

# Laying the Groundwork for Provider Success

NATIONAL HEALTH INSURANCE EXCHANGE SUMMIT

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# Increase in Role, Reward for Providers Requires Taking Risk

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*The ACA law directly increases access to health insurance benefits while indirectly addressing cost containment. Both can result in a greater role in care management and more revenue for physicians.*

- Health Care reform will increase spending on health services in initial phase
  - ➔ The Primary focus of ACA is on increasing access to insurance.
- The roles of providers and health plans is shifting. Providers are encouraged to become more accountable for the overall care of patients – both for quality and efficiency.
- Managing the health of a population requires taking risk and reallocating resources across a group of people
- The emphasis on Medical Loss Ratios (MLR) and Shared Savings in ACOs encourage greater payments to providers.
- There may be challenges to implementation that make it difficult to gain the rewards.

# CMS Is Making It As Easy As Possible to Get Health Benefits

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*More people with health benefits means more revenue for providers*

- Every State will have an insurance exchange run by either the State or by the Federal government
- States can opt into expanded Medicaid at any time. No fixed deadline.
- There will be “no wrong doors” for consumers to sign up for expanded Medicaid or Insurance Exchanges
  - ➔ Federal Government is designing a uniform “determination of qualification” form for Medicaid and insurance exchange subsidy.
  - ➔ If states accept it, federal determination will qualify people for expanded Medicaid and/or insurance exchange subsidy.
  - ➔ If states allow it federal government will transfer all information to State to make its own determination

# And Easier for Individuals to Keep Their Benefits

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*CMS is looking to reduce the paperwork burden and reduce unnecessary disenrollment / reenrollment churning*

- Currently people have to recertify their Medicaid eligibility annually and are dropped from Medicaid if they did not recertify.
- The majority of those who lose eligibility in a year do so, not because they no longer qualify, but because they did not do the paperwork to recertify.
- Going forward, a person will remain eligible unless there is evidence that they no longer qualify for Medicaid or a subsidy to prevent unnecessary “churning”.
- They will still be sent the same letter asking for updated information, but they will only be dropped from Medicaid or exchange subsidy if CMS has evidence that they no longer qualify.

# The “Triple Aim” Expands Provider Role And Responsibility

*Health Plans have traditionally had the major responsibilities in the triple aim. Payers and Providers will need to collaborate to achieve all 3 aims giving providers a bigger role.*

- **Better care for individuals**

- Applying Disease Protocols
- Safety; Effectiveness, Quality

**Traditional Provider Responsibility**



- **Reducing per-capita costs**

**Traditional Health Plan Responsibility**

- **Better health for populations**

- Case Management; Population Management
- Developing Disease Management Programs



**Don Berwick, M.D.**  
former Acting CMS Administrator

# Transfer of Care Coordination to Providers

*Where care coordination responsibility is shifting to providers*

- Aligning authority and clinical risk shifts more responsibility for care management to multi-specialty integrated providers along with financial risk



## Clinically Integrated Medical Neighborhoods

- Case Management
- Guidelines / Protocols
- Disease Management



## Health Plan

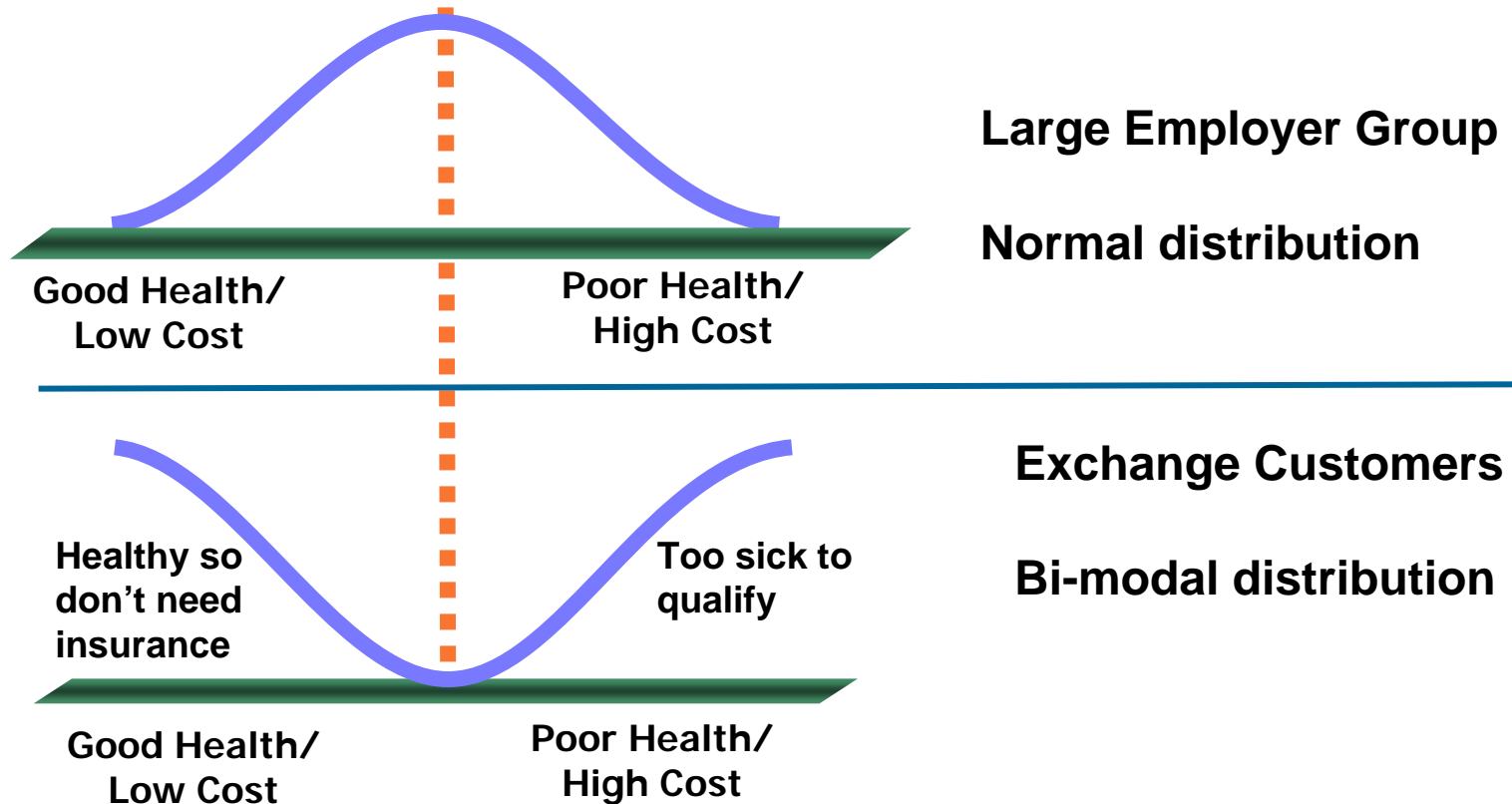
- Case Management
- Utilization Management
- Disease Management

**STAFF**

# Population Management Requires Resource Reallocation

*Insurance plays “Robin Hood” role redistributing \$ from healthy to sick*

- Provider groups who coordinate the delivery of care to the sick most efficiently will be able to share in the savings generated from more cost-effective care.



# Federal Rate Regulation Protects Plans from Adverse Selection

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- The Rate Stabilization Regulation protects insurance exchange plans from big losses during the first three years:
  - ➔ All exchange plans get reinsurance for high cost cases paid for by all plans
  - ➔ Establishes risk corridors that limit the amount that a plan can make or lose during first three years funded by cross-subsidizing between participating plans

This will help level the playing field between smaller, provider-sponsored plans and large national health plans

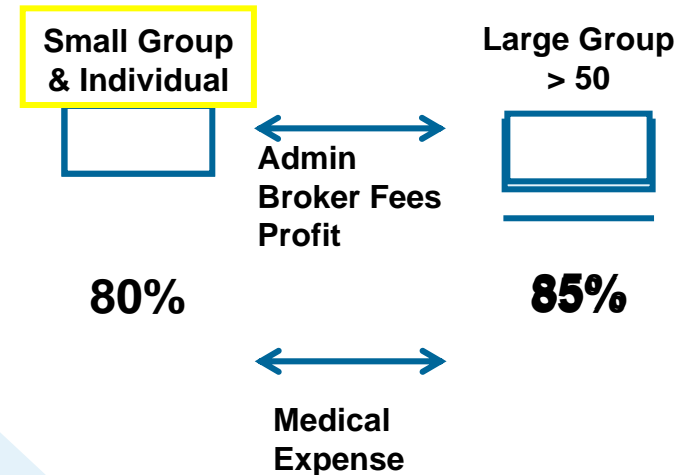


# MLR Gives Providers Opportunity for Greater Reward

By requiring Payers to spend at least 80% of premium on care, quality improvement and care integration expenses, providers can benefit

## Quality Improvement & Care Integration are Medical Expenses

- Investments in care infrastructure to:
  - Improve quality
  - Improve care coordination
  - Measure outcomes
  - Support meaningful use
- Nurse case managers; nutritionists, etc.
- Provider quality incentives and bonus payments
- Capitation payments providers
- Gains Share or Quality Bonuses



**Note: MLR Regulation does not apply to publicly funded plans or self insured plans. Medicare Advantage plans will have an 85% MLR requirement after 2014.**

# 1 Risk Pool for Public Exchange & Private Insurance MLR

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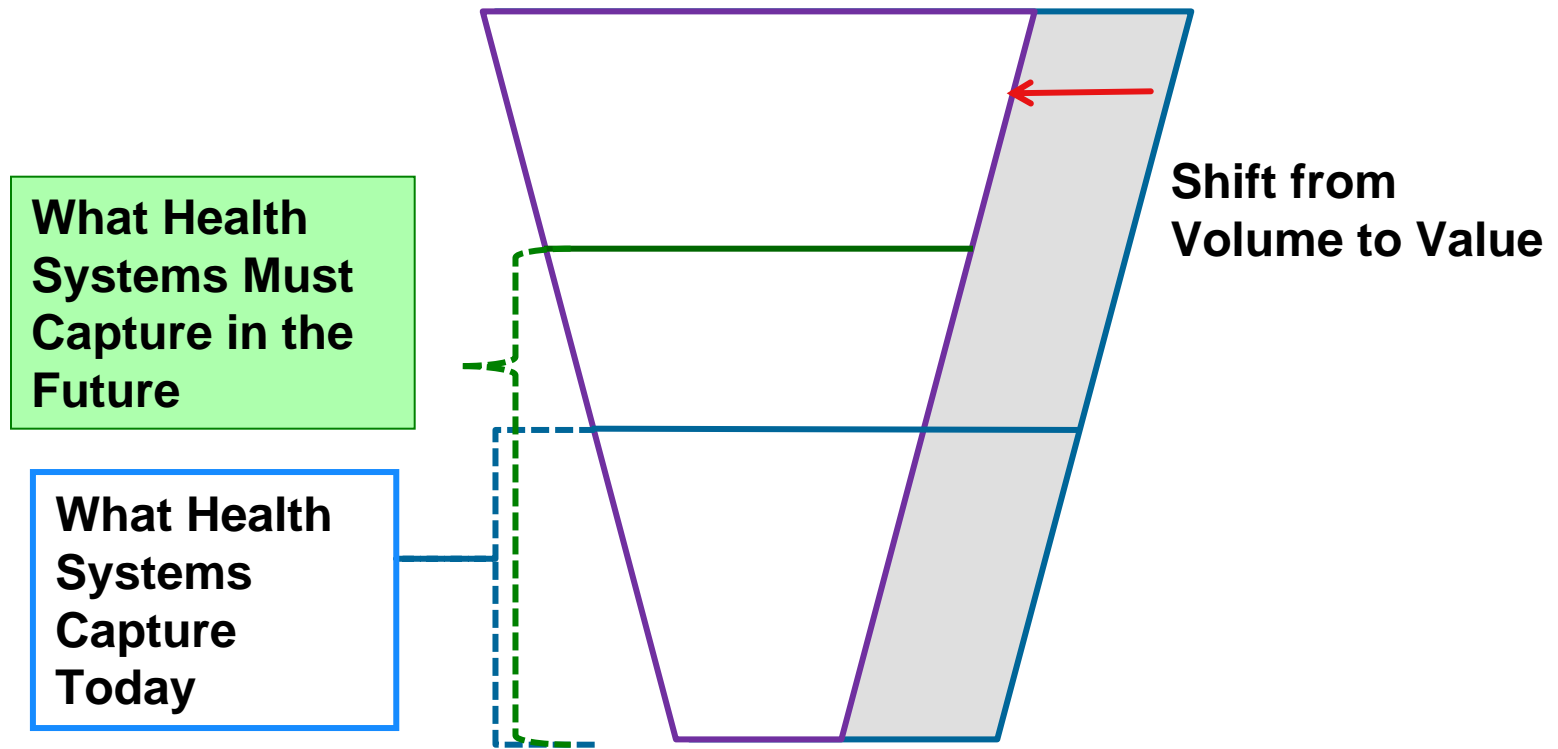
*CCIIO has issued new guidance to reinforce the concept of community rating for all individual or small group policies on & off of the public exchange.*

- New guidance requires all QHPs to use a single risk pool for products that they offer whether on the public insurance exchange or privately.
- This will have impacts on the premium risk corridor adjustments to premium calculations, as costs must be pooled before they are allocated proportionally to premiums received for a particular QHP in calculating MLRs
- This new MLR will be used by HHS to determine whether a plan's premiums will be retroactively adjusted up or down under the risk corridor program.
- This further divorces the relationship between any particular patient group's costs and the premium that the insurer will receive for that group of beneficiaries.
- Tying provider reimbursement too tightly to the plans MLR as calculated for CCIIO may not be appropriate as the MLR will reflect the medical costs of ALL individual products or ALL small group products that the carrier offers.

# The Shift From Volume to Value Rewards Efficient Providers

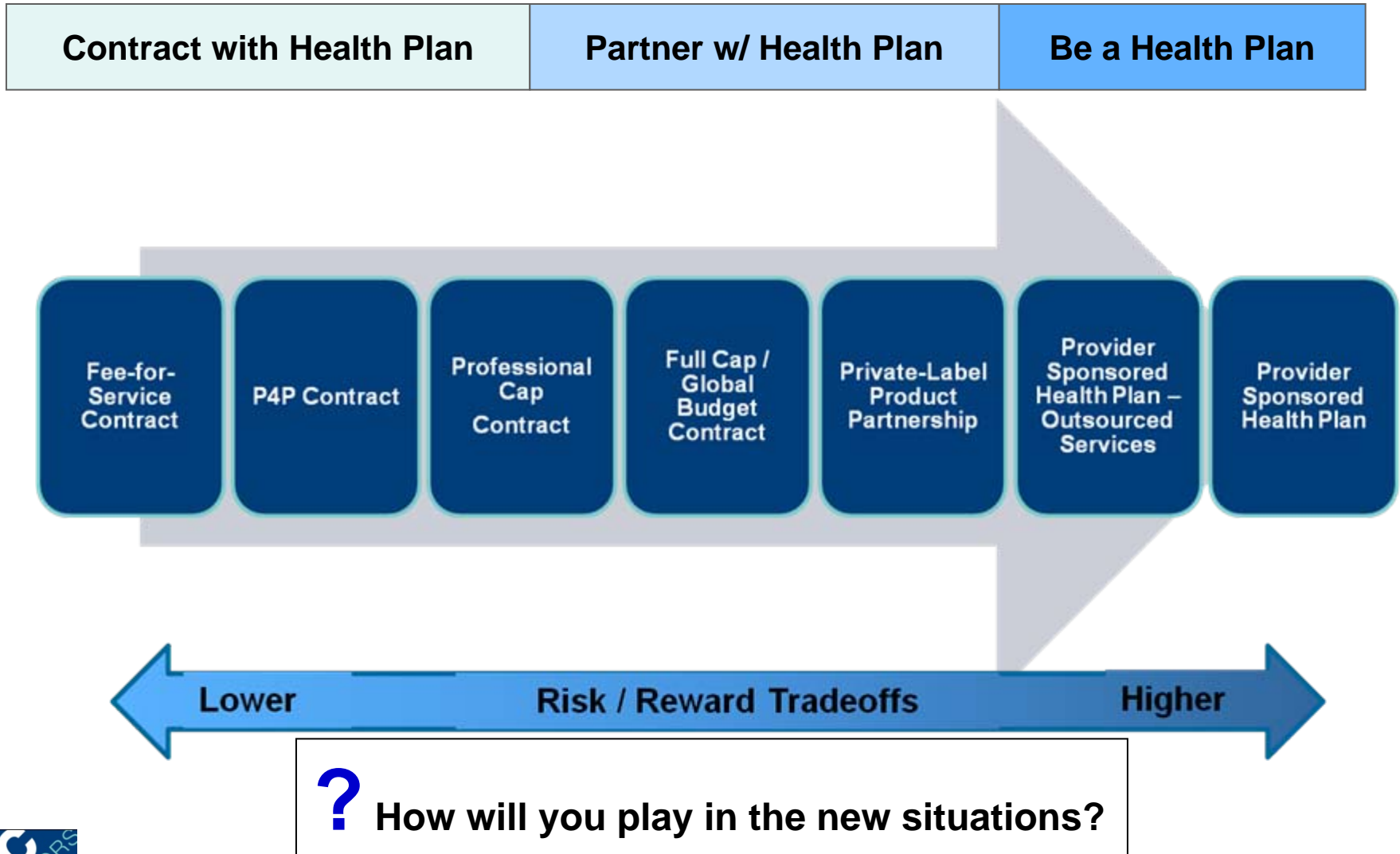
*As the amount paid per service and number of services decrease, providers will need to “move upstream” to capture more of premium*

- *To preserve revenues and maintain ROI, health systems must:*
  1. Capture market share from other health systems
  2. Capture more of the health care dollar from payers, other providers



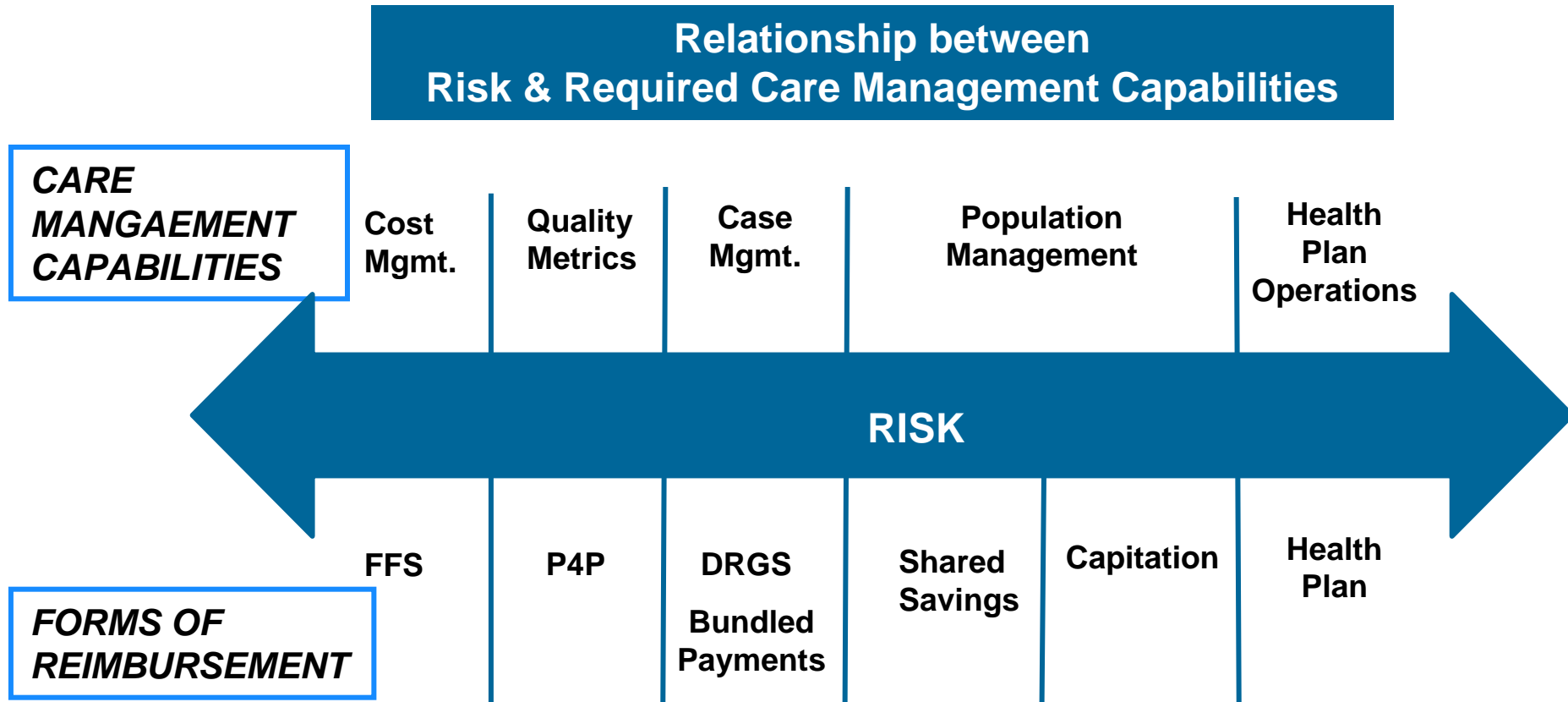
# Revenue Options

Health systems with networks have an expanded range of options for participating in Health Reform and “moving up the revenue stream”.



# Providers Interested in Gaining Revenue Must Manage Risk

*Contemplating growing your revenue stream requires a commitment to building the capabilities to manage risk for quality, utilization and unit cost.*



# Narrow Networks Are Growing As a Multi-faceted Solution

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*Working with a smaller group of providers willing to address quality & efficiency goals meets many needs*

- Health Plans preparing for the price competition of the Insurance Exchanges
- Recession has made employers willing to sacrifice network breadth for lower health benefit costs
  - School systems or other local government entities
  - Large employers in highly competitive industries (e.g. retail)
  - Small employers trying to avoid eliminating health benefits all together
  - Employers who don't want to raise employee cost –share more (affordability)
- Physician Groups that are forming clinically integrated networks and seek insurance partnerships for value-based contracting
- A disciplined, multi-specialty group of providers is at the core of the Accountable Care Organization concept

# Essential Community Providers Must be Included on Exchange

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*Qualified Health Plans on the exchanges must include providers from essential community providers*

- All Indian Health Service providers
- Insurers must include at least one of each type of ECP category in each county where such providers exist
  - ➔ FQHCs
  - ➔ Ryan White Providers
  - ➔ Title X family planning providers
  - ➔ Certain types of hospitals
    - Critical access hospitals
    - Rural referral centers
    - Children's hospitals
    - Sole Community hospitals
    - Some free-standing cancer centers and DSH hospitals
  - ➔ Providers for low-income, medically underserved populations