

WHERE THE FRONT LINE MEETS THE BOTTOM LINE: THE HEALTHCARE SYSTEM OF THE FUTURE

**AFT Nurses and Health Professionals
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Trends for 2016 - 2022:

Consumer “empowerment” (increased out-of-pocket expense!)

Continued roll-out of Obamacare (“value-based” payments; insurers bolt without promise of greater subsidies; more of that “patient financial responsibility”)

History as a guide

Health Care on Track to Become Nation's Largest Industry in 3 Years:

More than 15.4 million people now work in health care

503,000 new health care jobs created April 2015–March 2016

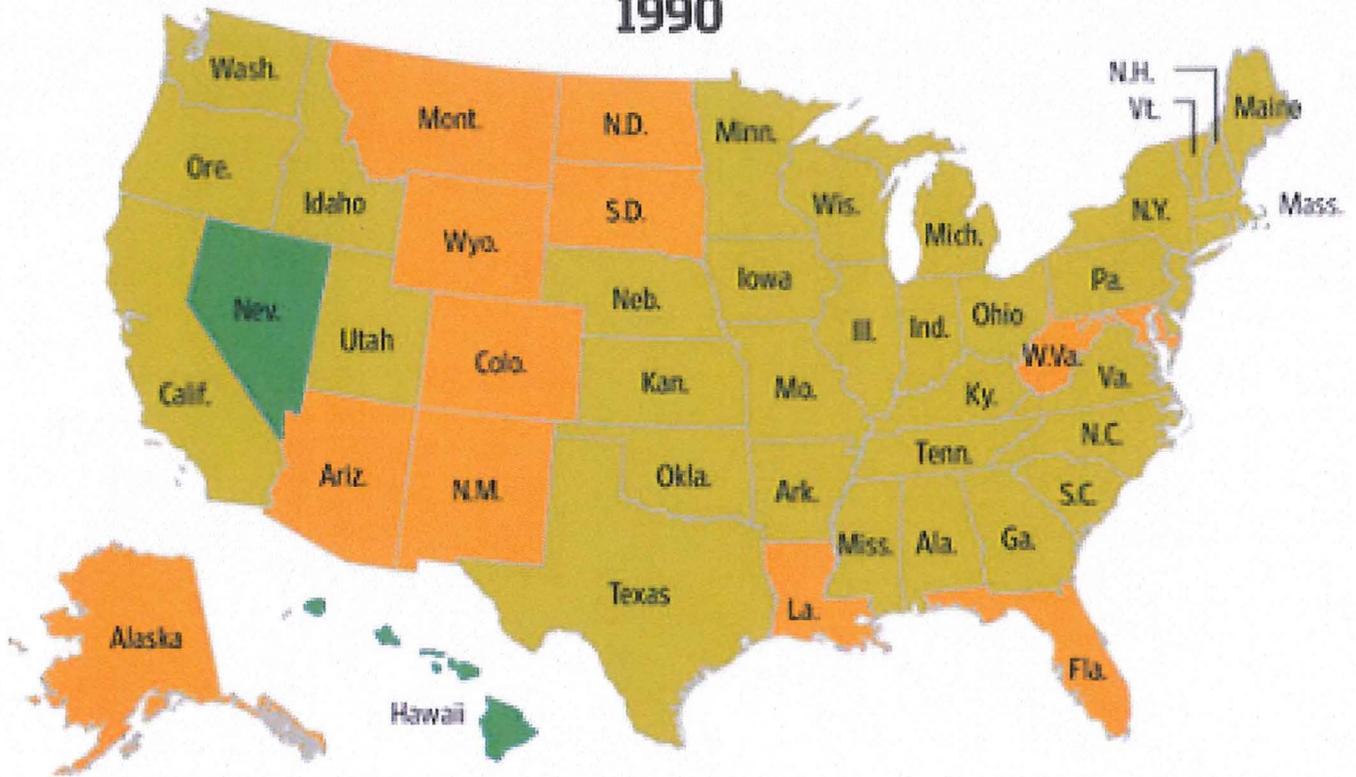
183,000 new hospital jobs in past year

Will surpass retail (at current rate of growth) in 2019

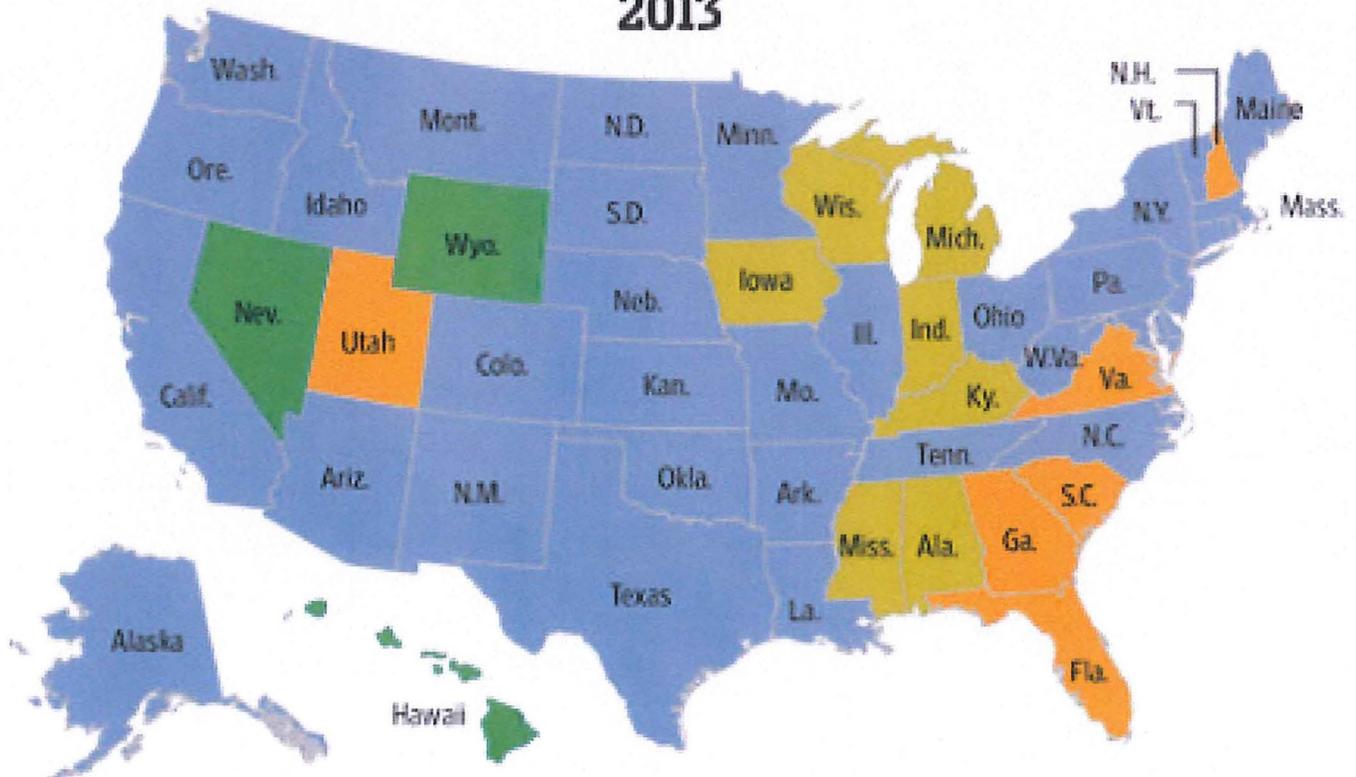
Work Then and Now | Industry with highest employment by state

Manufacturing Health care Retail trade Accommodation and food services

1990

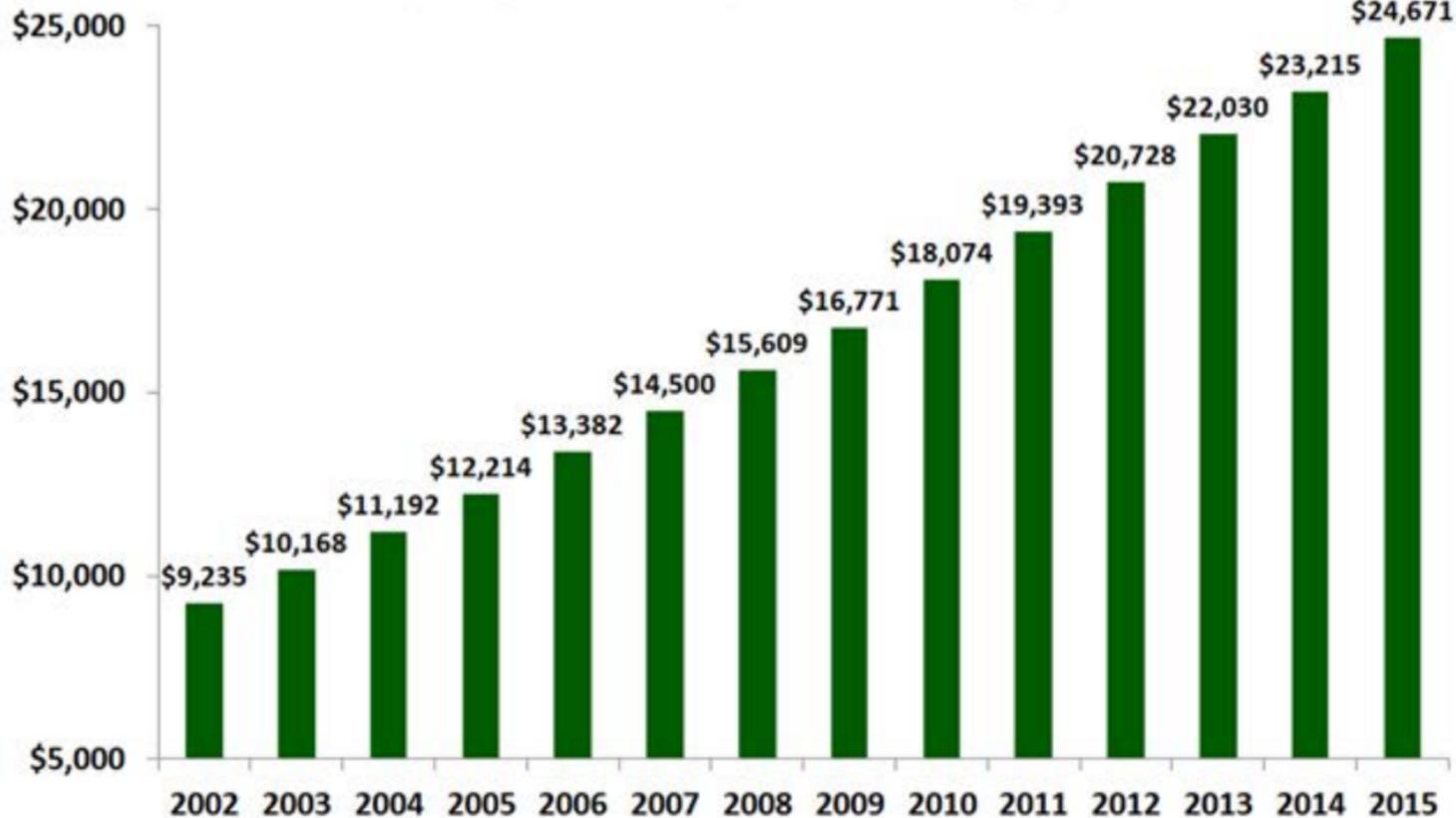


2013

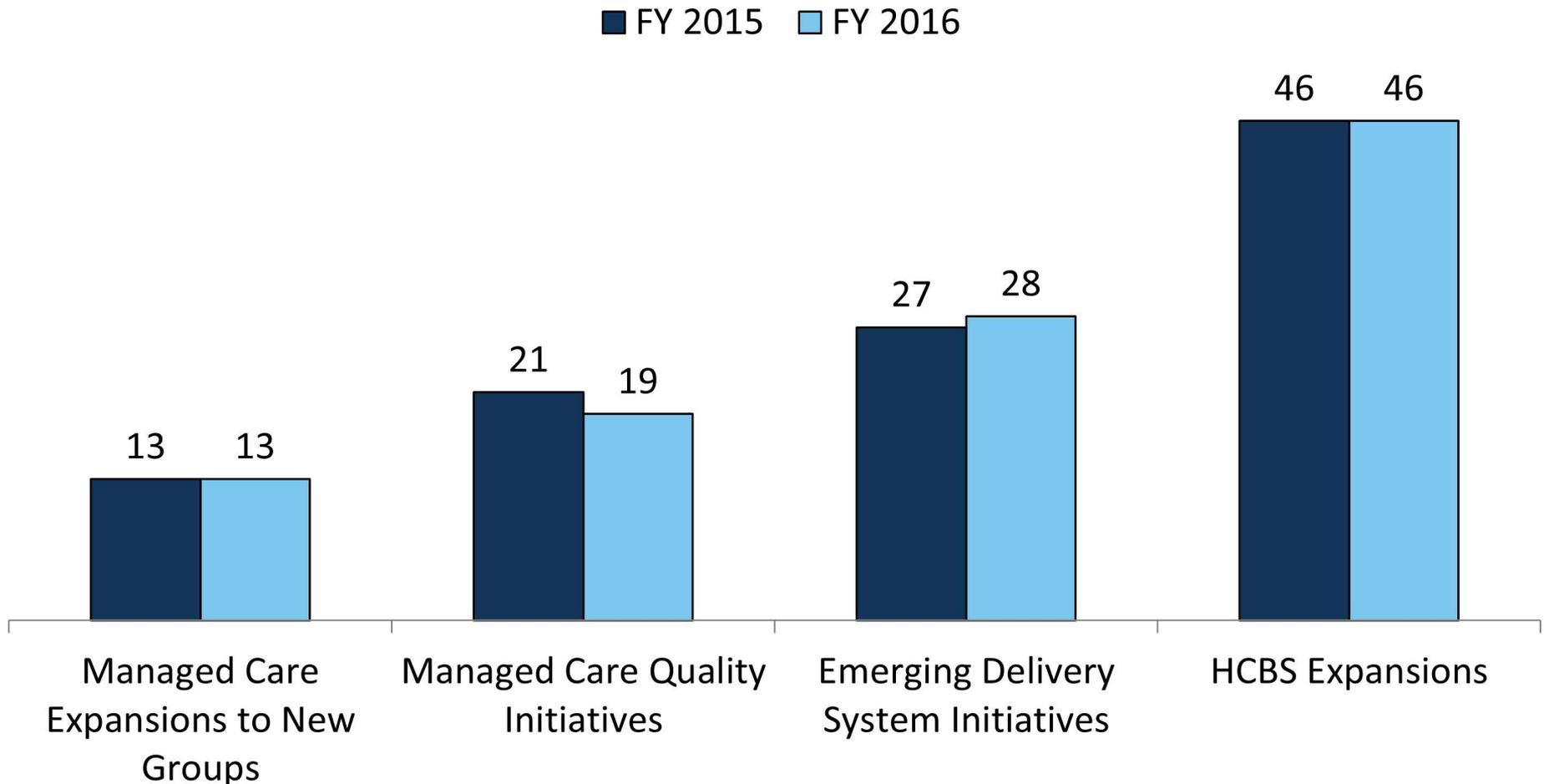


Milliman Medical Index

(Average Cost for Family of 4 w/ PPO Coverage)



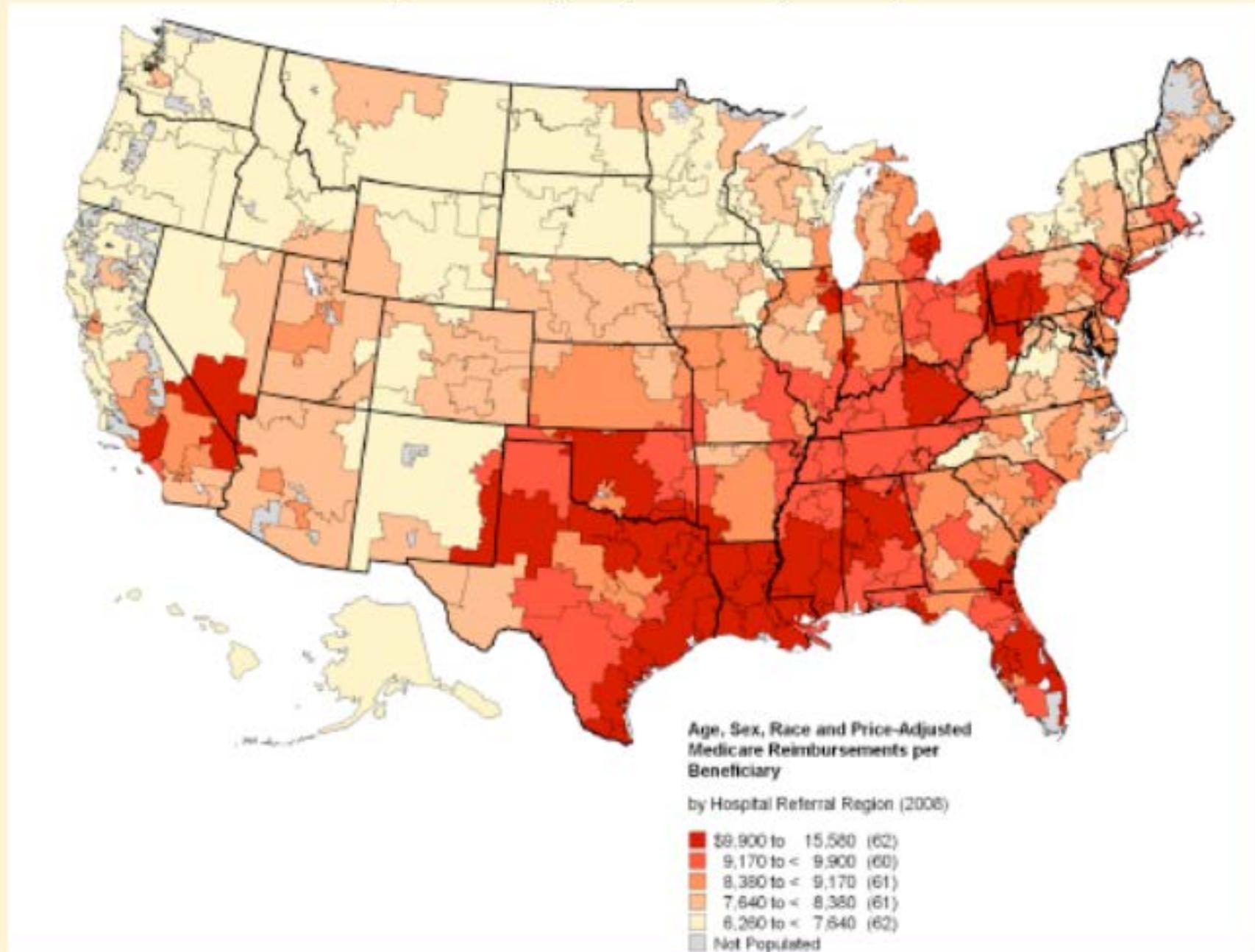
Medicaid programs continue to add and expand payment and delivery system reforms in FYs 2015 and 2016.



NOTE: Managed Care Expansions to New Groups refers to expansions to new groups, new regions, increasing the use of mandatory enrollment, and new RBMC programs. Other Delivery System Initiatives include new or expanded initiatives related to PCMH, Health Homes, ACOs, Episodes of Care, DSRIP and initiatives focused on dual eligible beneficiaries.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

Dartmouth Institute Map of Price Adjusted Medicare PMPM Spending by HRR (2008)



History, “Reform” of American Industry:

Telecommunications, cable, trucking, airlines, banking

Summary: Some good for consumers (Game of Thrones!), mostly bad for workers (tossed overboard, outsourced, commoditized)

Next Up for Reform: Health insurance, health care delivery

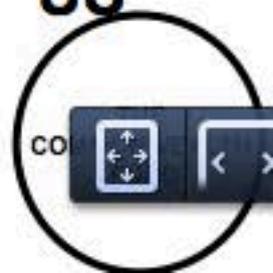
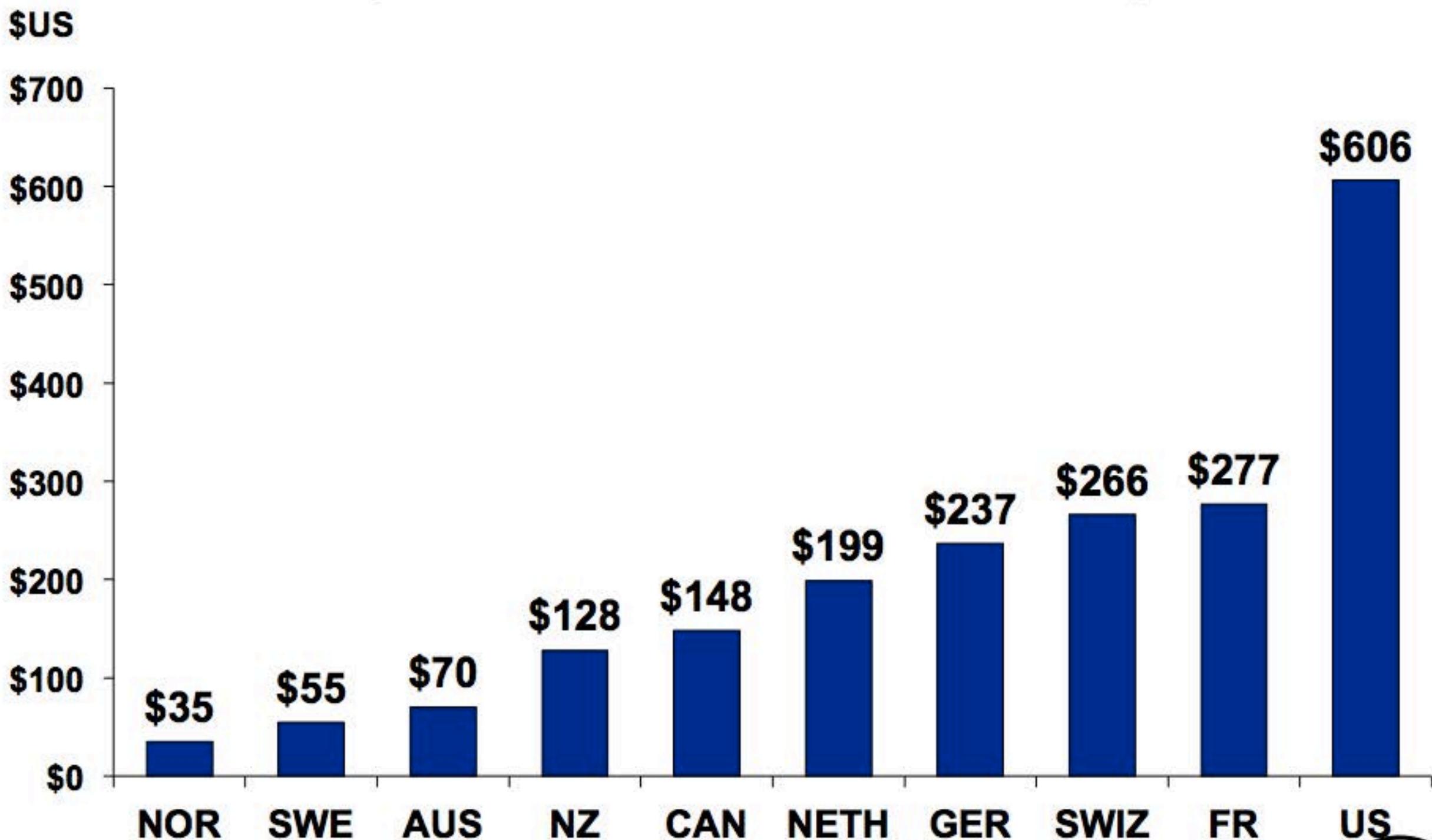
Health Care Delivery, Trends Which Will Probably Continue:

Consolidation (not “interoperability” between silos, but much bigger silos)

Integration, physicians continue to lose independence:

In 2014, more than 60% were employed or had their practices “acquired” by hospitals

Spending on Health Insurance Administration per Capita, 2011¹⁸ Adjusted for Differences in Cost of Living



“The Bigs” Consolidate:

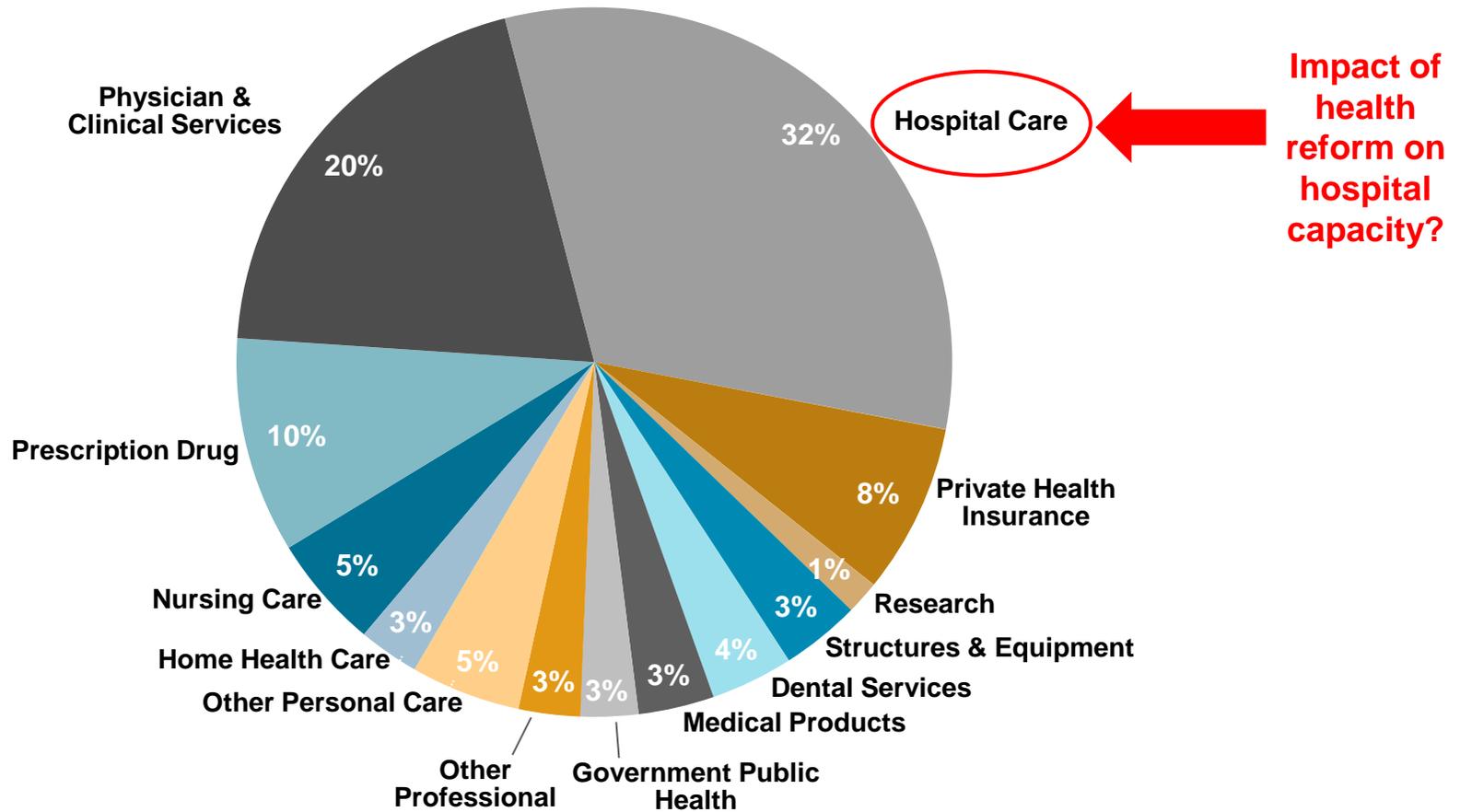
Major consolidation in larger metropolitan areas (Northeast, West and Northwest), not evenly spread in the country

30% reduction of “heads in beds” by 2020

Some national brands (Cleveland Clinic, Johns Hopkins, Mayo Clinic)

Physician consolidation into employment or larger groups

Provider consolidation: \$3T of U.S. healthcare expenditures

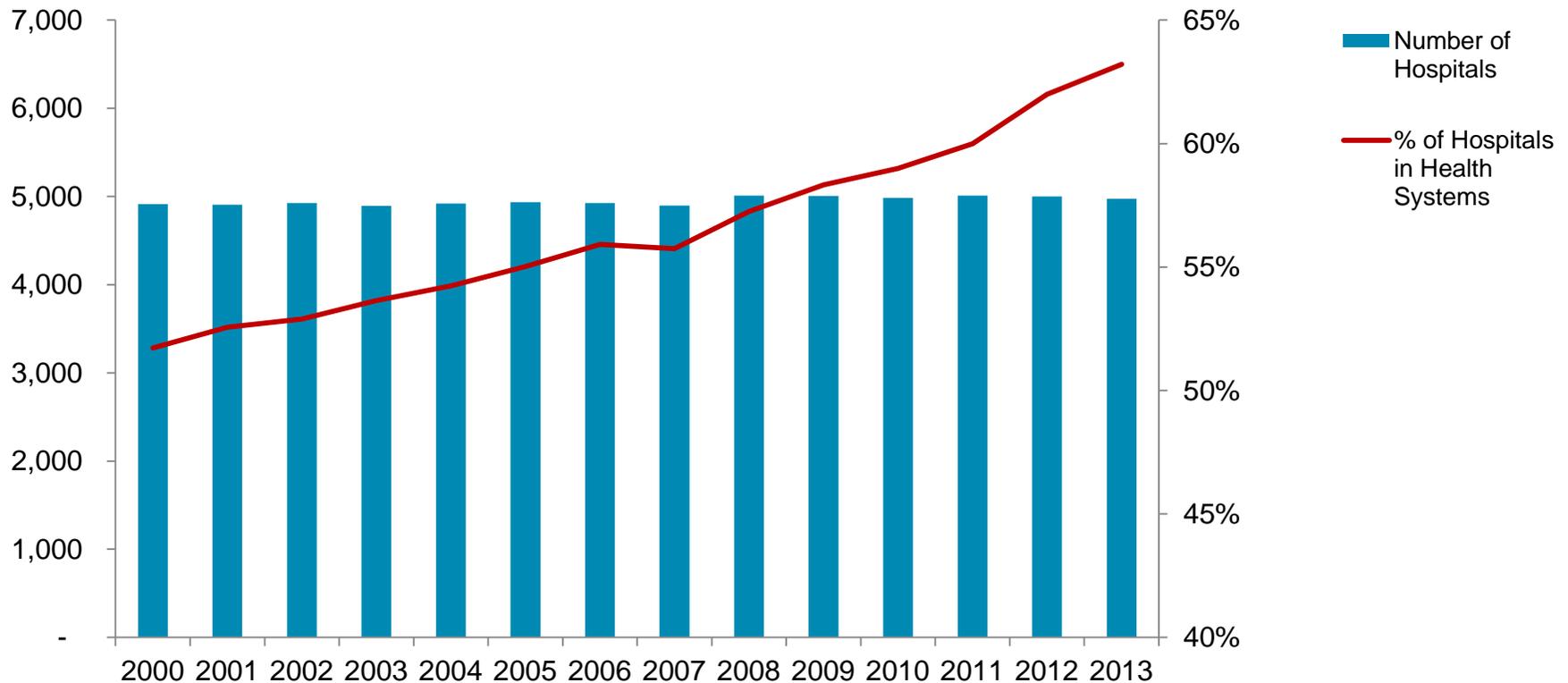


Source: Centers for Medicare and Medicaid Services, 2014

Provider consolidation: Hospitals into health systems

Increasing Affiliation of Hospitals with Health Systems

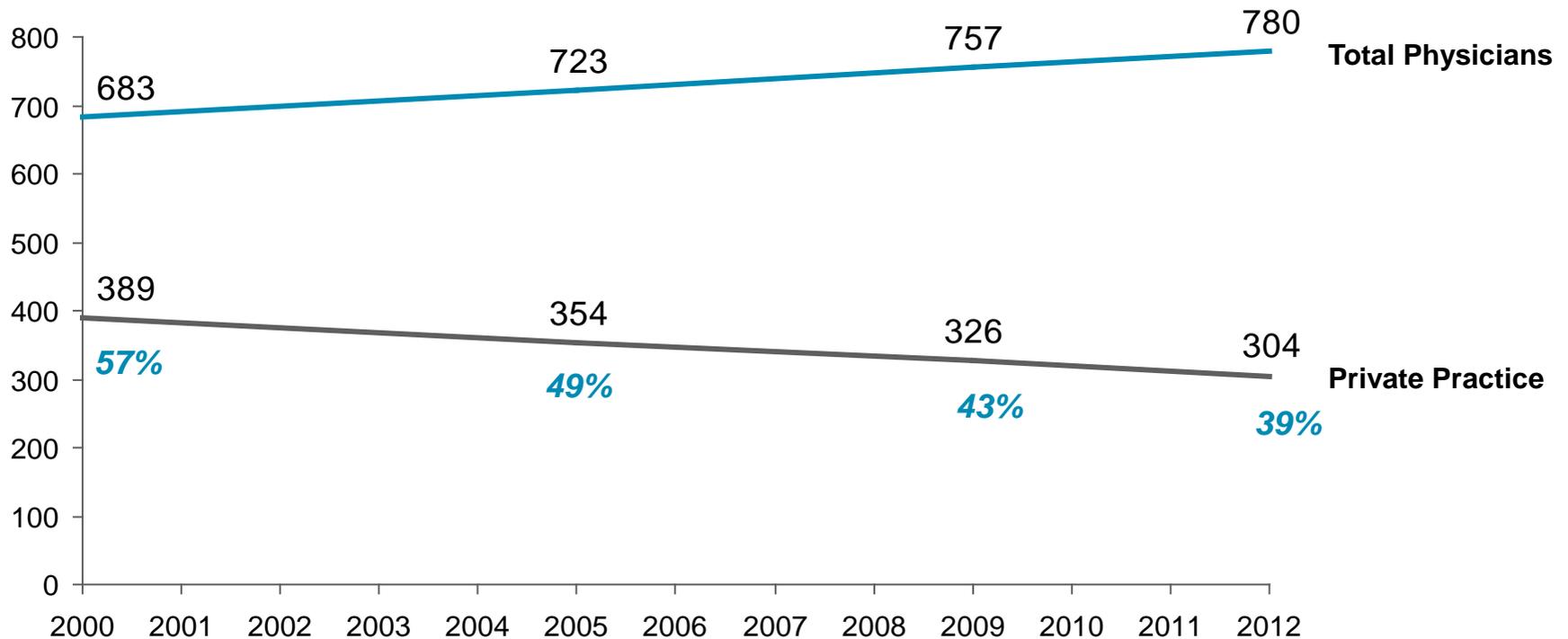
Community hospitals, 2000 - 2013



Source: American Hospital Association Annual Survey 2015

Provider consolidation: Physician practices

Total Physicians vs. Physicians in Private Practice (000s)
2000-2012



Source: Fee Schedule Survey by *Physician's Practice*; Moody's; Accenture

Newer Entrants and/or Newer Models:

Old news, failing: Google, Microsoft

New entrants: Aflac, GEICO, CVS, many others

DaVita: 2,017 dialysis centers in 45 states

Hanger: 745 orthotic and prosthetic clinics

Healogics: 700+ wound care centers in 44 states

SleepMed: 200 laboratories in 32 states

US Oncology: 350 cancer centers in 18 states

In New York City

(Hillaryland, but also Trumpland):

Three “accelerators,” 200 start-ups

Ten companies running urgent care centers,
backed by seven private equity firms

New entrants – urgent care in New York City and environs



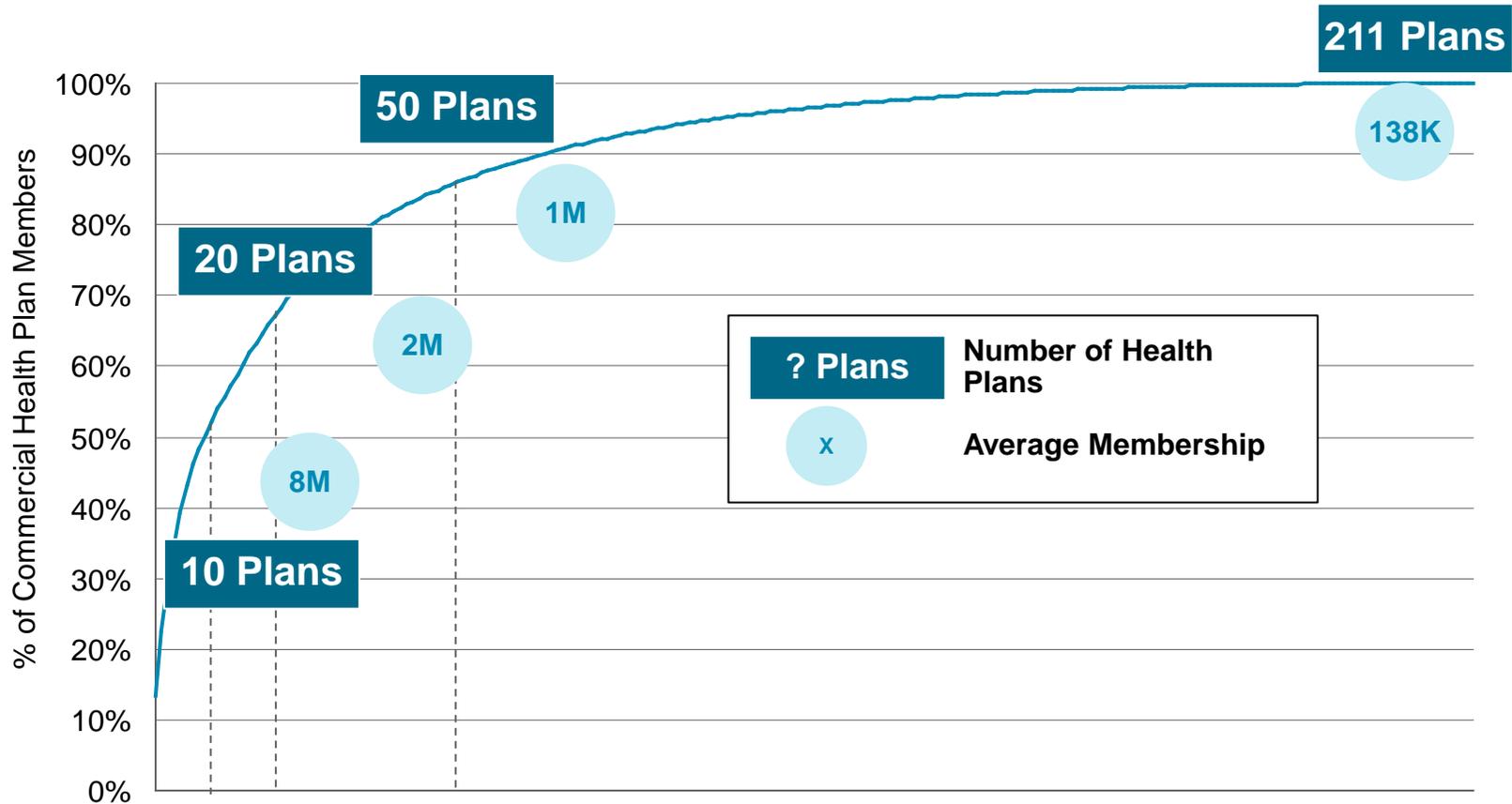
Source: Company Websites

Insurance Consolidation:

Currently, more than 200 health plans, but the top ten have 80 million members, many of the others very small

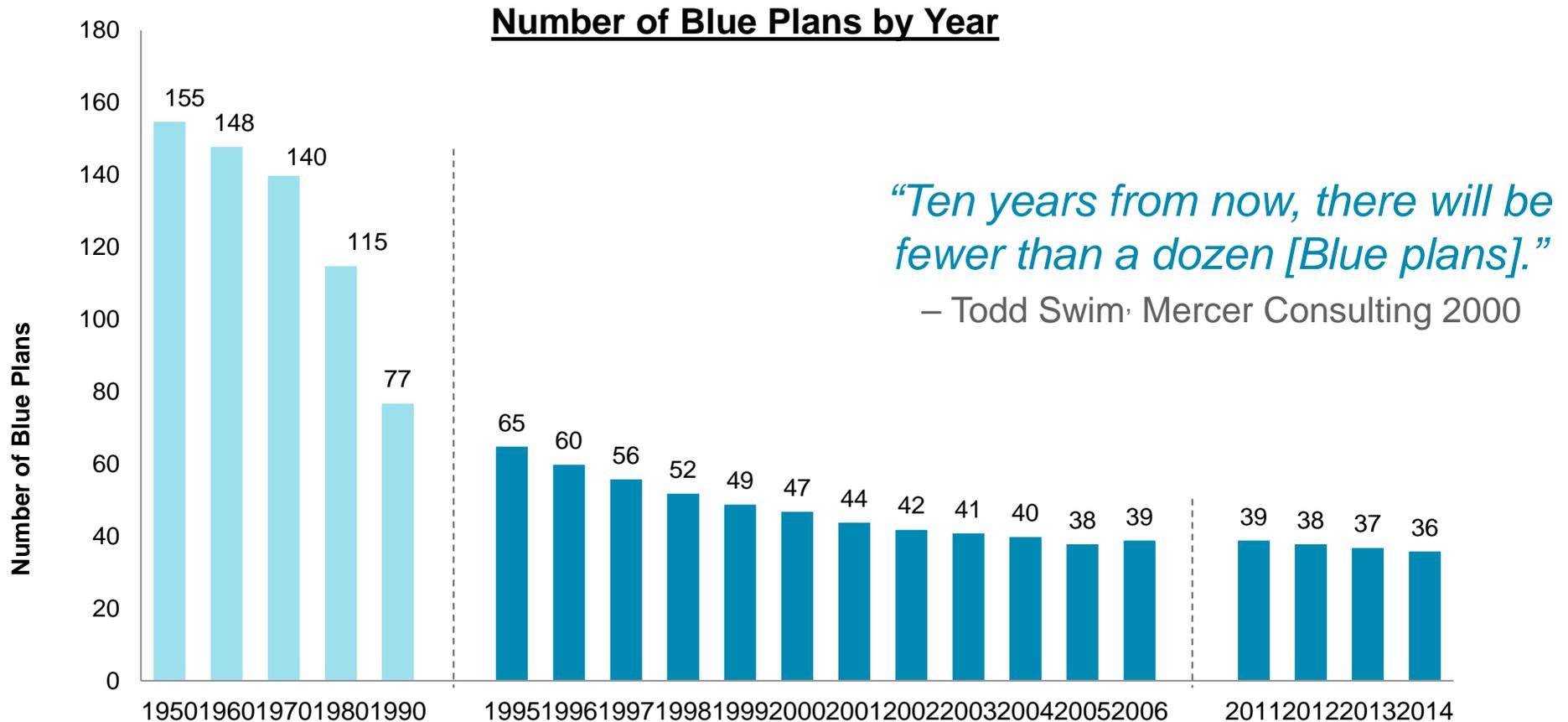
BCBS: In 1950 there were 155 Blue Cross/Blue Shield Plans, today there are 36

Consolidation of health insurers



Source: 2013 InterStudy Data of Commercial Health Plans; Excludes Medicare and Medicaid Enrollment and plans with no enrollment

Another wave of Blue affiliations on the way?



Source: Blue Cross Blue Shield Association (BCBSA) data

Insurer Strategies:

The insurers (receiving, say, 15% of the health care dollar, or about \$25 per member per month) are looking to acquire and/or assimilate providers (absorbing the other 85%, or about \$500 per member per month).

Provider and Payer Strategies:

Providers moving toward risk

Payers moving toward care:

Highmark

WellPoint-CareMore

Integrated Delivery Networks:

Kaiser acquiring Group Health, bearing both clinical and financial risk

Integrated delivery networks (IDNs): Clinical and financial risk in one entity



Source: Becker's Hospital Review

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Value-Based Payment:

Coordination of care, something that physicians and nurses did historically

Deaths per 100,000 residents, 1,100 at the beginning of the 20th Century, 600 at the end

Death from chronic disease: 40% at the end of the beginning of the 20th Century, 85% at the end

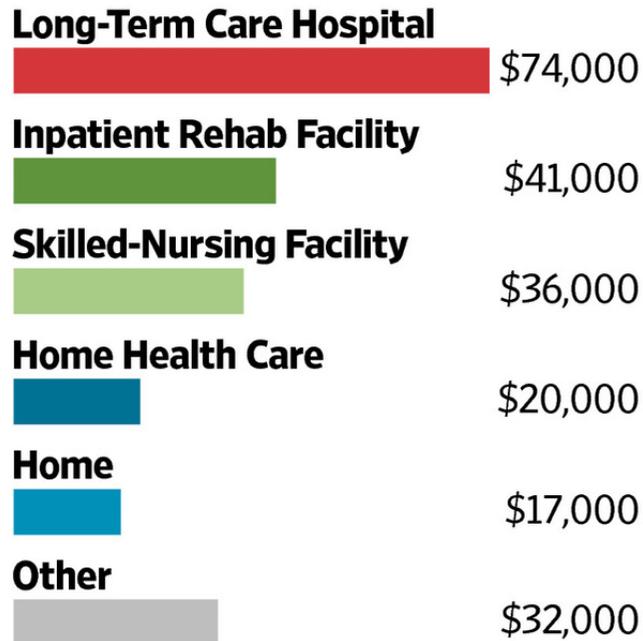
“Coordination” elusive, possible illusory, the “organizational” vs. “professional” model

Example: bundled payments (CCJR, doubling down on BPCI)

There's No Place Like Home

New Medicare rules will hold some hospitals accountable for the bundled cost of hip and knee replacements for 90 days. With a typical bundled payment of \$27,870, hospitals would lose money if patients go anywhere but home.

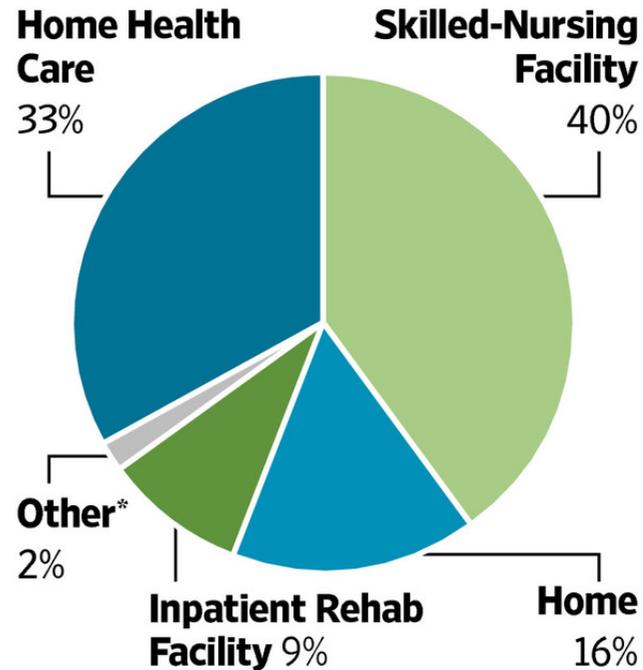
Average cost of hip or knee replacement-surgery package



Note: All costs include \$12,267 for surgery and inpatient hospital stay

Source: Remedy Partners

Where patients typically go first after the surgery

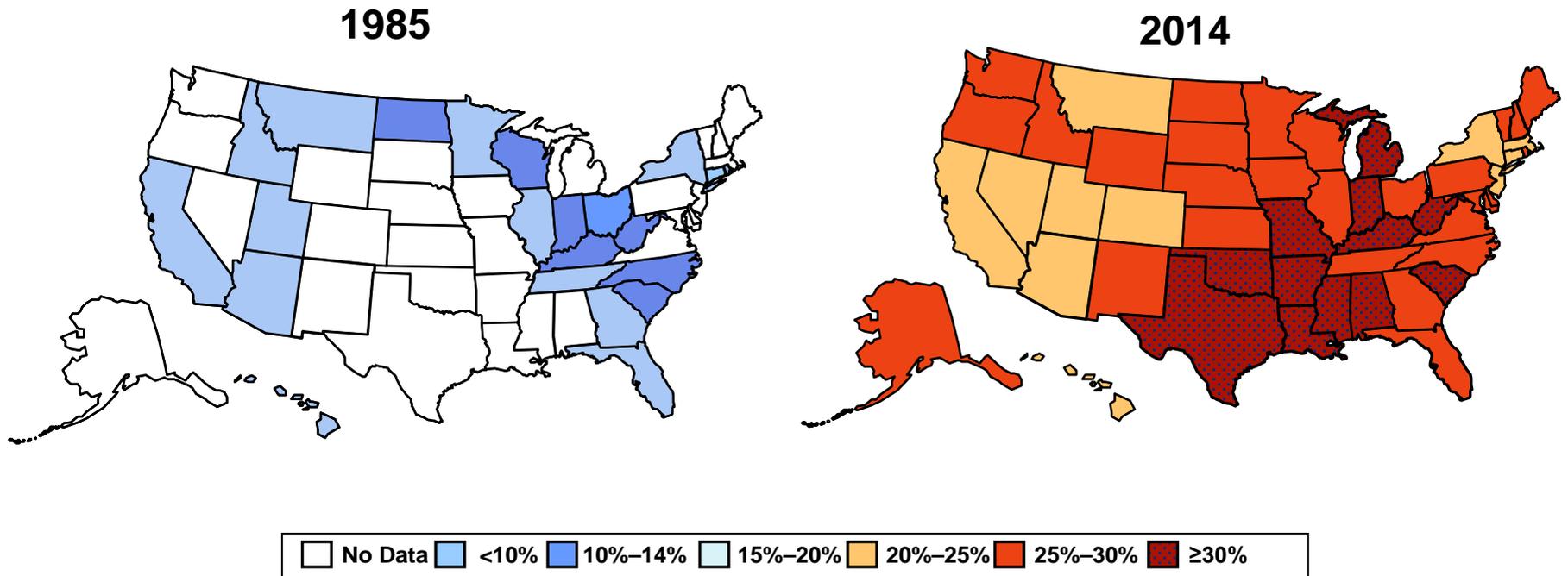


*Includes Long-Term Care Hospital

THE WALL STREET JOURNAL.

Only public health can tackle the toughest healthcare issues

Obesity defined as BMI ≥ 30 , or about 30 lbs. overweight for a 5'4" person



MU [Meaningful Use, HITECH, American Recovery and Reinvestment Act of 2009]

SGR [Sustainable Growth Rate, Balanced Budget Act of 1997, repealed with MACRA]

MACRA [Medicare Access and CHIP Reauthorization Act of 2015, signed April 16, 2015]

MIPS [Merit-Based Incentive Payment System, effective 1/1/19] will consolidate:

EHR MU [Electronic Health Record Meaningful Use] +
PQRS [Physician Quality Reporting System] +
VM [Value-based Modifier]

APMs [Alternative Payment Models, effective 1/1/19, criteria to be established by 11/1/16] expected to include qualifying:
Medicare ACOs,
Demonstration Programs,
PCMHs (Patient Center Medical Homes) and PFPM [Physician-Focused Payment Model]

Practices will have choices under MACRA

Fee-for-Service under a “Merit- based Incentive Payment System” (MIPS)

- Statutory updates
- Consolidated reporting
- Reduced penalty risk

Alternative Payment Models

- Higher updates
- Exempt from MIPS
- Preferred treatment for medical homes
- Specialty models encouraged

APMs

APM is a **generic term** describing a payment model in which providers take **responsibility for cost and quality performance** and **receive payments to support** the services and activities designed to achieve high value

- According to MACRA, APMs include:
 - Medicare Shared Savings Program ACOs
 - Patient-centered medical homes
 - CMS Innovation Center Models
 - Other federal demonstrations

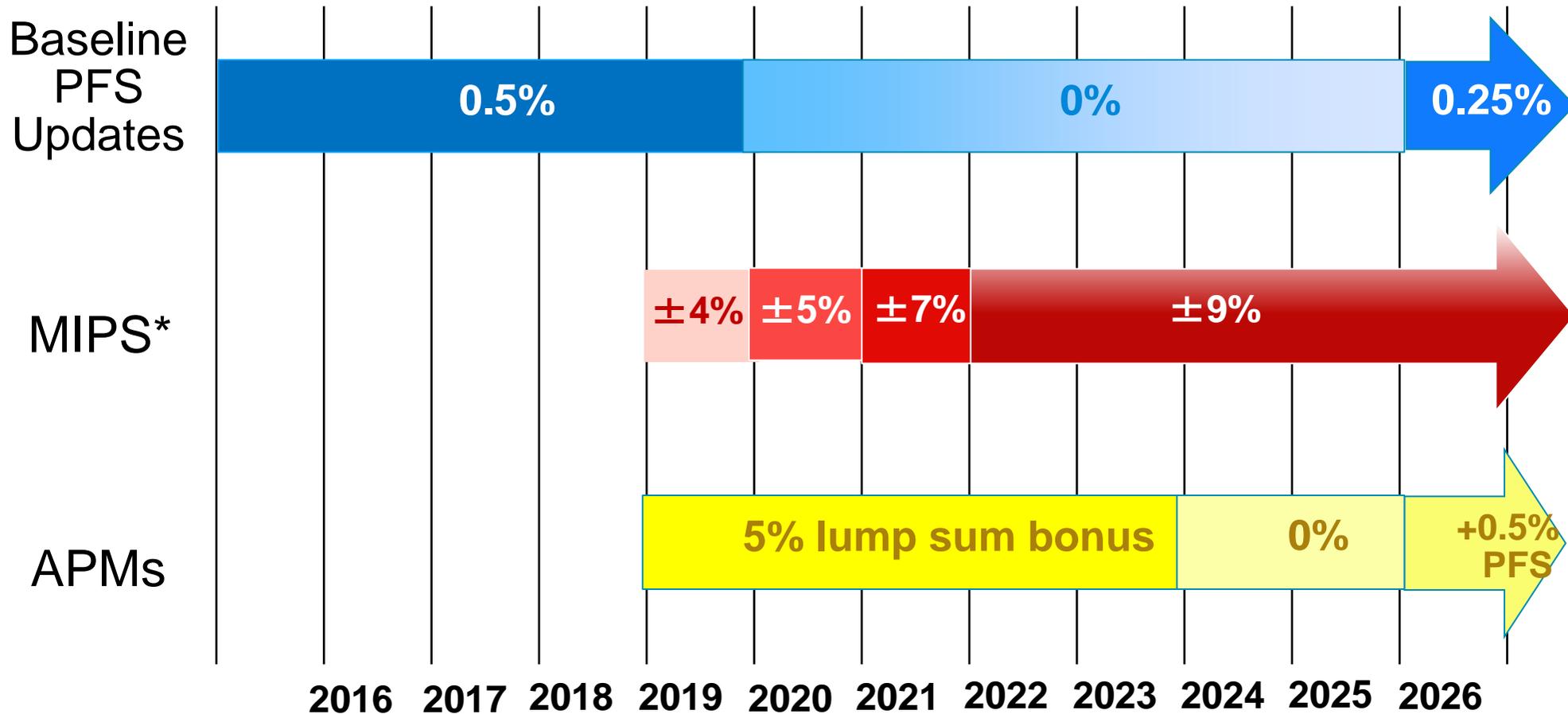
Incentives to participate in APMs

APMs offer greater potential **inherent risks and rewards** than MIPS

Under MACRA, qualifying APM participants in “eligible” APMs:

- Are **exempt from MIPS**
- Receive annual 5% lump sum **bonus payments** from 2019-2024
- Receive a **higher fee schedule update** for 2026 and onward

Medicare payments under MACRA



* Additional bonus available for exceptional performance

Prior Law	2019 adjustments
PQRS	-2%
MU	-5%
VBPM	-4% or more*
Total penalty risk	-11% or more*
Bonus potential (VBPM only)	Unknown (budget neutral)*

MIPS factors	2019 scoring
Quality measurement	50% of score
MU	25% of score
Resource use	10% of score
Clinical improvement activities	15% of score
Total penalty risk	Max of -4%
Bonus potential	Max of 4%, plus potential 10% for high performers

*VBPM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.

Acronyms reference guide

- ACO – accountable care organization
- APM – alternative payment model
- CMS – Centers for Medicare & Medicaid Services
- CPCI – Comprehensive Primary Care Initiative
- EHR – electronic health record
- EP – eligible professional
- HHS – U.S. Department of Health & Human Services
- MACRA – The Medicare Access and CHIP Reauthorization Act of 2015
- MIPS – Merit-Based Incentive Payment System
- PFS – physician fee schedule
- PQRS – Physician Quality Reporting System
- QRUR – quality and resource use report
- VBPM – Value-Based Payment Modifier