

## PODCAST 288: ACOS AND HEALTHCARE REFORM

By Mark Graban



*Dean Gruner, MD,  
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of ThedaCare  
<https://www.thedacare.org>*

*In this episode, Dean Gruner and I spoke about ThedaCare's experience running a pilot Accountable Care Organization Models.*

*For more conversations with Dean, you can also revisit Lean Blog Podcast episodes 119, 144, and 286.*

If you listened to episode 286 of the Lean Blog Podcast two weeks ago, you'll remember that my conversation with Dean Gruner, where we spoke about his reflections on his time as CEO of ThedaCare. We also talked about his experiences with Accountable Care Organizations (ACOs), the topic we spoke about five years ago in episode 144, along with some other big-picture healthcare reform issues, so I decided to make that a separate episode, number 288.

Back in episode 144, Dean explained that everybody has a different description of what

an ACO is, but he thinks of it as a mechanism for a group of providers, whether it's a group of physicians, hospitals, or health care systems, to be accountable for both their quality and the cost of the care they're providing to a group of patients.

Dean broke it down by comparing it to the usual fee-for-service model in three key areas from the perspective of the provider:

- Keeping people healthy: In the fee-for-service model keeping people healthy means not making money as you're

not providing any service, so there's no motivation to do that other than the moral incentive to keep people healthy. In the ACO model, there are incentives built in that mean the healthier you keep people, the better you do financially.

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- Restoring people to good health quickly and efficiently when they become ill: Once again, in the fee-for-service model, this comes with only moral incentives, whereas in the ACO model the care providing organization becomes a cost center instead of a profit center, and therefore providers can't afford to have complications, rework, and waste.
- A painless and short transition to death when time: Yet again, the incentives for keeping patients from pain suffering for years at the end of life are more abundant in the ACO model, which focuses on quality of life in addition to quantity, or length.

Summarizing the differences, Dean described the fee-for-service model as charging fees for volume, whereas the ACO model charges fees for value.

### **Pioneer ACO Model Pilot**

ThedaCare tested the ACO model in a pilot experiment in partnership with Bellin Health Systems, and physician partners from 2012 to 2014.

That pilot was with the Pioneer ACO Model under the Centers for Medicare & Medicaid Services (CMS), and was run with 20 percent of ThedaCare's revenue, meaning that the other 80 percent of their revenue was still getting paid under a fee-for-service model. Dean had explained that they piloted with 20 percent revenue so that they could learn with controlled and relatively low risk. The lessons to learn were not only whether the model worked, but what an eventual expansion of the model would require as far as skills, processes, and competencies.

You can learn more about the Pioneer ACO Model program and its overall results at <https://innovation.cms.gov/initiatives/Pioneer-ACO-Model>. Now that the experiment is over, Dean had his own insights to share.

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“We learned a lot. We were cited by Medicare in ‘13 and ‘14 as their highest-quality, lowest-cost ACO in the country, so we were very proud of that. Then, we sat out 2015 for a transition year,” Dean explained.

That transition involved both ThedaCare and Bellin each forming their own ACOs, though they still work together closely. ThedaCare has continued their ACO work with the Next Generation ACO Model.

### **Next Gen ACO Model Pilot**

According to the CMS website, the Next Generation ACO Model builds upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program and offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.

You can learn more about that program at <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model>.

“One of the things we've learned though, is over the last five, six years, we had numerous conversations periodically with some of the large insurance companies. They had told us that they were piloting different forms of total cost of care risk with providers around the country and that, as soon as they were ready, they would be willing to talk to us and expand that to our platform. In fact, that's never happened,” Dean explained. “We're disappointed with that and, I'd say, a little disillusioned with that, too, in that we think that the large for-profit insurance companies really do not have a sincere interest in sharing total cost of care risk with provider systems.”

Dean explained that in his experience, both through the ACOs and in the past when creating and running a provider-sponsored health plan that was later sold, for-profit insurance companies are in just business to make money for their shareholders.

“Although they talk a good game about how they're doing things to cool down the cost, the fact of the matter is they make a certain percent margin, on average, off premium dollar. As the premium dollar goes up 6, 10, 14 percent a year, they make that percentage up a larger and larger revenue base. They will deny this until the cow comes home. I definitely believe that they really are not as altruistic as they would claim to be. The reason they put in different mechanisms to reduce cost is so they can make more money.

“In fact, if they were to shift that total cost of care risk to providers, then when providers redesign healthcare using Lean and other strategies, and improve the quality of care, and reuse the cost, the

provider systems would benefit financially from doing that work.

"Today, when we do great work and redesign things, the beneficiary of that is the insurance company. They get the profit from our labor. They don't really want to change that because it's working well for them, so why would they change that? I can't explain why else, after five to seven years of conversations with insurance companies, why none of them have been able to follow through on what they claim they want to do in 2010, '11 and '12, right after the Affordable Care Act was passed?"

### Medical Loss Ratio

I asked Dean about one element of the Affordable Care Act, the Medical Loss Ratio, or as it's sometimes called the 85/15 rule, where the insurers have to spend 85 percent premiums on care. Dean was quick to point out that people don't talk about what happens to that 15 percent. Most

large national insurance companies are proud of the fact that their administrative costs are probably is between six and eight percent, meaning their profit margin, then, probably is seven to nine percent.

"It can be covered up by all sorts of clever things that CFOs do. You can cost over it RMD [required minimum distribution] expense, and this, and that, and the other thing, but it's a significant profit margin on average. As the revenue enlarges, that 15 percent becomes a bigger and bigger number," Dean explained. "If they were to have healthcare cost stay flat year after year after year, they don't win. If it's a capitalistic structure that we're in, I guess you can say you don't blame them because they're there to make a profit for their shareholders. They're not there to...that sounds pretty jaded, I supposed, but it's not intended to be jaded, it's just intended to take away the magic screen behind the Wizard of Oz, and let's just call it what it is."

I wondered if Dean though what he experienced is fairly representative of broader trends and, if the Affordable Care Act (ACA) remains the law of the land, if there are reforms or changes that would be helpful in terms of these incentives regarding ACOs, the medical loss ratios, pharmacy benefit margins, and so on.

"The way I try to explain this, Mark, is using the principles that we learned within Lean. If you do something and you do an improvement event, you're usually very happy using the 80/20 rule. You got 80 percent have it right, and I think that's what happened with the ACA. It got 80 percent of it right, roughly. What do you do with the 20 percent that's not working so well? You do a plan, new study, or just cycle it. You study it and adjust it. The logical thing to do with the Affordable Care Act is to keep the 80 percent that's working pretty well and identify the 20 percent that's not," Dean said.



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