

HEALTH REFORM: THE IMPACT ON PROVIDER-PAYER RELATIONSHIPS

AAIHDS

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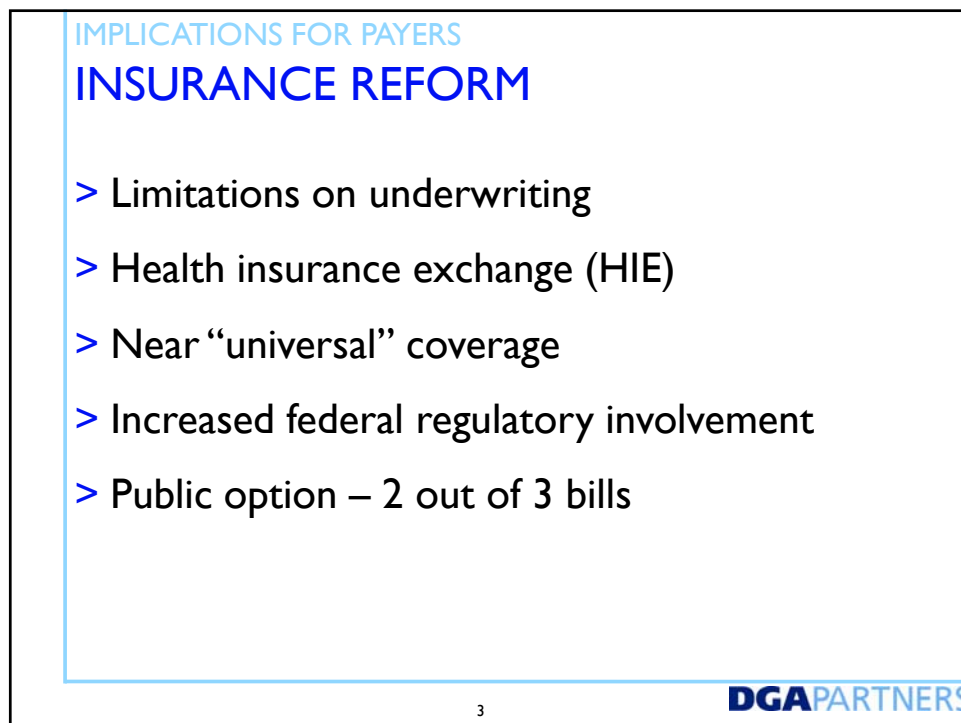
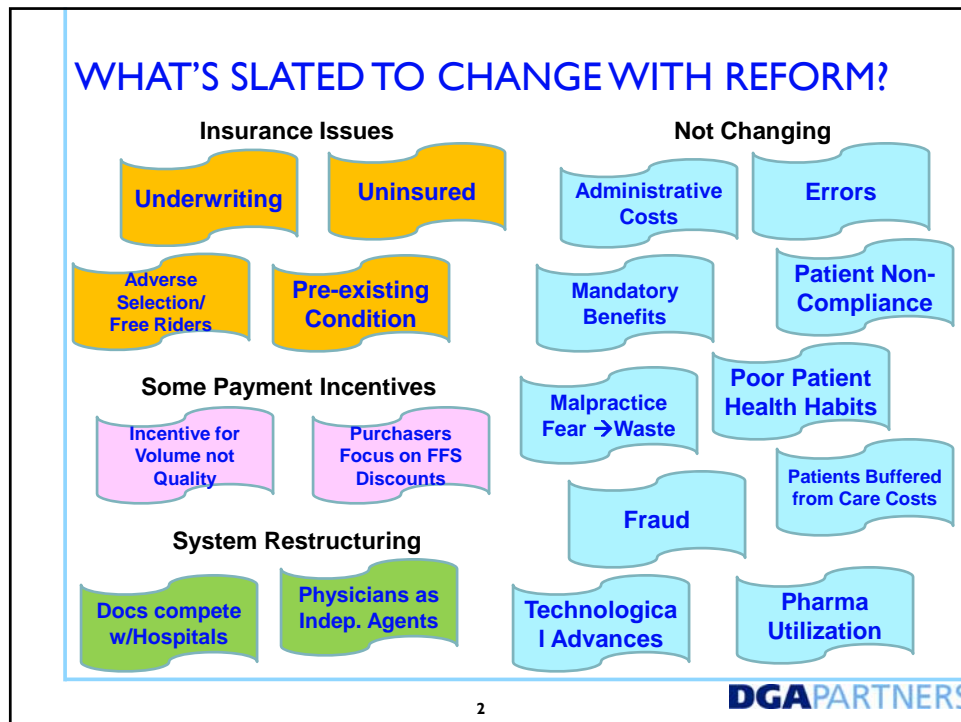
HOW WILL HEALTH REFORM AFFECT PROVIDER-PAYER RELATIONSHIPS?

Changing the
payer
marketplace

Promoting
payment
innovations
through
Medicare

Accelerating
integrated
delivery
system
development

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IMPLICATIONS FOR PAYERS

CHANGES IN UNDERWRITING

- > Small groups and individual market
 - o Guaranteed issue
 - o Prohibition on pre-existing condition exclusion
 - o Premium rating variation limitations
 - > e.g., only for family structure, geography, health plan benefit actuarial value, tobacco use, age
- > Maintenance of large group fully-insured and self-insured market

4

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IMPLICATIONS FOR PAYERS

HEALTH INSURANCE EXCHANGE

- > One-stop shop for private and public insurance products for individual and small group market
- > State-run (Senate Finance Committee and Senate HELP Committee) or national (House)
- > Defined benefit categories (3 or 4)

5

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IMPLICATIONS FOR PAYERS

“UNIVERSAL” COVERAGE

- > Individual mandates
 - o Enforced through tax penalty on individuals and employers
- > Premium credit subsidies to individuals eligible
- > Subsidies/penalties to small employers
- > Tax on high-cost plans – 1 of 3 bills

6

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IMPLICATIONS FOR PAYERS

INCREASED FEDERAL REGULATION

- > Minimum benefits
- > Underwriting regulations
- > Coverage mandates and penalties
- > Eligibility for subsidies

7

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IMPLICATIONS FOR PAYERS

PUBLIC OPTION

- > Community health insurance option offered through HIE (Senate HELP and House Only)
 - o Financed by premiums (not directly subsidized)
 - o Negotiated payment levels with providers (Not Medicare rates)
 - o Provider opt-out
- > Consumer Operated and Oriented Plan (COOP) member run in all 50 states (Senate Finance)
- > Rhetoric is intense
 - o “The end of private health insurance”

8

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PAYMENT INNOVATIONS

- > Broad consensus FFS is not working
- > Medicare Part A → bankrupt by 2017
- > Little public discussion about payment methodology changes
- > Reform is likely to give Secretary of Health broad power to redesign Medicare payment
- > When Medicare changes, commercial payers follow

10

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PAYMENT INNOVATIONS

PAYMENT MODELS UNDER DISCUSSION

- > Medical homes
- > Bundled payments
- > Accountable Care Organization (ACO)/
Accountable Health Organization (AHO)
- > Pay for Performance
- > Also hope for savings from
 - o Comparative Effectiveness
 - o EHRs

11

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DÉJÀ VU ALL OVER AGAIN

THEN	NOW
Global Capitation	ACO/AHO
Case Rates	Bundled Payments
Episode of Care	Bundled Payments
Primary Care Capitation	Medical Home

- > Translation isn't perfect, but you get the idea
- > May work better this time
 - o Providers are more integrated
 - o Information technology

12

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PAYMENT INNOVATIONS

BECAUSE "THAT'S WHERE THE MONEY IS"

- > Chronic disease
 - o Expenditures on chronic illness account for 75% of total US health spending
 - o Significant costs are preventable
- > Hospitalizations and care transitions
 - o Engaging physicians to manage hospital costs
 - o Avoiding readmissions

Much is driven by physician decisions

13

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PAYMENT INNOVATIONS

PATIENT CENTERED MEDICAL HOMES

- > A patient's entire care is coordinated from one physician practice under a capitated (or partially capitated) payment
 - o True care planning with Allied professionals
 - o "Work at the top of your license"
- > Prognosis
 - o Still under observation
 - o Issues regarding practicality in small practices
 - o Maybe overkill for non-chronically ill
 - o Focused care management models may win out

14

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PAYMENT INNOVATIONS

BUNDLED PAYMENTS

- > Episode of Care: Hospitals receive a pre-set amount for admission and post-acute care; split payment with physicians and post-acute providers
 - o Savings through reduced readmissions, redundancy
- > Case Rate: Hospitals receive a pre-set amount per admission; divide with physicians
 - o Savings through better inpatient cost management

Hospitals employing physicians may help

15

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PAYMENT INNOVATIONS

ACCOUNTABLE CARE ORGANIZATIONS
(ACOS/AHOS)

- > Hospital receive a global capitation payment and allocate money to involved providers
- > Pilot programs
 - o Mixed results in a North Carolina Medicaid demo
- > Prognosis
 - o Assignment of lives is an issue
 - o Probably requires IDs
 - o Interest in Congress and in Massachusetts
 - o Upside-only could be designed

16

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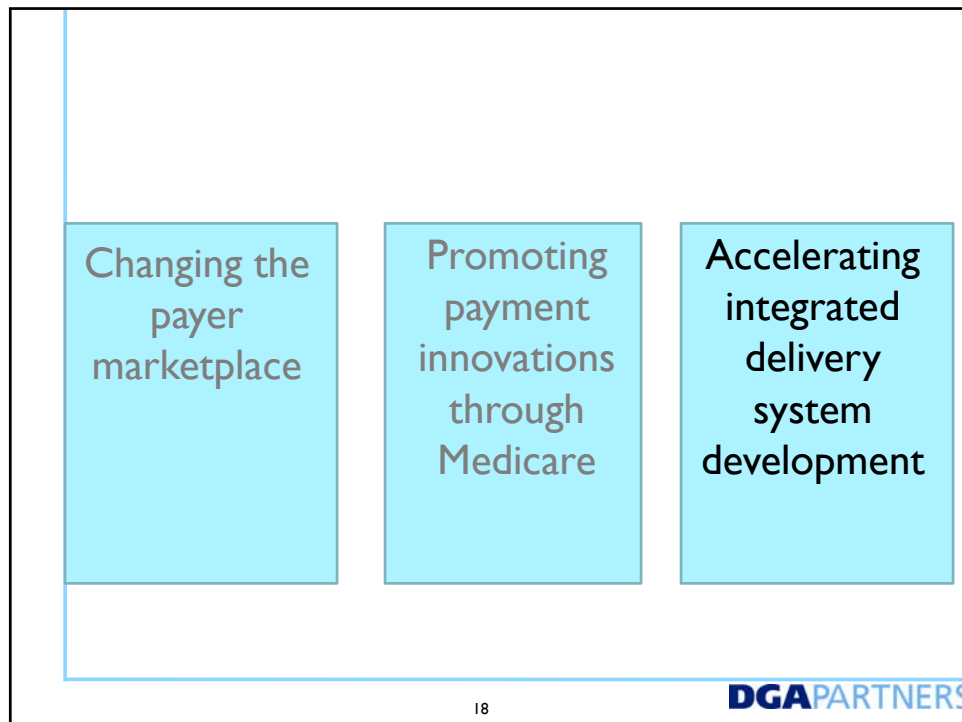
PAYMENT INNOVATIONS

PAY FOR PERFORMANCE

- > Payment tied to quality targets
- > Pilot programs
 - o 225 hospitals shared \$12 million bonus, poor performers penalized
 - o Improved quality, but incentive seen as low
- > Prognosis
 - o Improved care, but is it enough \$?
 - o Mostly improves quality, not costs
 - o Medicare likely to continue (e.g., PQRI)

17

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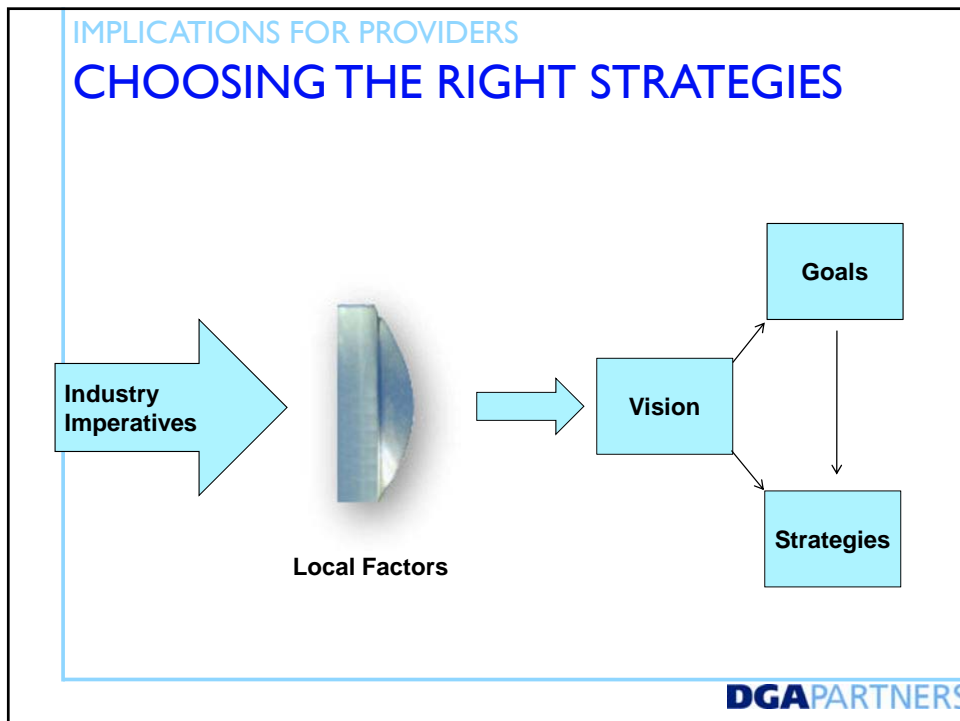
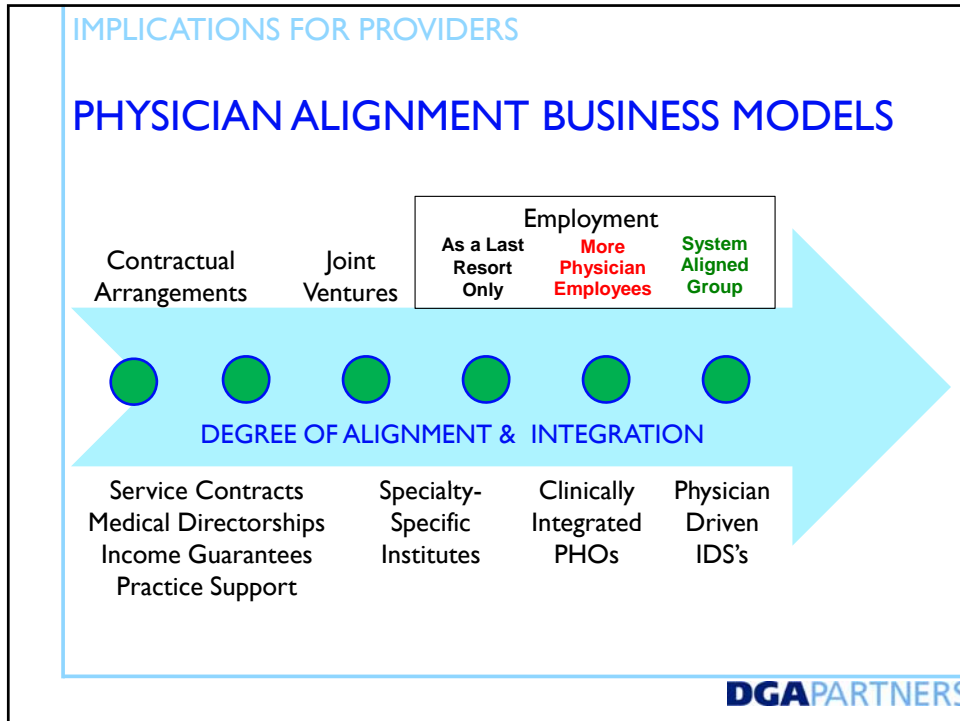


THE OTHER REFORM

- > Health care delivery is already transforming
 - o Hospital employment of physicians
- > Employed but often not yet integrated
 - o Compensation design is critical
 - o Struggling to engage employed physicians
 - o EHRs may help
 - o Still mostly FFS reimbursement and incentives
- > Challenge: Living with a mix of employed and independent physicians

19

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IMPLICATIONS FOR PROVIDERS

INTEGRATED PAYMENT METHODS WILL
DRIVE INTEGRATED SYSTEM GROWTH

- > Easier to address within one Integrated Delivery System (IDS)
 - o Challenges still remain regarding aligning incentives
 - o Physicians will need to be engaged in managing the overall cost of care
- > Can address contractually with independent physicians, but messy

22

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IMPLICATIONS FOR PROVIDERS

IDSs ON INSURANCE EXCHANGES

- > IDS may offer integrated, narrow network insurance products on an insurance exchange
- > Premise: more value in an integrated (closed) delivery system
 - o IDS would capture the benefits of improved delivery
- > Also get steerage

23

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IMPLICATIONS FOR PROVIDERS

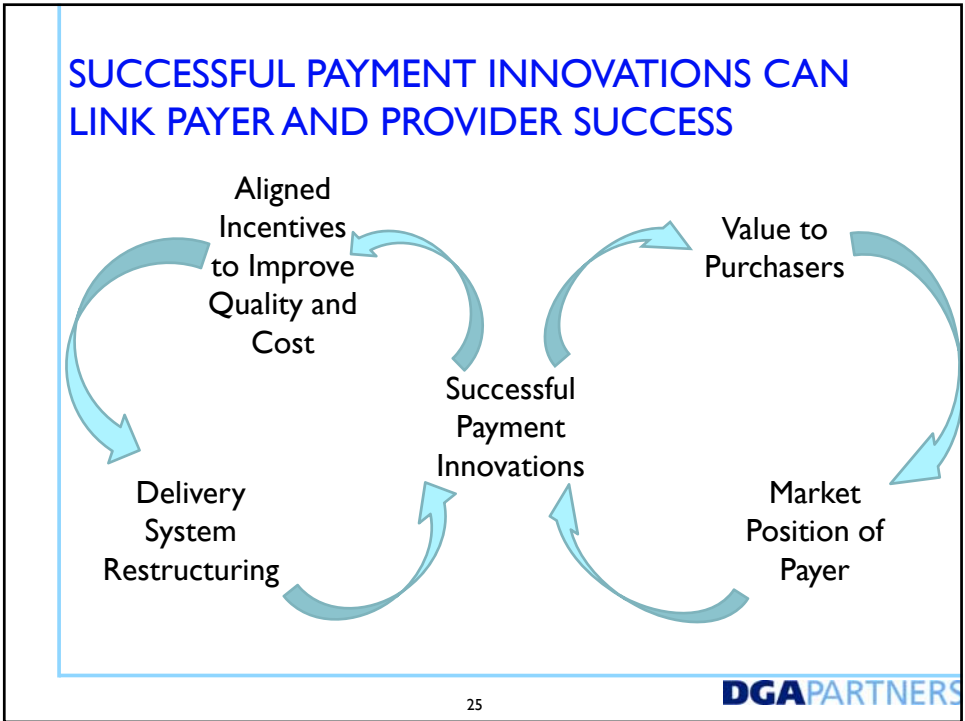
WHICH PAYMENT INNOVATIONS WOULD PROVIDERS PREFER?

- > Bundled payments are easier for providers
- > Medical Home is more primary care focused than hospitals are now
- > ACO/AHO could be acceptable if it is more focused on upside than downside

Employed physicians and EHRs help for all

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24



CASE STUDIES

CASE STUDY 1: BC PLAN MAY ACQUIRE HOSPITAL

> Insurer fears

- They cannot drive clinical change
- Will be beaten by integrated payer/provider competitors
- Will be forced to accept pricing from consolidated but non-integrated provider hold-outs

> Plan

- Acquire hospital and its physician network

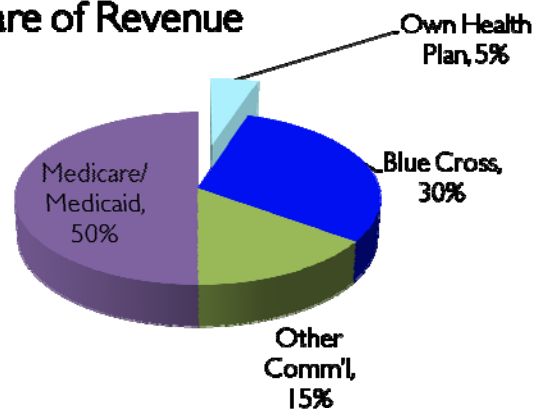
26

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CASE STUDIES

CASE STUDY 2: IDS SETS NEW VISION FOR ITS HEALTH PLAN

Share of Revenue



- > Provider sponsored health plan
- > Too small to drive change, bear overhead

27

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CASE STUDIES

CASE STUDY 2: PROVIDER OWNED HEALTH PLAN SHIFTING TO ACO

- > Tired of being enemy of hospitals
- > Address high-volume payers
 - o Possible partnership with local Blues plan - tiered
 - o Seeking Medicare demos
- > Focusing on generating value
 - o Bundled payments
 - o Clinical innovation
- > Dropping health plan sales and underwriting functions

28

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WHICH PROVIDERS WILL WIN IN THE END?

Traditional

- > Independent physicians
- > Fee for service payments
 - o Incentive for volume
- > Hospitals focus on market share

Integrated

- > Integrated physicians
- > Bundled/integrated payments
 - o Incentive for value
- > Hospitals focus on delivering value to purchasers

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RESOURCES

> JHarris@DGApartners.com

> www.KFF.org

- o Side-by-side comparisons of proposals
- o Mathematica study –
“Strategies for Reining in Medicare Spending through
Delivery System Reforms”

> www.CommonwealthFund.org

- o ACOs

> www.HealthAffairs.org

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