a patient base of 4,000 senior lives was retained. Ultimately, the move of those 4,000 patients earned more than $6,000,000 in the subsequent four years.

Engaging the lawyer in a novel way is the same as finding a medical team that sees itself as an intimate part of an ACO and the care of patients as a first priority. The lawyer is a
key member of the team. He can be called upon to resolve difficulties between physicians, between physicians and patients, and between the Health Plans, physicians, and patients. Contracting with a lawyer places someone on your team who has no motives for promoting litigation and who can talk with other lawyers in a factual and confidential way.
Chapter 13  Affinity Groups, Co-op Clinics, and Community Support

Affinity Groups

Each time a group of people come together in associations or work groups the thought of using group purchasing power to reduce personal and business expenses is promoted by the members and by outside vendors. In the case of ACOs, the most common attempts to use their purchasing power are in areas of professional liability insurance, medical insurance, property insurance, medical supplies and equipment, and staff leasing services. Large physician associations that are sponsored by hospitals have been in the forefront of this “Affinity Products and Services” offer for many years. As a consequence, it is very difficult for a small ACO to offer such products and services in competition with those offered through the larger associations. However, a national association of physician ACOs could deliver these kinds of cost saving benefits.

Started in 2012, The National Association of Physician ACOs is a tax exempt 501 c 3 organization that has put together a novel program aimed at reducing costs for providers while at the same time creating capital and income for ACO administration and its providers. Their announcement to eligible ACOs was published in June of 2015. It read as follows:

“The National Association of Physician ACOs is pleased to announce a development that will help our member ACOs and the Medical Groups they represent. The physician-directed ACOs can now obtain a large amount of capital for their organizations and for their member medical practices without huge debt loans and without giving up the management of the local medical groups. The capital is coming from a NAPACO coordinated program with Private Equity Investment Funds. The capital is available for local ACO’s and their member medical groups so the local ACO’s can cooperate regionally to become a true multi-group medical practice system. The NAPACO coordinated program rewards the ACOs and their member physicians far better than the alternatives of selling practices to hospitals and other types of medical businesses. NAPACO makes it possible for physicians to join together to create viable regional networks to service the Medicare ACO, Medicare Advantage, and Commercial insurance markets.

In summary, this is what is being offered to local ACOs through NAPACO:

- Each qualifying physician practice will be offered a substantial fee based on the market value of their practice per patient for the right to represent them exclusively in a Regional Medical Services Organization. An analysis of their two most recent years of practice income will establish the fee amount
- The local ACO will be the administrator for their physicians and will also receive a substantial fee per patient for each of their members’ patients that have been included in the final analysis of the practices.
- The ACO Consortium will receive a small fee per patient for their advocacy role in the national program.
- The Practice Owners will be required to sign a long term participation agreement in which they appoint the Regional Medical Services Organization comprised of ACO Physician Medical Advisors and the Local ACO Administration company to be their exclusive agent for contracting with third party payers.
5. Additionally, the physician and the administrative organization will own the majority interest in the Regional Medical Services Organization. A minority interest will be owned by the Private Equity Funds.

6. The RMSO will hold contracts with all of the payers needed to serve the patient population of the practices. The physicians will still own and manage their practices and will share in the performance bonuses gained by the RMSO contracts with payers.

7. The EMRs, Practice Management Systems, and ACO Systems for analysis of performances that are needed to run this program will be superior to any currently being used and will be supplied by the RMSO and its contractors.

8. What the program ‘Is’ and ‘Is Not’;
   - The Investors are not buying your physician license or right to practice medicine
   - The investors are not buying your patients
   - The investors are not buying your property or equipment
   - The investors are acquiring a minority interest in the RMSO in order to aggregate the physician contracting rights with third parties, which include the accounting, billing, and IT. The management of the local ACO stays in place and the local organizations combined have the majority interest in the Regional Medical Services Organization.

9. By aggregating the contracting rights of many patients, RMSO will have significant negotiation leverage not available to the local ACO and cause a major infusion of capital for the local ACO and their member practices.

If your ACO or IPA has 60 Primary Care Providers (PCP), assuming an average of 2,000 patients per PCP, the estimated capital infusion the local ACO would receive ( $13,440,000). Practices and ACO Combined would be $114,240,000. As illustrated, this program will make the local ACOs and the ACO Consortium among the strongest in the country and make us independent of the contingencies involved in programs that are wholly dependent on Commercial insurers and Medicare.

**Other Benefits NAPACO put in place for Association members:**

**Capital Development Program** The program described at the beginning of this letter which could be as much as $114,240,000 for you and your member practices.

**Community Based Health Plan/Patient Physician Cooperative** in which the ACO can make provider agreements with employer groups that share saving with the ACO while reducing their cost of health care in plans that comply with the PPACA and are less expensive than the exchanges.

Software for analytics and care coordination that is market proven and lower in cost than any being offered to ACOs.

Advanced analytics that are based on national databases provided by CMS that allow the ACO to see in detail the referral relationships between their providers in terms of encounters and drug usage. This enables the ACO to see in advance what the natural teams are and where their leakage problems will happen.
Full sets of documents that are open-source related to the development of an ACO, the Application to CMS, and the reporting requirements to CMS and to commercial vendors.

Weekly webinars in which the ACOs and their staff can flush out the information they need about all of the practical matters of running an ACO. It is sharing best practices and critical information without having to wait on the top down approaches of the regulators or spending thousands of dollars going to remote meetings sponsored by the hundreds of vendors.”

Co-op Clinics

Individually, many physicians willingly and unwillingly provide free care to many patients. When indigent patients come through the emergency room of a hospital, physicians are sometimes reimbursed at Medicaid rates by the hospital. Religious based hospitals in the Houston area have some compensation policies regarding physician reimbursements, but the majority of the hospitals have no payment policy. Since there is a very large percentage of the population that has no insurance and can’t pay large medical bills when the bills come unexpectedly, there is much bad debt accrued. Private employers think they are paying for doctor’s and hospital’s bad debts through higher premiums, and the government thinks it is paying through Medicare and Medicaid programs. Doctors think they are just getting hammered for no good reason. Ours is a peculiar system that looks very much like “taxation without representation” in that there are laws against refusing people emergency medical care but no laws about payment for the services. This failure of payment could be interpreted as a form of taxation of the population that is licensed to deliver medical care.

Historically, there has been a failure to provide a reasonable means to pay for care. Some limited thought has been given to reform. The payment problems addressed through PPACA, the new health insurance law, are still wrong and reform of this law is blocked. The true nature of the problem is not understood at all by the medical care providers or by the money handlers.

Solutions to health care reform and payment are outside of our system of government and outside of the economic models leaders understand. The correction could be in the hands of the people who suffer most from the problems, patients. It is likely that the economic system that would address the problem is Parecon (participatory economics). Parecon, in this case, would mean that patients form and govern cooperatives through which they hire or contract for appropriate medical services. Effectively, doing for themselves what they want government to do for them. The sayings from Peter Maurin in his “Easy Essays” are now true, “That people in the past said of the Christians that they took care of themselves at a personal sacrifice, but now they pass the buck to the government.” Of course, Peter Maurin was living through the depression and helping feed people in soup kitchens in New York and did not see much positive in what governments had done in his lifetime. The difference between Peter and most of us in this time is that Peter did something every day at a personal sacrifice about the problems he saw.
Patient/physician cooperatives can be created in which everyone gets care. It would not seem so easy if the amount of money for primary medical care were not such a small percentage of the insurance dollar (less than 10%). It means that people who thought they could not have access to healthcare because they did not have health insurance can really afford to pay for primary health care using a few hours of minimum wage labor per week. Even the folks with the signs who stand on the corners in our cities can get enough money to “participate.”

Organizing cooperatives is not as difficult as grass roots political organization. Cooperatives are based on common needs of members for better access to health care. Since no economist, state, or federal government has yet addressed this access problem well enough to solve it for all citizens, no competing system has been created to limit the formation of community based cooperatives. Such entities can become insurance companies as has happened in the past with farm co-operatives and fraternal organizations, but until they want to pool their money and buy health care services from multiple types of medical care providers, specialists and hospitals, then the complexity of insurance organization can be avoided. They may want to be a purchasing group for those kinds of services that go beyond a simple payment agreement between their members and the primary care physician taking care of patients.

About ten years ago, physicians in many areas of the country started dropping out of insurance plans and offering their patients a monthly payment agreement for their medical services. They called this “Concierge Medicine.” The motives of the physicians seemed elitist, reports were that doctors wanted patients to pay them substantial monthly fees for special attention in addition to using their insurance. The advertised concierge rates were more than $100 per month or about five times as much as the health plans pay for primary care services. The fact that an individual can pay a physician a monthly fee for medical services that are not part of the insurance system is empowering to both the patient and the physician. A system of care and payment can be constructed, however without the overtones of elitism. Such a system could be the backbone of a patient/physician cooperative.

**Community Support**

How one cooperative got started:

*Members of a non-profit Christian organization in Houston incorporated a Non-Profit Association in 2005 for the purpose of providing members with health care services. The sponsoring non-profit organization’s income producing work since 1995 had been the management of contracts between of physician groups and Health Plans, mostly Medicare Advantage Plans. As a consequence of that work the organization had very detailed information about the cost and quality of health care in the Houston area and was able to create a Patient Association that is both economical and supported by many highly qualified physicians and nurses.*
The Association they created gave the cooperative proper governance and helped it recruit about 1500 individual members.

The cost of primary health care services at the clinic was set at $30 per month per person on average. These fees covered the cost of the physician, staff and overhead and no additional fees were charged for services at the clinic. Membership was set at $15 per member per month and that amount covered administration and other member benefits.

People who had Medicare and Medicaid could join a plan that contracted with the clinics and receive complete and comprehensive health care services including prescription drug coverage for no premium. Employers could also buy a plan that contracted with the clinics and have comprehensive health care services at a much reduced cost to the patient.

Individuals without Medicare, Medicaid, or employer sponsored Health Plans could join the clinics for primary health care services and use their health insurance to cover the specialty and hospital services that were required at other locations.

The clinics also saw people who needed medical services whether or not they could pay the monthly dues.

The initial response from the mailer was 670 people in one month. That response was followed by another mailer and by meeting with those who made the pledges, so that in three months the co-op was formed and the first clinic was started.

In time this first Cooperative grew by inclusion of many individual primary care practices and addition of payment plans with Imaging Centers, Labs, and Telemedicine and discounts from Dental, Vision, DME and Hospital and Specialist nationwide. It has become the foundation for a “Complete Medical Care System.” It is designed by the people who use it and serve as the care givers, Patients and Physicians.

This is a description of the cooperative as it now operates:

**Value Based Health Care**

**The Cooperatives**

The organizers find physicians who support the idea of a patient association in which physicians can help and serve patients and mutually improve their health and well-being.

**Community Organizers**

The organizers and physicians find people in the service areas of their practices who know their neighbors and who like to talk with them and help them. The physicians and nurses teach these people to be community health workers and teach them key skills in health care and public health so that these workers can then teach others and thereby build membership in the Cooperatives.
Members

People join the Cooperatives to get quality health care from selected providers at fair and reasonable prices—pre-paid by retainer plans and fee-for-service.

Benefits

1. Medical Care in the neighborhood 24/7/365
2. Patient advocacy to solve problems of access, cost and quality
3. Monthly payment plans (Concierge Medicine)
   Primary Care
   Lab Tests
   Diagnostic Imaging (CTs, MRIs, PETS, X-rays, Ultra Sound)
   Teladoc 24/7/365
   Roadside Assistance
4. Discount Plans
   Dental
   Vision
   Pharmacy
   Durable Medical Equipment
   Specialists
   Hospitals

Cooperative's Prices

<table>
<thead>
<tr>
<th>Ages 0-17</th>
<th>18-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>$72</td>
<td>$90</td>
<td>$100</td>
</tr>
</tbody>
</table>

Monthly fees paid by: Bank Draft, Credit Card or Debit Card

Creating the Value Based Health Care System

History and Opportunity

Flat wages, weak money, rapidly developing communications technology, and restrictive access to medical education have converged since the early 1970s to create an environment in which the “Accountable Care Organization” (ACO) has evolved. It is seen by many people as a good solution for government and private business to finance health care. This evolution began with Public Law 93222, the HMO Act, in 1972. That law was an attempt by Congress to keep health care and insurance in the private sector yet have price controls which many congressional advisors thought were needed because of the increasing dependence on Medicare and Medicaid programs.

The HMO idea was to siphon off the patients that were in indemnity health insurance plans, both employer sponsored and public, into companies that would accept the full financial risk for their care. After forty-five years, enough patients were drained into the HMO pools to prove that it could contain cost, make profits for the corporate owners, and
not produce any worse medical outcomes than the open access contracts of insurance. The HMO competition created hybrid health plans called Preferred Provider Organizations (PPOs) that used access-to-care controls and limited panels of providers in order to compete with HMO pricing, but did not transfer the financial risk to the health care providers.

In spite of the gradual transfer of patients to the HMOs, the cost of health care has risen to 18% of the GNP, about $9,000 per person per year. Also, the quality has fallen to a rank of last among the industrialized countries. This per capita cost is twice as much as should be needed and the ratio of physicians to patients is one half what is needed. These facts create a larger than normal population of patients that cannot pay for health care. The physician shortage creates a false demand for services. Combined, these conditions lead to higher morbidity and mortality rates and are reflected in the low ranking the United States has in medical outcomes compared to most other countries.

The financial medical crisis is such that the government cannot wait for the one-by-one conversion approach of the HMO model. It is faced with two choices: (1) pushing out the private sector, putting in price controls and establishing a universal health care system, or (2) eliminating the enrollment barriers and transferring the financial risk to the providers within private corporate structures. They chose the latter and have had the support of the major players in the medical industry, but will have difficulty maintaining that support if the majority of providers continue to suffer losses.

As a consequence, the business of the ACO is taking premiums from government and private corporations and then distributing those premiums to medical providers who are contracted to perform their services within the limits of those premiums or be paid less. It is a zero sum game. The providers within a particular ACO gain or lose money depending on whether their services are needed in the judgment of the owners of the ACO. The entities that are most likely to lose are the hospitals and facilities that have the greater share of the premiums and a declining technology. The gain can be great for the other providers because benchmark premiums are high now because of a distorted market share for medical services (18% of GNP).

Therefore, creating or joining a physician based ACO in which you are aligned with the non-facility providers in this zero sum game that is being played within an inflated pricing model will produce windfall profits for well managed groups in high benchmark areas for at least a decade. If the model is generally successful, as the government intends it to be, then the game will switch to a technological competition in which the companies that can deliver health care in the safest environments with the best communications systems will get the premiums.

The National Association of Physician ACOs was granted 501c3 status in 2012. In the first year it enrolled 38 member organizations that contract with about 8,000 Primary Care Physicians. These physicians have been serving Medicare Advantage Plans for many years and have operated profitably in that risk taking model. The members want
ACO and MA plans of their own into which they can transfer their patients and retain the needed capital and surpluses to build a true Value Based Health Care System.

**Steps in building the Value Based Health Care System**

1. Have a Comprehensive Health Care Plan the providers can use and that patients can afford.

2. Have Physician Teams led by Primary Care Physicians that have a stake in the operation of the Health Plans.

3. Have Patient-Physician Cooperatives through which patients and physicians can have purchasing power and personal involvement in every aspect of the health care delivery system.

4. Grow the Cooperatives in each targeted neighborhood.

5. Have the Physicians and Nurses teach Community Health Workers (CHWs) about preventive health care and medicine so that they can spread that knowledge to each patient in the Cooperative.

6. Have the CHWs serve as paid “Patient Physician Advocates” at a ratio of 1 to 600 households.

7. Train the Medical Team in Care Coordination and Quality Assurance and define the population they will serve and in which facilities.

8. Use the safest medical facilities possible considering them in this order:

   - A. Patient’s Home
   - B. Primary Care Physician’s Office
   - C. Urgent Care Clinic
   - D. Diagnostic Center
   - E. Ambulatory Surgery Center
   - F. Local Acute Care Hospital
   - G. Specialty Hospital

9. Improve the Medical Facilities by better designs and construction to make them safer.

10. Use technology that will make care easier and more natural for the patient and the physician while creating a medical record that is true.

11. Partner with organizations that share this vision and are willing to help build the Cooperatives, the safer facilities, and invest their time and money in the programs.
The Accountable Care Organizations (ACOs)

ACOs are physician medical care organizations which have a triple aim:

- Better health for the populations where they serve
- Better care for their individual patients
- Fair and reasonable prices that will be better than in the open markets

Primary Care Physicians

Those who are trained to diagnose, treat and coordinate the care of most patients:

- Family Practitioners
- Internists
- General Practitioners
- Naturopaths
- Masters and Doctors of Eastern Medicine and Acupuncture
- Nurse Practitioners
- Pediatricians

Specialists (30 Types)

<table>
<thead>
<tr>
<th>Allergists</th>
<th>Cardiologists</th>
<th>Chiropractors</th>
<th>Endocrinologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterologists</td>
<td>Hospitals</td>
<td>Hospices</td>
<td>Nephrologists</td>
</tr>
<tr>
<td>Obstetricians/Gynecologists</td>
<td>Ophthalmologists</td>
<td>Optometrists</td>
<td>Podiatrists</td>
</tr>
<tr>
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<td>Psychiatrists</td>
<td>Pulmonologists</td>
<td>Radiologists</td>
</tr>
<tr>
<td>Radiation Oncologists</td>
<td>Rheumatologists</td>
<td>Surgeons-Cardio-vascular</td>
<td>Surgeons-Colon-Rectal</td>
</tr>
<tr>
<td>Surgeons-General</td>
<td>Surgeons-Neuro</td>
<td>Surgeons-Orthopedic</td>
<td>Surgeons-Plastic</td>
</tr>
<tr>
<td>Urologists</td>
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Payment Agreements

- Monthly payment plans for patients (Retainer Payment Agreements)
- Fee-for-service at fair and reasonable rates
- Bundled payments from health plans that are the equivalent of #1 and #2 above
- Performance bonuses for providers based on 50% to 10% of the cost savings compared to market rates for professional, hospital and ancillary costs of medical care
- Medicare bonuses paid annually
- Commercial health plan bonuses paid quarterly

Quality Measures

- Equal to or better than the professional standards
- Medical outcomes better than the community averages
Electronic medical records are kept and the encounters, services, diagnosis are coded correctly.
Patients have access to and can easily share their medical records.
Patients are satisfied with the advice, care and treatments from the physician and his or her staff members and the staff members at the facilities to which they are referred.
Credentials are in order and up-to-date.

**GAP Health Care Plans**

Most health care encounters do not require insurance but can be handled between the patients and their physicians more efficiently and less expensively, as in our monthly payment plans. However, if there is a major medical problem that requires multiple providers and hospitalization then insurance or cost sharing pools are very helpful. There are three examples of plans used by PPC members.

**Indemnity Plans**

1. Reimburses for professional services at fair and reasonable rates based on a published fee schedule like the Medicare fees used by the government.
2. Reimburses $1,000 per day for outpatient services.
3. Reimburses $2,500 $1st per day for inpatient services and $2,000 per days 2-15.

Average monthly price
All Ages $130

**Healthcare Cost Sharing Ministries**

1. $1,000 personal responsibility.
2. Reimburses for inpatient and outpatient hospital services and surgeries after price negotiations.
3. Reimburses up to $2,500 for maternity bills from hospital or from a midwife.
4. Maximum lifetime limit of $125,000.

Prices from one of the plans offered by **A Healthcare Ministry** (1 or more)

<table>
<thead>
<tr>
<th>Ages</th>
<th>0-17</th>
<th>18-44</th>
<th>45-64</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$85</td>
<td>$85</td>
<td>$85</td>
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</table>

*This is not insurance and it is exempt from the Accountable Care Act. People who use this plan are exempt from any tax penalties related to not having health insurance.*

**Charity**

Membership dues also provide funds to help members pay for their health care benefits when they are having financial problems. It is the duty of us all to help one another to survive and to prosper. It is the duty of the individual to cooperate and to participate in the recovery of both their physical and their financial well-being.
Health Insurance Exchanges

1. Gold, Silver, and Bronze plans are offered
2. Premium subsides are paid by the government based on family income levels up to four times the poverty rate
3. Gold Plans pay about 90%, Silver 80%, and Bronze 60%
4. Prices vary from $0 if you are poor to between $400 to $500 per person per month if you do not qualify for a subsidy

There is an open enrollment period once a year
An ACO having less than 100 primary care physicians and 30,000 patient members requires about 20 employees to manage its contracts and provider relations. It takes about five employees to start the ACO, contract with the physicians, and complete the credentialing. You will then need an added employee for every 750 patients assigned to the ACO through its contracts with Health Plans.

An ACO of this size will likely have five teams of PCPs and Specialists and each team will have a QA committee and Medical Director. Five of the employees will be administrative coordinators for these teams. Ten of your employees will be assigned to PCP offices and their assigned patient populations as care coordination specialists. That leaves you with your CEO, accountant, two credentialing specialists, and a secretary - the beginning staff.

The administration is not there to guard an office, answer the phone, and pass the buck to the Health Plan or back to the physician, though it would be very easy to fall into such a trap. It is field organization that is in constant contact with physician’s offices and with patient members. It is all about relationships and having your ears to the ground about the medical needs of the patients and the support requirements of the physicians in terms of facilities and patient outcomes.

In Chapter 5, I discussed a new technical and sales support system in which some of the primary care physician offices would have an “embedded consultant.” Those consultants or “Patient Physician Advocates” are in addition to the administrative staff and are self-funded. And in Chapter 6, I discussed the home visits by nurses and the medical and economic benefits of that activity. They are also in addition to the administrative staff, and their labor is paid by the Health Plans from their professional medical claims pool. These added consultants and nurses are a further enhancement of the relationship building between the patients, the physicians, and the Health Plans. It is administration on steroids and should take you further along the eightfold path to enlightenment by Right Speech and Right Action.

The logistical problem of this kind of administration is the continuous contact with the patients and with the physician offices. Twenty people cannot see 30,000 people very often, but one hundred physicians, plus twenty consultants, plus twenty nurses can see the 30,000 people several times a year. When everyone is in the game, then the contacts have great benefits in terms of health outcomes. Simple things, like having the correct contact information for each member and each physician and each of their staff, can be maintained through this continuous activity. The way you know it is not happening in the present systems is from the massive numbers of errors in their databases, both on-line and in printed directories.

You cannot appreciate this until you are trying to call patients who have reported problems or you are trying to make a referral to a consultant and you are depending on information from the published directories. In the last week our nurses were given the names of one-hundred fifty patients who had to be seen for particular problems within sixty days. The
“unable to contact” because of bad numbers or addresses was thirty percent. The nurses corrected most of the bad information, but not all of it. They made the system better, but not perfect. They relieved some suffering, but not all. Had this “continuous contact” not been done, then the owners of the data would have been trapped in the delusion of their world, “not as it is.” These are simple things, but errors are found in complicated things, in medical records, in family support systems, in the environment in which people live. If you become just a bean counter, a paper shuffler, and a phone call forwarding agency, you have missed the whole point of ACO administration. You are either dynamic or you are dead. You may be reporting to an office, collecting a salary, and feeling good about yourself, but you are really just dead.

If you need incentives other than the job itself, ordinary wages, benefits, and mutual support to do this administration then you have the same problem as in the selection of the medical teams. If the administration seems more powerful and more aggrandizing than the medical team or the Health Plan, then it all will become a competition instead of a service. The goal is still the relief of suffering through the health maintenance of the members. Agencies that find people jobs in which they are placed based on the usual compensation for the skill category the applicant represents sounds perfectly reasonable, but often these placements just transfer whatever is wrong in the whole community to your company. Consideration for the job should be based on need, circumstances and the compensation of the whole administrative team. The material maintenance of the team members should not be on their minds in relationship to this job. There should be such a commitment to what is being done for others that mentioning job offers from anyone else would seem shameful. The company attends to the health of its members: patients, physicians, and staff. This includes physical, mental, and financial.
Chapter 15  Communication and Technologies

The ACO, in order to compete with others, will require a solid information infrastructure. Infrastructure means that you must possess the ability to communicate effectively with your customers, employees, providers, insurance carriers and business partners. This can be accomplished by using a mixture of formal and informal tools, starting with the basic telephone and ending with the software applications that are needed to manage all activities. This process of implementation can be a daunting task and requires the support of a well-qualified and creative technologist and the presence of some employees who have, at least, computer operator skills.

Communication

The Health Plan’s patient members must be able to reach the support staff to answer questions about their plans and benefits; or to find their PCP and, in some cases, pay their bill. Members will call you because they are unable to negotiate the insurance company’s voice messaging system or their doctor’s reception staff will not be able to answer questions. If you don't have a traditional “brick and mortar” office, your staff will need to use cell phones during business hours. Your providers, as well as other business partners, will have similar needs and should have ready access to the ACO staff.

In the past, our company provided cell phones or reimbursement plans to employees. However, it is better that employees are paid well enough to afford a cell phone that also can be used for needed business. Several options are available for Voice Over Internet Protocol (VOIP) and other hardware-based switchboard options that are both cost-effective and will provide the appearance of a main office to your customers and business relationships, without incurring the expense. These systems can provide a single or toll-free number and are configured to forward callers to individual phone numbers. (You should avoid making this directory too complex and simply provide either categories or roles for callers to access, ie: “Press 1 for customer support, 2 for provider relations, 3 for accounting...etc.”)

These days, the Internet is pervasive and you must also have a web site that represents the ACO, however, do not be surprised if it is not accessed often. But, if your website is missing information or what is presented is wildly out of date, this could hurt you in the future when providers and business partners search there. To that end, you should keep your site simple and up-to-date. I recommend implementing a web-based tool that will allow a non-technical person to update the contents, do announcements, introduce new products and update or add physician information.

Most Internet Service Providers have web page tools for their customers. Choose something like WordPress, which is a simple and free package, and is offered in a framework that supports dynamic web content and blogging. WordPress is a good example of the concept of Free Open Source Software (FOSS) which I will discuss later in this chapter. There are many thousands of these tools that can save many dollars over time.
To be effective, and stay on top of the ACO's priorities and business activities, your employees will need be in constant communication with each other. There are several effective tools for accomplishing this.

The first of these tools is using email. If you want a consistent corporate identity, you will need to have an email service. This usually can be obtained by establishing a business Internet account at your ISP, but it can also be handled inexpensively through a Google Gmail service or similar other vendor. If you have registered a domain name specific to your business for your website, gmail.com can be your email service, but use your domain as the email address, ie: jane_doe@your-ACO-name-here.com. You also can use creative names such as janedoe-your-ACO@gmail.com.

The second tool for use is called “groupware” by the technical industry. Groupware consists of a set of tools that are shared by everyone to allow the sharing of common documents, messages, “to do” lists and company information, without duplication. These tools range from standards systems like FOSS Lucane and PHP Groupware, to very expensive systems like IBM Lotus Notes or Jive. Google also provides group-ware tools that include shared files and document collaboration.

Your choice should be based on how easy it is to use or your employees simply won't access it. Another such tool which is provided is a web-based service produced by 37Signals.com. They offer a simple service called Backpack that allows for the creation of shared calendars, “to do” lists, FAQ pages, attached documents, messaging and collaborative writing tools. They also have a more advanced service called Basecamp that includes project management and time-tracking tools. Both services are very inexpensive and are delivered over secure, encrypted Internet, behind password-protected logins.

**Data Management**

There are several types of data that the ACO will need to acquire, manage and maintain. These include membership and provider demographics, claims data, including raw transactional and diagnostic information as well as data about hospitalizations. Other obvious accounting data, such as information for employee payroll, A/R and A/P, can be handled as needed either by a designated employee or by an outside accounting firm. This data is typically delivered by the insurance company and the providers.

It is important that this data be formatted in a way that can be easily loaded into a tool for processing and analyzing, such as in a spreadsheet or database form. Automating the regular retrieval and delivery of this type of data is a must. Because acquisition and delivery of data should be handled in a HACOA-compliant manner, data should not be sent in free text as an unencrypted attachment via email.

Because insurance companies are willing to provide data in their own formats, but will, in some cases, provide in a format that you prefer. Some companies provide a secure web mail account for your staff members to use and others may provide a data share that is usually accessible by FTP or similar protocol.
It is more difficult to get the data in a format that is usable with providers in your network. The providers may or may not have a computerized system for management of patient records. For those that do, many different systems exist. There is no guarantee that the provider’s software will support any of the defined, recommended, data exchange formats such as HL, nor will the provider be willing to pay for customization when their software doesn’t support the data exchange. The solution may be access to a consulting firm that specializes in medical information integration. However, to accomplish this some creative financing may be required.

For those providers that are not already automated there are FOSS options for Electronic Medical Records that are inexpensive, e.g., OpenEMR, OpenVistA, ClearHealth and PatientOS. These systems, though not well-known, are heavily used within the industry. According to the American Medical Informatics Association Open Source Working Group, there are about 2,500 sites and 28,000,000 patient records. (The AMIA published a white paper on this topic in December, 2008, This paper can be found on AMIA’s web site at www.amia.org.) The advantages of FOSS are discussed more in the next sections.

Application Software

The ACO will require various kinds of software for processing and management of the necessary data. Our past experience is that such software exists in three distinct forms, as follows:

The first form is the expected, proprietary model that is from a vendor of medical/health information software. These systems usually are very expensive and don't always deliver exactly what is needed without the added expense of custom work.

The second form is personally developed. This method can be successful if requirements are rigorously defined and an excellent development staff is hired and supplied with the proper tools for the job. The positive aspect of this process is to get exactly what is specified. The negative aspect is it takes longer to implement than might have been planned.

A third option to consider is Free Open Source Software (FOSS). This form is a hybrid of the first two mentioned. Start with finding an open source software system that meets as many of your identified requirements as possible. Customize it for your specific needs. This approach is the best of both worlds: first, by starting with a working system supported by a wide community of developers development time is saved and many mistakes are avoided. Usually, many of the experienced developers in the supporting community will help to customize the programs to fit the desired specifications. The rule in FOSS is to share the requested changes and improvements with the rest of the community.

Free Open Source Software (FOSS)

The scope of this document cannot include a full discussion of FOSS, but references to more complete explanations and the history of its development are in the appendix. The
term “free” in this context does not mean “free of cost.” Software licensed with a FOSS licensing model can be downloaded from the internet, but some money will be spent to get it installed, running, and to get employees trained to use it just as is required with proprietary software. “Free” means the freedom to modify the programs to suit specific needs and to share the application in almost any way that is fitting.

There is a large community of developers that creates and supports FOSS software. To See: www.sourceforge.net.

Members of the National Association of Physician ACOs that our company serves use the following FOSS software.

1. Linux (CentOS, Ubuntu) – servers and user workstations
2. Open Office Suite – Word processing, Spreadsheet, Presentations
3. Thunderbird Email
4. Firefox Browser
5. MySQL – database services
6. PhpMyAdmin – database administration
7. Apache Web Server
8. WordPress – Website and Blog
10. Development tools like perl, php, java and their libraries
References:


Chapter 16  Clinic Buildings for Participating Medical Practices

In 1977, in the Annual Medical Supplement to the Encyclopedia Britannica, there was an article about HMOs. It stated that HMOs were the future because they addressed the issues of cost and quality of care. It also stated that the public and the insurance companies would rail against them because of patient freedom to choose any physician or hospital. The article focused on group practice and staff model HMOs as the only ones that made practical sense in the achievement of the dual goals of lowering costs and increasing quality in health care. Most of what was written in that article has come true, so that even the indemnity insurance plans have copied features of these HMO models in outward appearance. They have adopted “managed care” practices, like “pre-admission” authorization, “pre-approval” for specialists referrals and diagnostic testing, and assignment of patients to Primary Care Physicians for coordination of care. Such adaptations are more economical than an open system like Medicare but still far short of the outcomes that can be achieved in Group and Staff Model HMOs. It takes no special wisdom to understand why, and of course there are stories about HMO members not getting the care they needed because the HMO owners were greedy (listen to Nixon’s comments about Kaiser’s profit motives from the Watergate tapes).

An evolution of the ACO into a group practice model of care is coming. That could happen easily because the facilities being used by the primary care and specialist physicians change over short time frames as the owners are attracted to new medical office locations and buildings. If the ACO membership grows and the amount of money from that source of business becomes more important to the participating physicians than their other revenue the ACO will construct facilities to exactly meet the needs of the practices within a group setting.

This idea of group facilities for ACOs has developed into the complete design of such facilities and the pricing of their manufacture and construction and equipping. There are three types of clinics in the designs: (1) those that can be manufactured and put onto the site in about sixty days and (2) “big box” stores that can be converted into multi-specialty clinics, diagnostic centers and surgery centers. The “big box” conversions are the most economical and will enhance the ACO’s ability to keep most of the medical care in the local neighborhood where it can be delivered quickly and safely, and (3) Specialty Centers for new sites that are iconic in design, machine-like in functions, built with high quality material, safer for patient care, long lasting and economical.

The new clinics are more attractive for the physicians to buy or lease than the usual medical office buildings. They are distinctive buildings that will be easily identified by patients as special places in which they can get quality health care.

Description of the Medical Services Organization and the Facilities Projects

The patient populations served by the primary care physicians of a local Medical Services Organization is about 40,000 lives. About 6,000 thousand of these lives will have Medicare or Medicare Advantage health plans and as many as 2000 may be covered by Medicaid
and the remainder will be in private health plans. Providers are engaged in diagnosing, treating and teaching patients medicine and health maintenance and in providing care coordination. These services are currently provided based on fee for service agreements with as many as sixty to seventy insurers. However, since the passage of the Patient Protection and Accountable Care Act (PPACA) there has been a shift by CMS and private insurers to risk contracts, as done in the past with HMOs. Health insurance has become a Zero Sum Game in which providers of care that make profits will do so from other providers in the game and not from increases in premiums and taxes. The most likely targets for reduced income are hospitals and the private insurer’s administrative service companies. Specialists are the third target for reductions. The only way physicians can win at this game is by being in a Medical Services Organization (MSO) that can manage, coordinate, and facilitate the care that their patients need.

MSOs function best when they serve a defined population of at least 150,000 in a specific geographical area. The physicians must act as teams in the delivery of care. Since they are paid a capitation for their services they will only be rewarded for performance by savings on facilities and insurer charges. The medical teams do this by reducing admissions to hospitals and other high cost facilities. Past experience with HMOs has shown that such medical teams can do that job well and cut costs by 15% to 20%. Average medical costs in the United States are twice as much as needed when compared with other industrialized countries. Therefore, savings of 15% to 20% are rather easy to reach.

A team consists of thirty primary care physicians and fifteen specialty groups for a total of about 60 providers. It will require a **Medical Director**, **Chief Operating Officer**, and **Chief Financial Officer**, an **Accountant**, an **IT specialist**, two **Secretaries** and ten **Patient-Physician Advocates** who work in the offices of the primary care physicians to help with training and care coordination.

Fortunately, over the last twenty years many of these teams have been organized and need only to be joined into Medical Service Organizations for the purpose of contracting with the Insurers and CMS for the best capitation rates and the lowest risk exposure. The Medical Services Organizations have been developed already as well as a Non-Profit Physician Association approved by the State Medical Board and empowered by the State to contract with CMS and Insurers in risk agreements. Further, the managing partner of this Association is a corporation that provides the access to funding, general accounting, contracting and legal services for all of the local MSOs and for the Association. The staff of this entity includes a **Medical Director**, a **CEO**, a **CFO**, two **Secretaries**, 5 **Liaisons**, one for each of the local MSOs. It also needs contractors for IT Systems, Data Analysis, Planning, Marketing, Design and Building of Facilities, Capital Raises, and sales of health plans to patients and their employer sponsors.

The first step in the creation of the Health Care System is a **Capital Raise**. Given the feasibility of the project the start-up capital for five local MSOs in one Regional will be $20,000,000. Additional capital for obtaining long term exclusive contracts with primary care medical practices and complete communications infrastructure will be $210,000,000. Facilities which will be leased to these practices will cost $100,000,000.
After the local MSOs are established, equipped and trained and the payer contracts obtained and the patient populations are attributed the next steps are improvements in communication systems and population management.

Specialty Centers are a logical step toward making health care easier to access for the patient and their primary care physician. The medical organizations that are charged with budget responsibilities soon discover that staying within that budget without some local control over consults, final diagnosis, and prompt treatment is very difficult. Our company will build our specialty centers that serve defined patient populations located close to the patient’s homes and the office locations of their primary care physicians.

The Specialty Centers will be leased by the practices that are in the Local MSO. The model facility is 70,000 sq. ft. They are from three to four stories and have a 5:1 parking ratio. They have a contemporary design that unites glass, steel, and concrete in contrasting colors of blues, clear glass, and aged copper, white and natural stone. The ancillary services are located on the ground floor to provide easy access and potential extended hours of operation. The site will be improved by beautiful landscaping, green spaces and fountains for customer use and enjoyment. Street signage will be prominent to reinforce the MSO brand through further use of the logo and advertisement of the specialty services provided.

The Center is delivered with finished tenet spaces. The design and cost efficiencies are enhanced by the design of some shared common elements such as waiting rooms, staff restrooms and break rooms. Physician offices will include the required elements such as administrative work area, three (3) exam rooms visible from a centralized nurse/work station, patient restroom and private physician office. Practices with multiple specialists simply add additional exam rooms per each nurse station and private physician offices as required. The Developer plans to build move-in ready suites. The physician simply chooses between a solo practitioner (1-pod) office or multi-practitioner(s) office (2 or more pods), and selects final paint and carpet colors. This greatly expedites the design and decision making process. It also assures finish quality and consistency of design and concept in the Specialty Center. The goal is to have construction fully completed prior to opening, so that practitioners and patients are not disturbed by on-going construction.

Cost efficiency is realized by providing shared amenities. Sharing reduces both construction costs and rent costs as each physician pays only his pro-rata share of the amenities.

The MSO and its physicians are expected to have their own capital to run their Medical Practices and the MSO. BBVA Compass bank has approved a loan program for the individual practice to fund their working capital needs in these projects. The individual loans are a very low interest rates and can be repaid over as long as ten years. The usual amounts have been $50,000 and $100,000.
Chapter 17  Community Hospitals for Local Support of ACO’s Patients

Finding a Community Hospital with a passing grade from the Leap Frog organization is a daunting task. They count reported deaths and injuries first, then they look at the experience of the staff in doing really serious operations and procedures. There are five rating categories and grades of A through F. Nobody has gotten all As. In fact, in Texas, in the “Great Medical Centers,” there was only three As in one category, Cardiovascular Care, and that was not in the Texas Medical Center’s famous hospitals, but in Scott and White Clinic (the big group practice HMO), West Houston Medical Center, and UTMB in Galveston. All of the other grades were C and below. So, physicians whose ethics are “to first do no harm” will try very hard to not use hospitals unless there is no other choice.

The hospital problem can be solved and there are two ways to approach it. Remember, the solutions are not for the whole community but just for the patients enrolled with the ACO. Consequently, it does not take a very large hospital to handle almost all of the hospital care for a population of 150,000 patients. The admission rate for a senior population is 250-275 per thousand per year and for a 1-64 age population is 100 per thousand. The length of stay is six days for the seniors and two days for the under 65 group. Therefore the number of beds needed is 80. Ten of those beds will be in level three hospitals so that your chosen community hospital will need only 70 beds to serve your patient’s needs. The physicians could pick one hospital where they can influence the quality of care and drive away the natural desire of administrators and owners to perform only “wallet-ectomies.” Or, the physicians and patient members of the community could build a new hospital that fit their needs, was based on a better design, and had no entangling alliances with others that would put the administration into the wallet picking business, rather than the patient caring business.

A new hospital would address the issue of how the current facility designs contribute to the injuries and deaths of so many people. Most of the injuries and deaths come from bacterial diseases caught in the hospital, from medication mistakes, and from surgeries. When this problem was presented to our medical architects they saw it as a traffic management problem, a communication problem and a plug and play design issue. Observations of hospitals in which disease control problems are chronic showed that the building allowed a flow of patients, visitors, suppliers, and medical staffs in all areas except the surgical suites. Just that flow meant it would be impossible to prevent bacterial diseases from spreading in the hospital and into the community as well.

One Architect, Blair Korndorffer, designed a two corridor bed wing connected to core surgical and diagnostic suites with no public access to the suites. Visitors to the hospital were identified at the entrance and only allowed access to the patient’s room that they had the right to see and only through the public corridor. Walking past all of the nurses, physicians, other patients and visitors to see your relative or friend is not allowed. The communications would track medicines and patients directly from the pharmacy to the patient without mixing anyone or dispensing the wrong kind or amount of the medications. Several of these systems are in use now in Texas hospitals like the Harris System in Ft. Worth.
A hospital is not really a building, it is more like a big computerized machine. When it is thought of as a building and when its property becomes a precious asset, it is no longer a hospital. It is an anchor that will sink the medical care system. It is a museum in which the donors display their art and their golden name plates. The public is sometimes impressed with this opulence and some among them may be inspired to want a golden name plate as well. When you see it as a machine, then you design it to use for its main purpose: the safe care of a patient. Let donors, visitors, physicians, staff, and suppliers socialize and conduct their businesses elsewhere. Don’t put anyone in harm’s way.

The machine has a core with surgical and procedure suites. It then has plug-in diagnostic units, MRI, PET, CT, Nuclear Medicine, Lab, and Pharmacy. There will be up-grades and new kinds of plug-ins. You will not have to put the hospital into the deconstruction and reconstruction modes to make technical improvements. You will merely unplug the old unit and plug in the new one. The plug and plays are made in factories where the quality control can be better assured. Even the bed wings are plug and plays and can be made elsewhere.

Another aspect of this idea is that the hospital need not become larger on the site where it is located, but another “Core Surgery-Double Corridor Bed Wings- Plug and Play” hospital can be located near the population it serves. Even a town of 40,000 could support a facility like this with only 24 beds. Big facilities do not serve physicians or patients any better than small facilities, especially if the small facilities are better machines.

The hospital designs proposed by Blair Korndorffer, AIA, are included in the Supporting Documents. Also, there is a summary presentation of his other major works which show his talent, ability, and experience.
Chapter 18  Capital for Development and Ownership of Medical Teams

Initially, ACOs have to support five people and an office and equipment for about two years before you can get enough income from administrative fees to operate in the black. The burn is about $500,000 a year. If the ACOs are organized into five teams and each team commits to $200,000 capital then you will have a stable capital balance that will allow you to contract favorably with the Health Plans. If you think there are no contingencies and no need for this level of capital, then take the money to Vegas and play dice, at least when you lose you will not have had any unrealistic expectations.

When the insurers required a “Letter-of Credit” deposited with their Health Plans in order to have a contract in which they would share profits, you needed about $3,000,000 to get off the ground. Fortunately, times change and there are bargains in the current market.

Once the local ACO owners have committed their seed capital of the $1,000,000 without debt and show that they can produce bonus income from global capitation agreements with CMS, with HMOs and with commercial insurers, then substantial added capital can be raised from Private Equity Funds.

The basis for additional capital is the profit that the ACO can make in the future from reductions in costs for the Payors which are by contract shared with the ACO. The fat in the Medicare and Commercial insurance premiums that can be cut are from misuse of facilities, drugs, diagnostic procedures and from uncoordinated care. ACOs have been able to do that in Medicare Advantage programs over the last twenty years and can do it in other kinds of shared saving agreements with CMS and Commercial Insurers. Sometimes the percentage of saving that will be shared is restricted to ten percent of the gross premiums, but not always. It is possible to contract for as much as 87% of the gross premiums for the professional and hospital pool and to retain all of the savings. You have to take all of the risk and post all of the reserves when you make those kinds of agreements, but the margins can be well worth the risk. When 85% of the average gross premium is $7,225 per year per patient and the fat portion of that is 15%, then the potential gross profit is $1,000. This kind of profit has been made many times in the Medicare Advantage Plans. Half that amount is $500 and when you raise capital selling 49% of your futures, then you could get six to ten times $250 per patient in a shared savings contract. At six times that would be $1,410 per patient. Most practices could qualify about half of their patients for this kind of investment.

Assuming a Local ACO had 20 primary care providers and each provider had 1,000 qualified patients ( those for whom a shared saving agreement could be made ), then the capital raise could be 20,000 times $1,410 for a total of $28,200,000. Assuming further that this Local ACO was a member of a Medical Service Organization of five local ACOs, causing it to have a better chance of contracting, a better communication infrastructure, and the ability to support an exclusive specialty group. Here, the division of the capital raised by all parties would look like this:
The idea behind this kind of capital infusion is to make each practice capable of employing the labor and technology required to achieve the savings. Their sacrifice is to agree to let the MSO represent them exclusively in contracts with all of the third party payors. It is as if they were professional football players and had gotten a signing bonus for agreeing to ten year contracts while playing the game to the best of their abilities, where those abilities were well known to the owners.

The professional football comparison is actually very interesting from a financial perspective.

**Compare an NFL Franchise with a Local MSO Physician Team**

<table>
<thead>
<tr>
<th></th>
<th>NFL</th>
<th>Local MSO</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Players or Practices</td>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>Coaches</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Gross Revenue</td>
<td>600</td>
<td>800</td>
</tr>
<tr>
<td>Operating Income</td>
<td>250</td>
<td>265</td>
</tr>
<tr>
<td>Salaries, Bonuses, Overhead</td>
<td>150</td>
<td>120</td>
</tr>
<tr>
<td>Net Income</td>
<td>100</td>
<td>145</td>
</tr>
<tr>
<td>Market Value</td>
<td>1 Billion</td>
<td>1.45 Billion</td>
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</tbody>
</table>

When you compare the numbers it would seem investors would prefer a highly performing medical group to an NFL franchise. There are certainly fewer barriers to entry with the medical group than with the NFL franchise. Also, the selection of the medical group should probably be done using a selection process as good as that used by the professional football teams. Pick the very best players that can perform well as a team. Recruit them early and help them along as they are learning. Play “Moneyball.”
Chapter 19  Summary

The politics involved in health care reform seem to be too contentious to get the kind of program that would insure everyone and make any difference in health care outcomes. PPACA is the law and it has survived the courts, so let us see how much it will help. The root causes of bad health in America have more to do with public policy regarding agribusiness, oil, industrialized food production, air quality, water quality, unemployment, pharmaceutical plunder, and treating physicians as piece workers, rather than with the lack of access to health care advice and treatment. When the FDA raises the allowed level of puss in milk so as to keep the large dairies in business you know the wheels are off of government and whatever they expect of physicians and patients is meaningless.

Since health care costs twice as much in this country as in other developed nations and the outcomes are not as good, then any kind of fix must first start with removing that which is not needed. If everyone were covered by the plan, then you would take away the sales and marketing expenses, a 5% reduction. If the money for medical, hospital, drugs, and other facilities were in one pool, then you would eliminate both the underwriting risk and the profit taking from the health funds, a 10% reduction. If the claims processing were bid competitively, then the cost from past experience in self-insured large groups would be about 3.5% instead of the current rate of about 8.5%, another 5% reduction. Finally, if the physicians and hospitals were organized into quality teams as has been suggested then the way in which they could be compensated could be based on the types of problems they are trying to solve for their patients, much like the hospitals are paid based on diagnosis. The savings from converting the medical providers to a “quality first with matching compensation model” would remove much of the waste in the current system by avoiding duplicate and unnecessary services and procedures. Just these changes could fix our system, but they all depend on universal coverage, and if not a single fund, then at least a regulated rate for the medical, hospital, other facilities, and drug costs.

If you start at the grass roots with patient-physician cooperatives and ACOs and new clinics and hospitals you can make acute care and chronic care of patients less expensive. If you control the enrollment of the patients in the Health Plans through the ACOs you can squeeze the fat out of claims administration and accounting. If you don’t do something about making food local, water and air pure, energy green and employment full, then health care costs will continue to grow by treatment of diabetes, heart disease, lung disease, kidney failure, war injuries, and all types of mental illness.

There should be a prize for giving a straw man a brain, a lion courage, and a tin man a heart instead of a clock. A $10,000,000 prize for fixing the health care system in the United States in a competition is not enough. That is not even one’s month’s premium from Medicare for 10,000 patients who are going nowhere in the current system. If the goal of the competition is to cut the cost by 50% to make the final five, then you could do that on paper in one day by dumping the profits, administrative and marketing loads, and the cheating that goes on with coding and piece-work forms of compensation. You don’t need to see patients for three years to prove you are number one if the standard is within the norms of health maintenance and the personal disciplines of individual patients. This is
really a political battle about how the whole of society is going to become fair, moral, green and cooperative. The people at the grass roots can get there. The people at the top of the current systems may have to find other work.

People seem to be too close to the pretend fights between the capitalists and the socialists to arrive at a political solution for the health care delivery system and the unnatural causes of bad health and poverty. If there are stakeholders in the game and there is a workable solution to unnatural causes of bad health and the corrupting effects of the claims and medical records reporting systems, then a compromise is possible:

1. Separate the health fund pool that is used to pay health care providers from the claims administration funds.
2. Let the private insurers bid on the administration of the plans and add their price to the universal premium that makes up the health fund pool. The premium would be set by the claims actually paid, but the rates would be age and sex related in ten year brackets: (0-10, 11-20, 21-30, 31-40, 41-50, 51-60, 61-70, 71-80, 81+)
3. Patients could enroll through approved administrators with no underwriting risk and the competition would be between the carriers based on their administrative charges.
4. The benefits would tract those of Medicare Advantage Plans and the Medicaid Plans for the poor, and they would not be loaded with high deductibles and coinsurance which creates a secondary market in extremely expensive supplemental insurance.
5. Pharmaceuticals would be subject to the same kind of price regulations as the physicians and hospitals are now under.
6. All plans would pay into the universal health fund whether they are ERISA, Commercial, Medicare or Medicaid. Claims would be paid by the administrators from the universal fund.