Revere Healthcare Solutions Inc.
4121 W. 83rd Street, Suite 151
Prairie Village, KS 66208
Phone: 913 283-8223 | www.reverehs.com
"An Ounce of Prevention is Worth A Pound of Cure" – B. Franklin

The Comprehensive Solution For The Complex Issues Affecting Healthcare In The State of Kansas. Simplicity.

In early February 2015 Revere Partners LLC, received a call from a health & wellness company seeking help, as that company was experiencing financial distress, and was ready to shut down its several employer-sponsored, direct primary and preventive healthcare clinics in the state of Kansas and Missouri.

With a background in private investments and turn around situations, Revere Partners had received several calls of that nature for years but had never found a suitable opportunity to get involved. This time was different.

In March 2015, Revere Partners incorporated a new subsidiary, Revere Healthcare Solutions Inc. (RHS), headquartered in Prairie Village, KS. In late May 2015, RHS acquired the assets of the distressed company, and on June 15th, 2015 RHS re-opened the city-sponsored "Grow Well" clinic in Garden City, KS, serving the local municipality's employees and family members (880 insureds).

Roll forward three years, and in early 2018, RHS has partnered with the South-Central Kansas Medical Center (SCKMC) in Arkansas City, KS, opening a second similar clinic on the hospital's campus: "Cowley Health WoRX" (www.cowleyhealthworx.com).

RHS has also helped the SCKMC management team design a turn-around plan for the entire hospital operations.

In the meanwhile, the Grow Well clinic in Garden City has enrolled six more local employers, and in 2017 delivered more than 3,200 visits.

At both Grow Well and at Cowley Health WoRX, RHS direct, primary and preventive healthcare program complements, but does not replace employers' healthcare insurance. While basic services like primary and urgent care, vaccinations, allergy shots, labs, nutritional counseling, and chronic disease management visits are delivered at RHS' clinics at no cost for the patient, secondary, specialty and emergency medicine remain covered by the employer's healthcare insurance plan.

RHS is confident that its experience and expertise in delivering high-quality healthcare in smaller communities can be applied to both identify and fix most problems affecting healthcare in **the State of Kansas and nationwide. Our solution: *simplicity*.**

Nationwide, especially in rural states like Kansas, the reported shortage of convenient and affordable access to primary and preventive healthcare is a critical issue[1]. Today, in primary care at least 40 cents for each $1.00 of spending covers administrative costs. Such costs produce no benefit in quality of care, are partly covered by and generate the need for visits' co-pays, artificially increase the delivery cost of and the price paid for care. Economics teaches us that when the price goes up, demand goes down. Simply put, administration costs in primary and preventive care are largely responsible for its under-utilization. The under-utilization is exacerbated in smaller communities where discretional spending is more constrained. In such areas, a $25 or $30 co-pay for a primary care visit is perceived as "discretional spending". The result? In an effort to save, the consumer skips primary care visits. That is until their related condition becomes more acuite and requires secondary or emergency care visits (usually at 10x the cost of the skipped / saved primary care visit).

Also, as reported by the Kaiser Foundation's "Employer Health Benefits – Annual Survey", healthcare costs' growth has

[1] According to the National Association of Community Health Centers, in 2013 in the State of Kansas, 42% of the population or 1.2 million people experienced some degree of shortage of access to primary care)

outpaced both inflation and workers' wages. In an effort to curb such trajectory, employers have shifted and will shift an increasing portion of the cost to employees (and their families), in the form of co-pays and deductibles. According to the Foundation's Survey, in 2016, 81% of workers paid more than $20 co-pay per primary care visit. In 2006 it was only 49%. It is such structural dynamic that compresses the utilization of primary and preventive healthcare. The consequences are predictable: less prevention means more catastrophic events down the road. Catastrophic claims have the ability to generate significant healthcare costs increases, regardless of whether the payor is Medicare, Medicaid, private insurance, or the patient. Prevention is a payer-agnostic fix for high healthcare costs: this is the reason why RHS believes that our experience in employer-sponsored direct primary care can and shall be applied across the entire payer spectrum.

To complete the picture of the current complex situation of healthcare, two more issues have to be included.

First, smaller community hospitals are struggling to keep their doors open. This is the result of wider structural shifts happening for the entire hospital sector: inpatient volumes are under pressure, reimbursements are declining, and the hospitals' increased exposure to co-pays and deductibles to be paid by patients significantly increases smaller hospitals' risk of bad debts and write offs.

Second, in smaller communities, the incidence of metabolic diseases (most of which are reversible or controllable with adequate access to primary care and lifestyle management education) is well above average. Metabolic diseases are a silent, sometimes undiagnosed, but dangerous health risk factor; their costs silently compounds over time and become explicit, sometimes down the road, in the form of a catastrophic event.

When the entire picture is put together, it is quite clear: smaller communities are suffering from a self-reinforcing "vicious" loop responsible for higher and accelerating healthcare costs. Shortage of access to quality, affordable healthcare (exacerbated by struggling hospitals) cycles into lower utilization of prevention, then into higher risk factors, then into higher healthcare costs. Then again into lower utilization. The problems are complex. But the solution is *simple*.

RHS clinics in Garden City, KS and in Arkansas City, KS do not process claims. Employers contract directly with RHS, paying a flat monthly fee. The employees (and family members) on the healthcare insurance plan of the contracting employers have unlimited access to RHS' clinics, benefiting from an interdisciplinary approach to health & wellness, including primary / urgent care, nutritional counseling, and fitness education. The employers also receive services such as visits for workers' compensation and pre-employment / employment screening.

The direct relationship between the employer and the provider requires none of the administration costs encountered in the fee-for-service, insurance-based healthcare market. Patients do not incur any co-pay for their visits. And they utilize freely primary care and prevention. The "preventive" portion of the healthcare delivered (approximately 50% of the visits are delivered to a patient when she is "not sick") improves the overall health of the covered population, resulting in a reduction of healthcare insurance premiums well in excess of the RHS program cost.

The City of Garden City, KS was an early adopter of the employer-sponsored, direct, primary and preventive healthcare clinic. Today their insurance premiums are 4.4% lower than they were in 2014, while the typical comparable employer in the State of KS has accrued at least 10% *per year* increases since then. Such divergent trajectory represents in 2018 a savings of $211 per month/life. RHS program costs less than $45 per month per life (with implied gross and net returns of 4.7x and 3.7x). Apply such savings to employees of Cities, Counties, and School Districts and/or also to the Medicaid population, and estimate the "economic" boost that would come from redeploying such saved (and probably currently wasted) resources. It is simply enormous.

When RHS proprietary data are looked at very closely, it is evident that healthcare in general, across the board, offers an opportunity to do more with less. RHS estimates that direct primary care while compressing the long-term trajectory of healthcare insurance premiums, actually boosts insurance carriers' profits. As it always happens in insurance, it is far more profitable to cover a low-risk population, with lower premiums, than a high-risk population with higher premiums. Today's high healthcare costs function as a depressant on our society, to no one's benefit. Removing what economist call a "dead-weight loss" from the economy, by making populations healthier, would translate into financial benefits for employers, state / federal run agencies, and insurance carriers.

Such conclusion is evident in the recent announcements of consolidation between retail operations with small clinics (CVS and Walmart) and healthcare insurance carriers (Aetna and Humana). The calculation behind such merger is simple and complex at the same time. Providing convenient access to CVS and Walmart clinics, for Aetna and Humana insured populations, would make both carriers more profitable than they are today. It is an assumption, probably correct, that by leveraging the thousands of clinics owned by CVS and Walmart, Aetna's and Humana's insured populations will "consume" less

healthcare outside of such clinics, and therefore boost profitability.

The results that the RHS program achieves are a combination of a "lean" payment / contractual model and of "systematic" prevention. We have developed a population health management model which allows RHS, for large populations, to track health risk factors and to test corrective actions targeting those specific health risk factors, that can generate catastrophic events.

The Garden City's population, as any employer's an aging population, has achieved stabilization or reversal of risk factors such as weight, cholesterol, LDL, HDL, and glucose: such improvements have been achieved for both the general population and a subset of "repeat" patients that our statistical model is capable to isolate to provide like-for-like comparisons across the period.

It is RHS' experience that when talking to employers considering our program, sometimes their answer is: "What drives our healthcare costs are large catastrophic claims. RHS offers primary care. It would be just an added cost for us. We do not think your program can help us". Because healthcare benefits are so complex, employers usually rely on third party consultants and they are less prepared the causal relationship between under-spending today in prevention and exponentially over-spending in re-active healthcare, tomorrow. RHS data objectively show that spending more money on prevention, lowers the all-in cost of healthcare. Such equation is, again, payer-agnostic. It applies to employers, to individuals, but also to government run payors like Medicare and Medicaid. As an example, Kancare's budget trajectory would certainly be contained applying, systematically RHS' model of "direct" and "preventive" healthcare. To some extent the issue of Medicaid expansion is a truncated discussion. It should be analyzed whether "filling the coverage gap" in the State of KS could be funded by the reduced costs of covering the existing Kancare population, once a systematic direct and preventive healthcare program is introduced in the mix of healthcare provided under Kancare. The same reasoning applies to county health departments: so much could be done by migrating such points of care from purely re-active to preventive medicine, incorporating RHS' unique formula to deliver healthcare efficiently and with high quality, in areas where the cost of delivery and the price really matter.

RHS is more than direct, employer-based primary and preventive healthcare: it was born as a turn around and it has in its own DNA, the expertise to help smaller, struggling hospitals re-thinking their function in their communities by identifying the correct mix of increased revenues and lower operating costs.

The hospital sector is affected today by a perfect storm, which has the potential to wipe out hundreds of hospitals nationwide. Unfortunately, based on RHS' observations, smaller hospitals are in the eye of that storm. Their management teams are facing challenges which are relatively new, and require, at least initially a framework that is driven more as much by operational and financial considerations, as it is by strictly healthcare ones. RHS' view is that in smaller communities, hospitals should migrate to health and wellness centers, retaining and developing core competencies in primary care, prevention, wellness, common chronic disease management, and ER. In Arkansas City, KS RHS has helped SCKMC assess their own performance from an historical prospective. Once RHS highlighted historical trends by department, SCKMC' management team was ready to set into action and has in the last few months, already put in place some of the identified corrective actions, balancing quality of care with the need to reallocate resources. Such approach and framework can be (and should be) replicated across the State of Kansas and, of course, across the nation: RHS is ready to partner with any management team that is willing to listen. Hospitals' ownership should remain in the community. Because hospitals are pillars of future economic development: without a hospital the long term economic growth of a community is certainly negatively affected. RHS' objective is to make such hospitals stronger and capable to serve their communities for the next century.

In the end, whether addressing employers' skyrocketing healthcare insurance costs, or access to quality primary care, or sustainability of federal and state funded healthcare program, or the future of county health departments and hospitals, Benjamin Franklin said it all: "*An Ounce of Prevention is Worth a Pound of Cure.*"

Carmine Di Palo is the Managing Partner of Revere Partners LLC (www.reverepartners.com) a private industrial holding founded in 2009 and with interests in healthcare, construction, and oil & gas. He is also the Chairman and CEO of Revere Healthcare Solutions Inc. (www.reverehs.com), and the Chairman of Bell Masonry Inc. (www.bellmasonry.com). He holds a MS in Chemical Engineering from Politecnico di Milano, Italy and a Master in Business Administration from M.I.T. Sloan School of Management.