The Evolution of Health Insurance and the Delivery of Care

GA-HERO

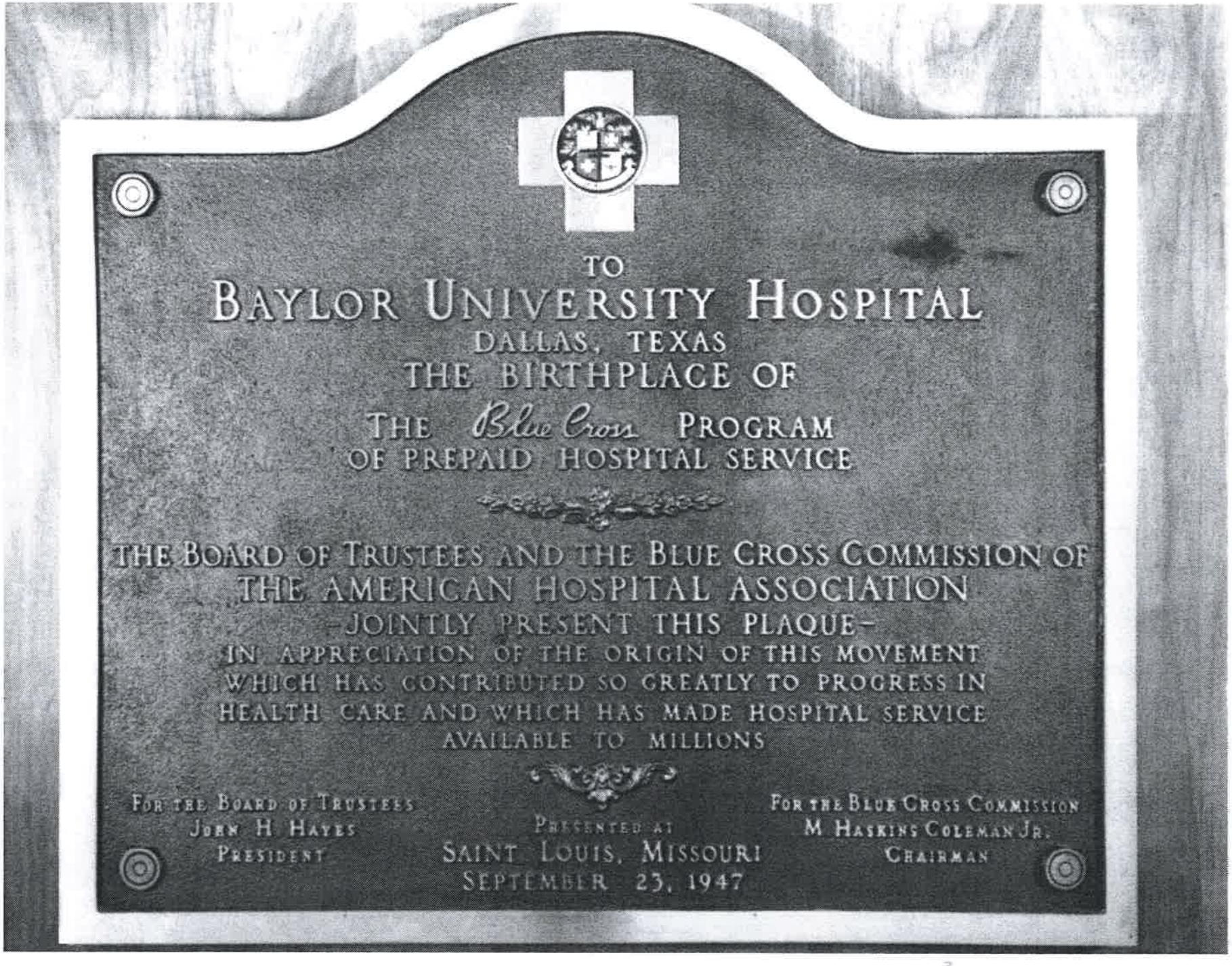
Georgia Association of Higher Education Retiree Organizations

William S. Custer, Ph.D.

May 2, 2018

Georgia State University
J. Mack Robinson
COLLEGE of BUSINESS

APPENDIX A


TO
BAYLOR UNIVERSITY HOSPITAL
DALLAS, TEXAS
THE BIRTHPLACE OF
THE Blue Cross PROGRAM
OF PREPAID HOSPITAL SERVICE
THE BOARD OF TRUSTEES AND THE BLUE CROSS COMMISSION OF
THE AMERICAN HOSPITAL ASSOCIATION
-JOINTLY PRESENT THIS PLAQUE-
IN APPRECIATION OF THE ORIGIN OF THIS MOVEMENT
WHICH HAS CONTRIBUTED SO GREATLY TO PROGRESS IN
HEALTH CARE AND WHICH HAS MADE HOSPITAL SERVICE
AVAILABLE TO MILLIONS
FOR THE BOARD OF TRUSTEES
JOHN H HAYES
PRESIDENT
PRESENTED AT
SAINT LOUIS, MISSOURI
SEPTEMBER 23, 1947
FOR THE BLUE CROSS COMMISSION
M HASKINS COLEMAN JR.
CHAIRMAN

KAISER PERMANENTE

A Brief History

1933: Dr. Garfield's prepaid health plan in the California desert

1938: 6,500 workers at the Grand Coulee Dam, Washington

1942: Kaiser shipyards in Richmond,CA; Vancouver, WA; and steel mill in Fontana, CA

1945: Membership opened to the public

1948: The Permanente Medical Group founded

1955: The Tahoe agreement, roles of PMGs and KFHP set

Birth of Medicare and Medicaid 1965

National Health Expenditures
Total & as Percentage of GDP

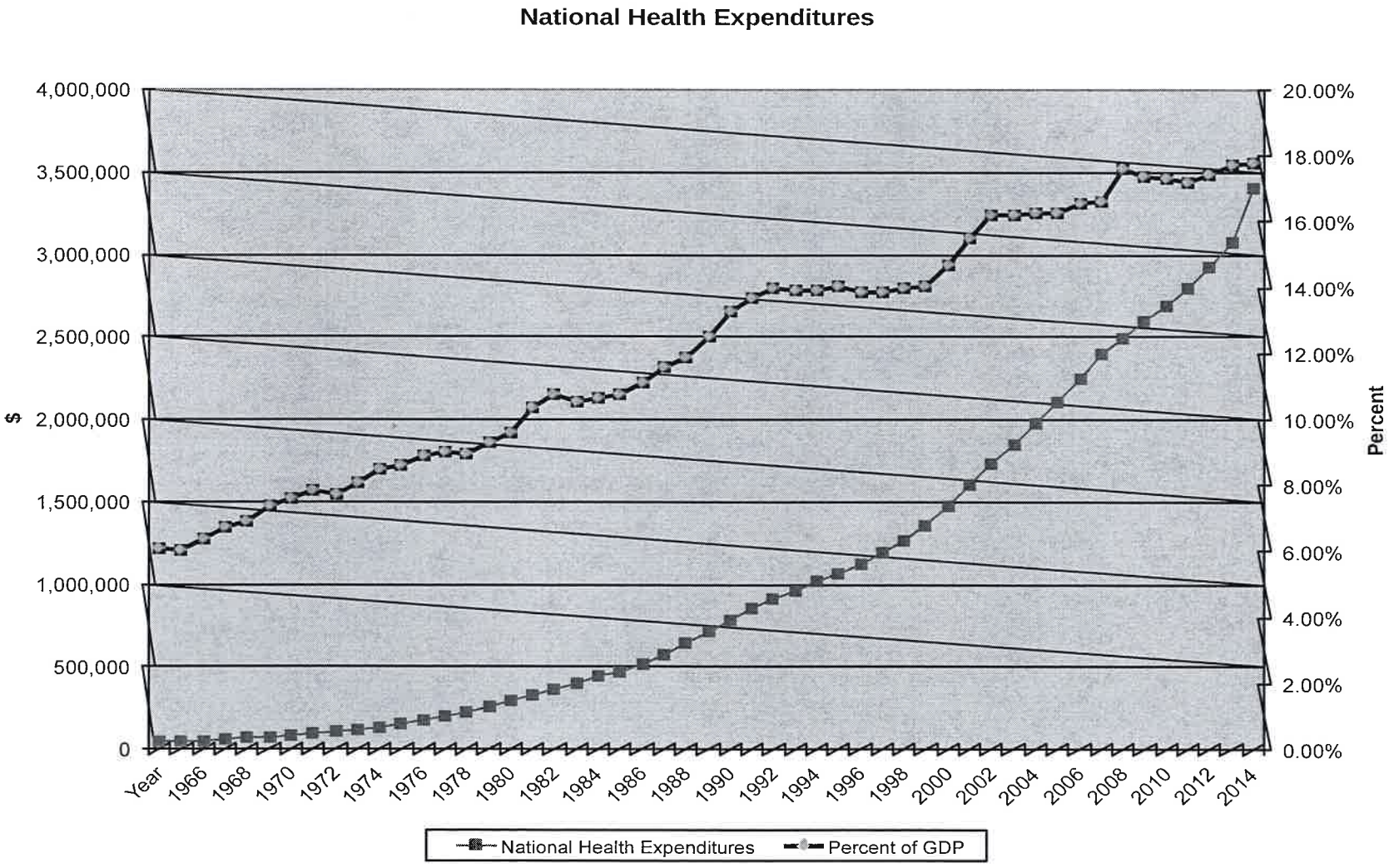
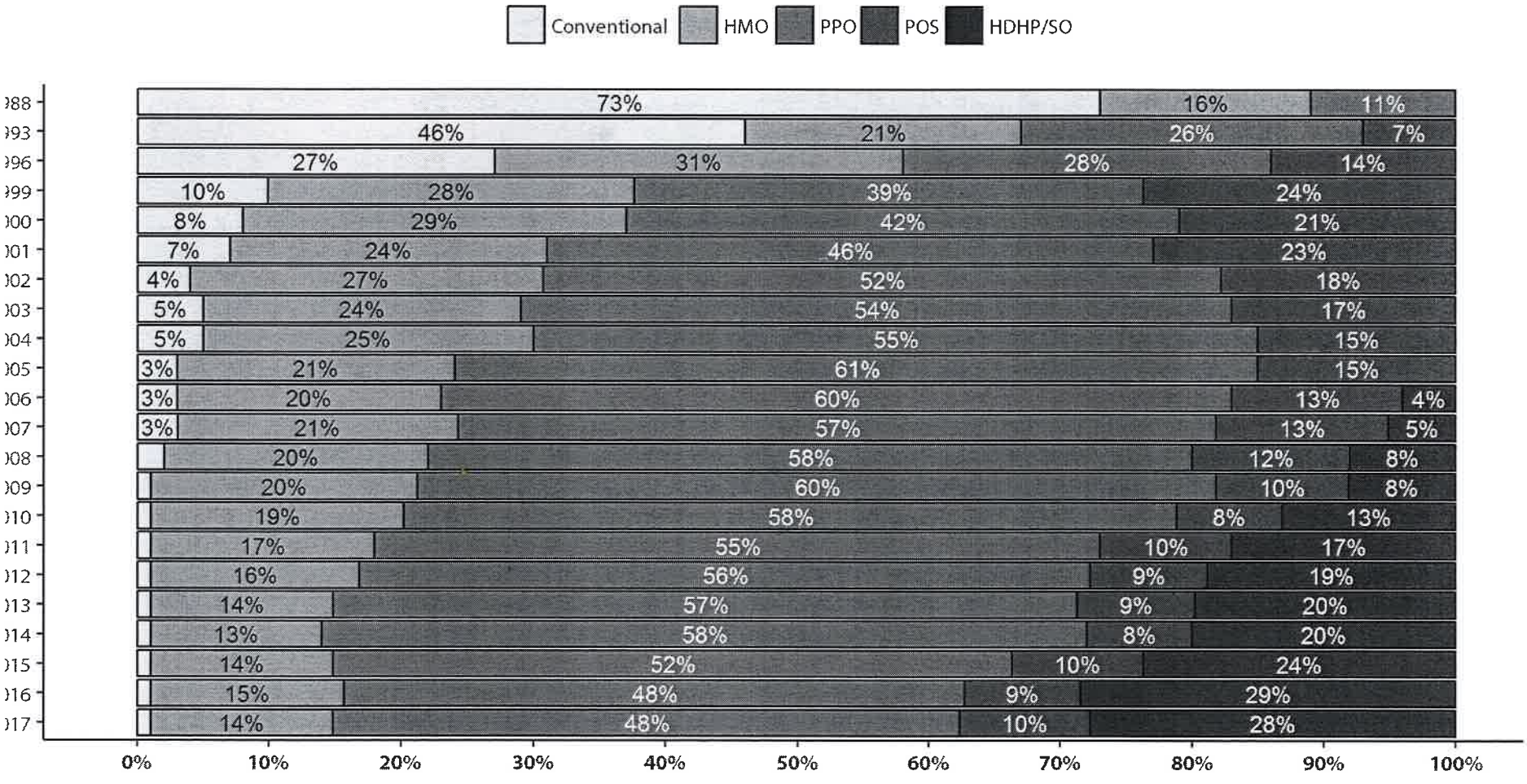


Figure 5.1

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2017

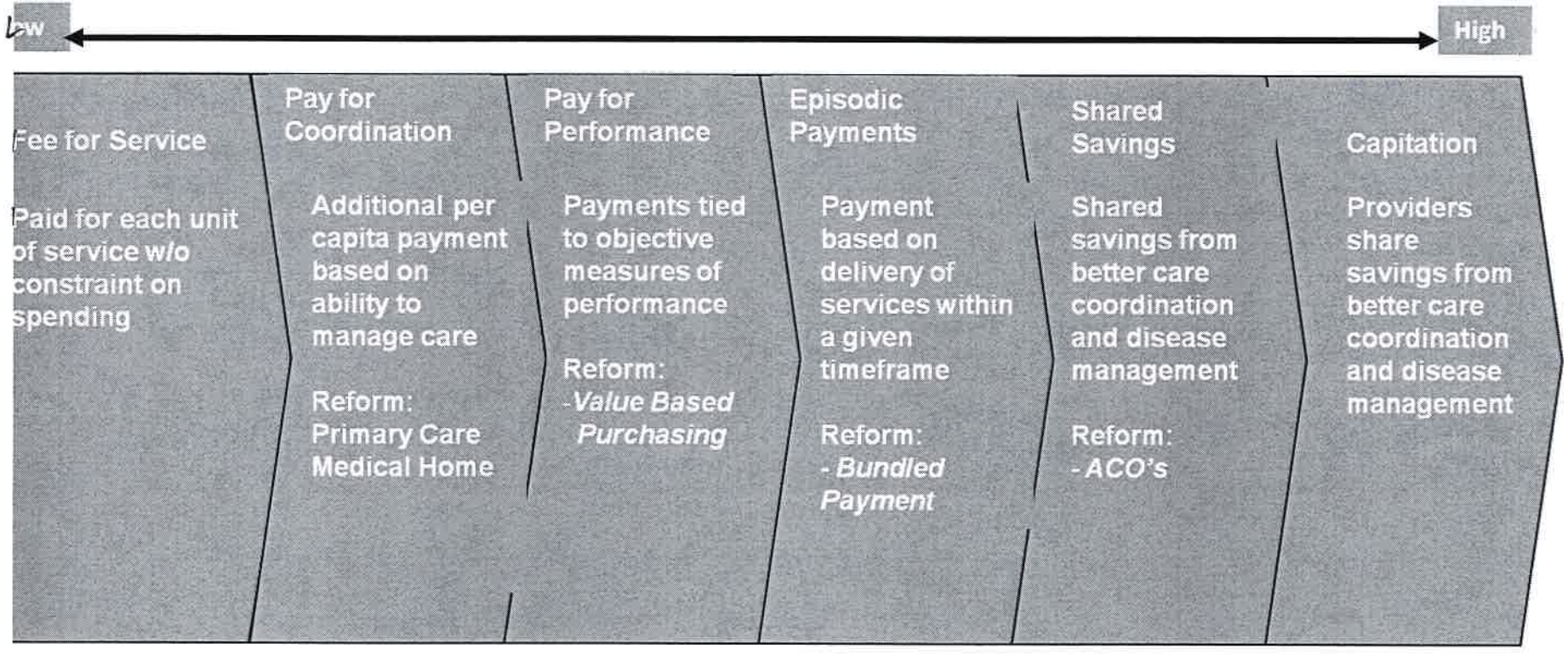


NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

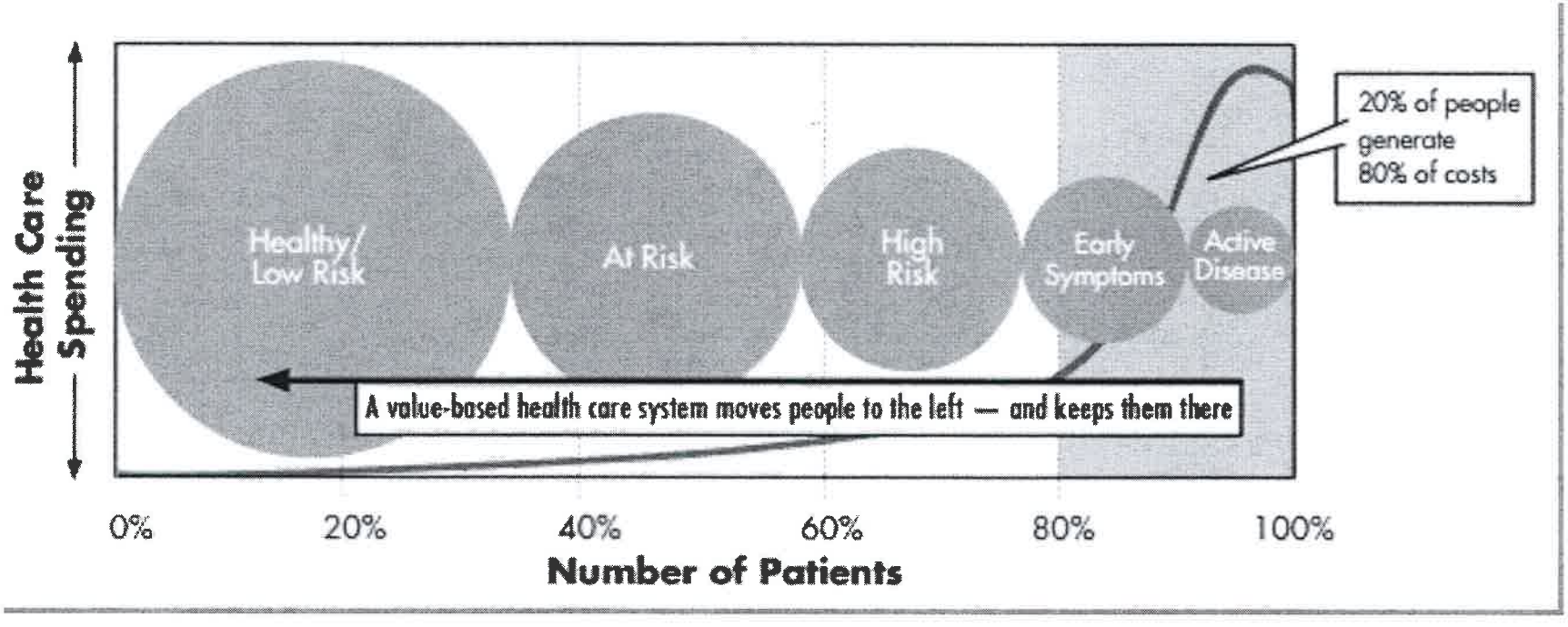
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.

Shifting Risk

Degree of Population Risk Transferred to Provider by Payment System

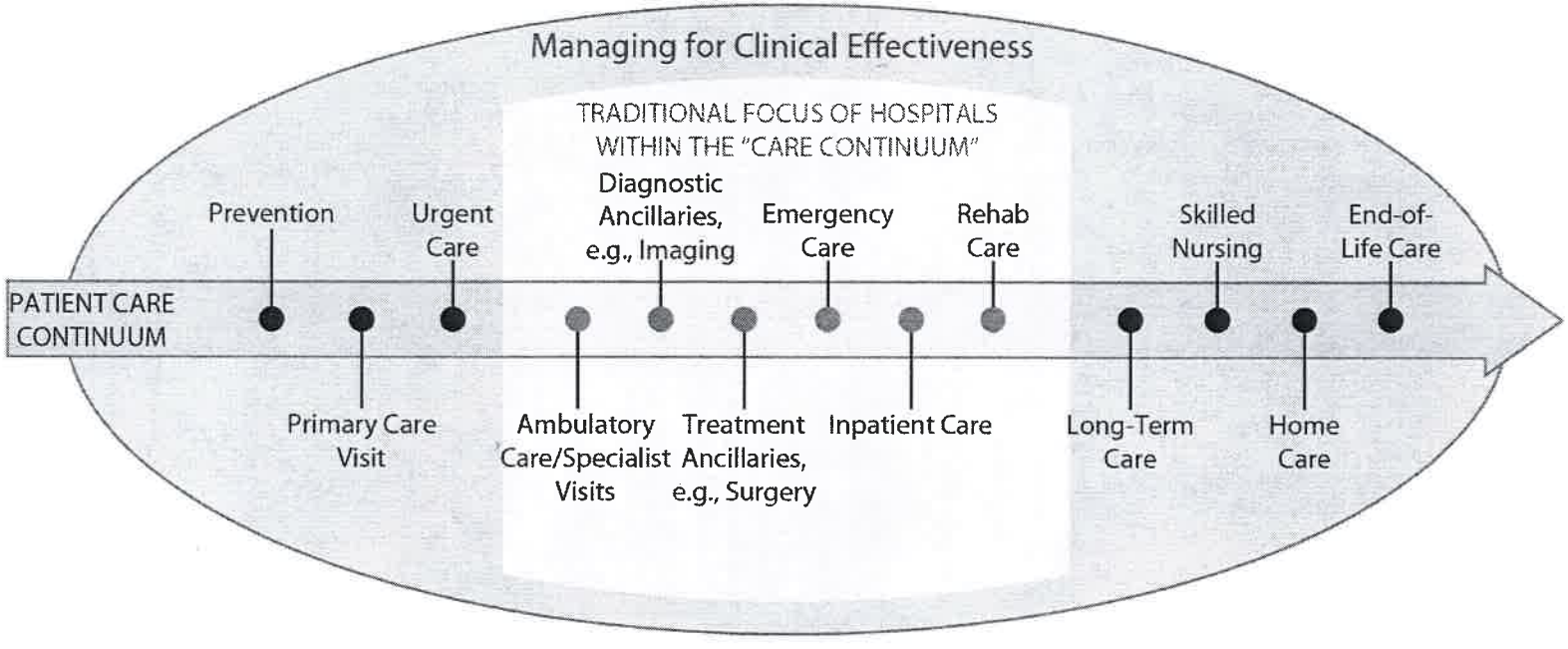


Where We Are Going


Health Care Spending
Healthy/ Low Risk
At Risk
High Risk
Early Symptoms
Active Disease
20% of people generate 80% of costs
A value-based health care system moves people to the left — and keeps them there
0%
20%
40%
60%
80%
100%
Number of Patients

Continuum of Health Services in the U.S.

EXHIBIT 5: Healthcare Continuum



ttp://www.kurtsalmon.com/US/vertical-insight/Bringing-Certainty-to-Uncertain-Times?vertical=healthcare&id=383&popup=1&language=en-us#.UlwooFDkvkU

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
escription	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
‹amples				
ledicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
ledicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

ajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

Pay for Performance:

"Use of incentives to encourage and reinforce the delivery of evidence-based practices and **health care system transformation** that promote better outcomes as efficiently as possible."

-Kongstvedt

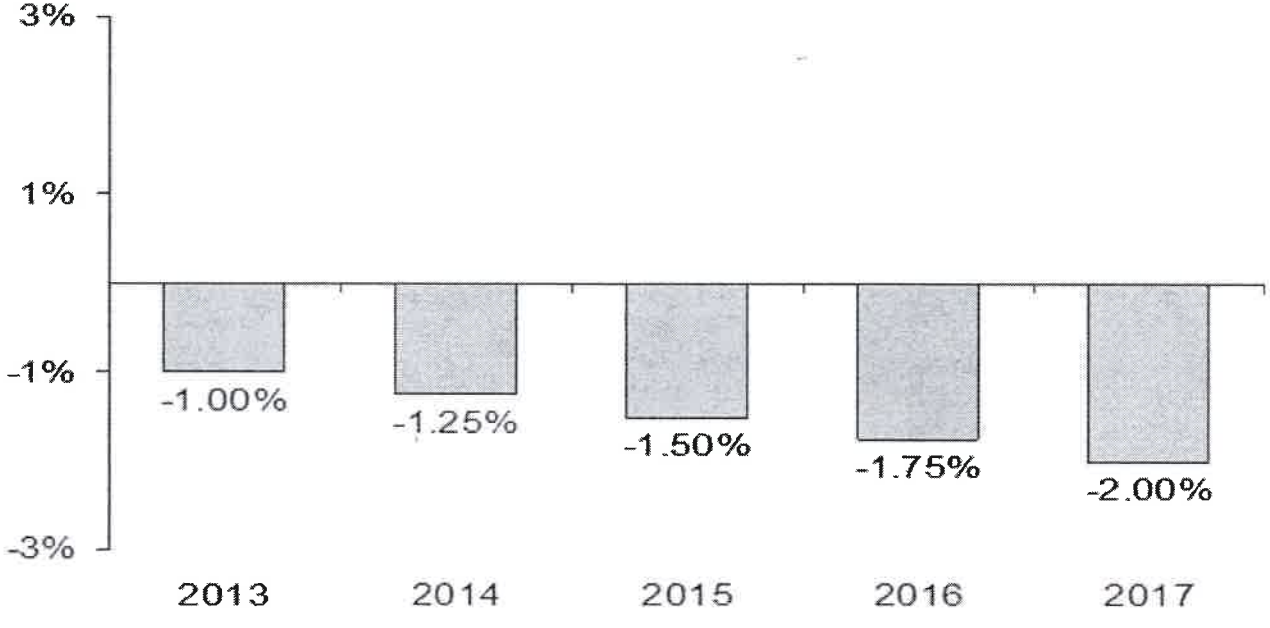
Medicare 30 Day Readmission Rates

- Reimbursement penalties (1-3%) for high rates
  - Congestive Heart Failure
  - Acute Myocardial Infarction
  - Pneumonia
    - In 2016 list includes:(i) patients with aspiration pneumonia; and (ii) sepsis patients coded with pneumonia present on admission

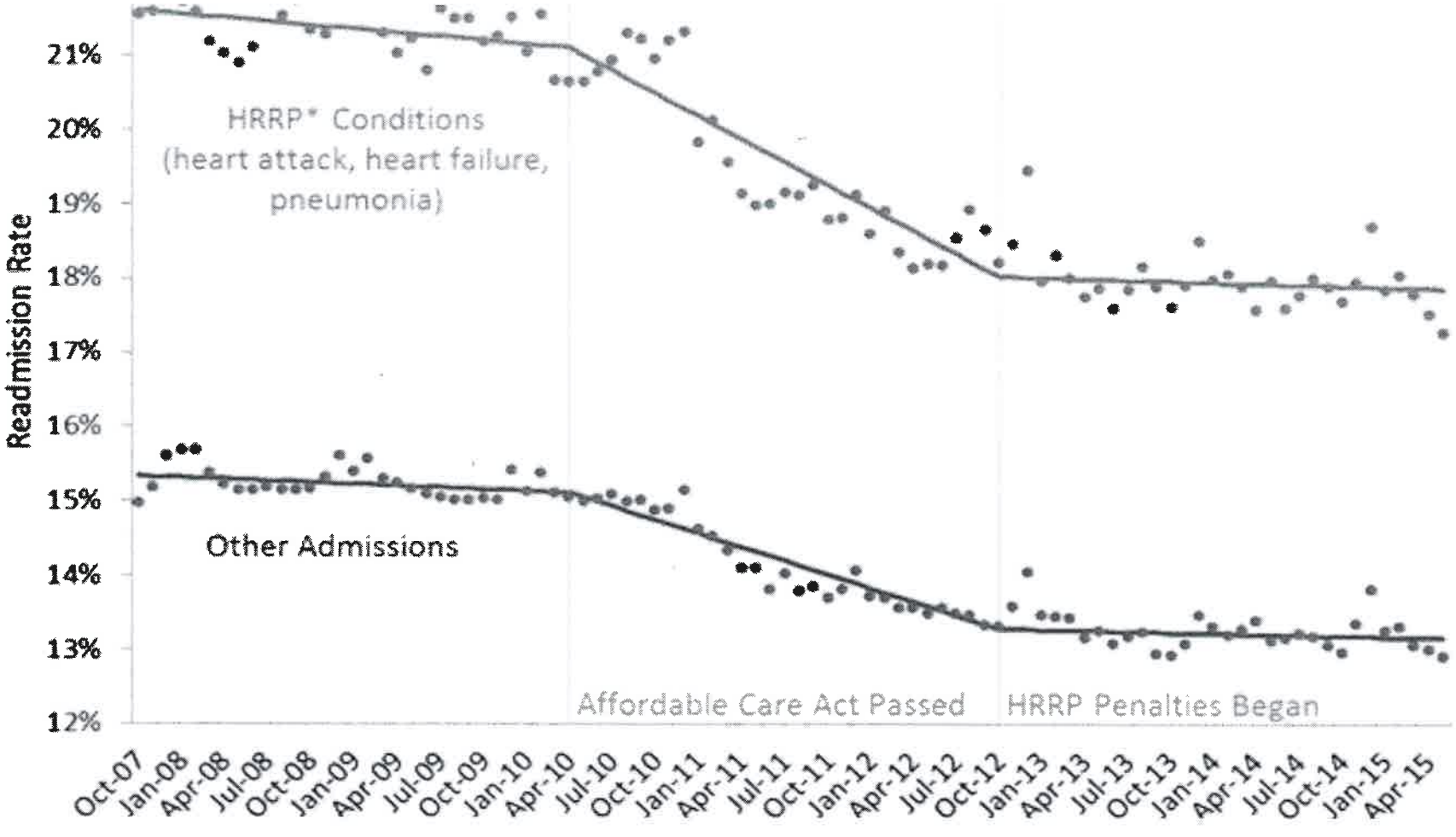
- Condition specific list expanded in 2015
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Total Hip Arthroplasty/ Total Knee Arthroplasty (THA/TKA)

Funding for Pay for Performance - Hospitals

- Withhold from baseline DRG payments

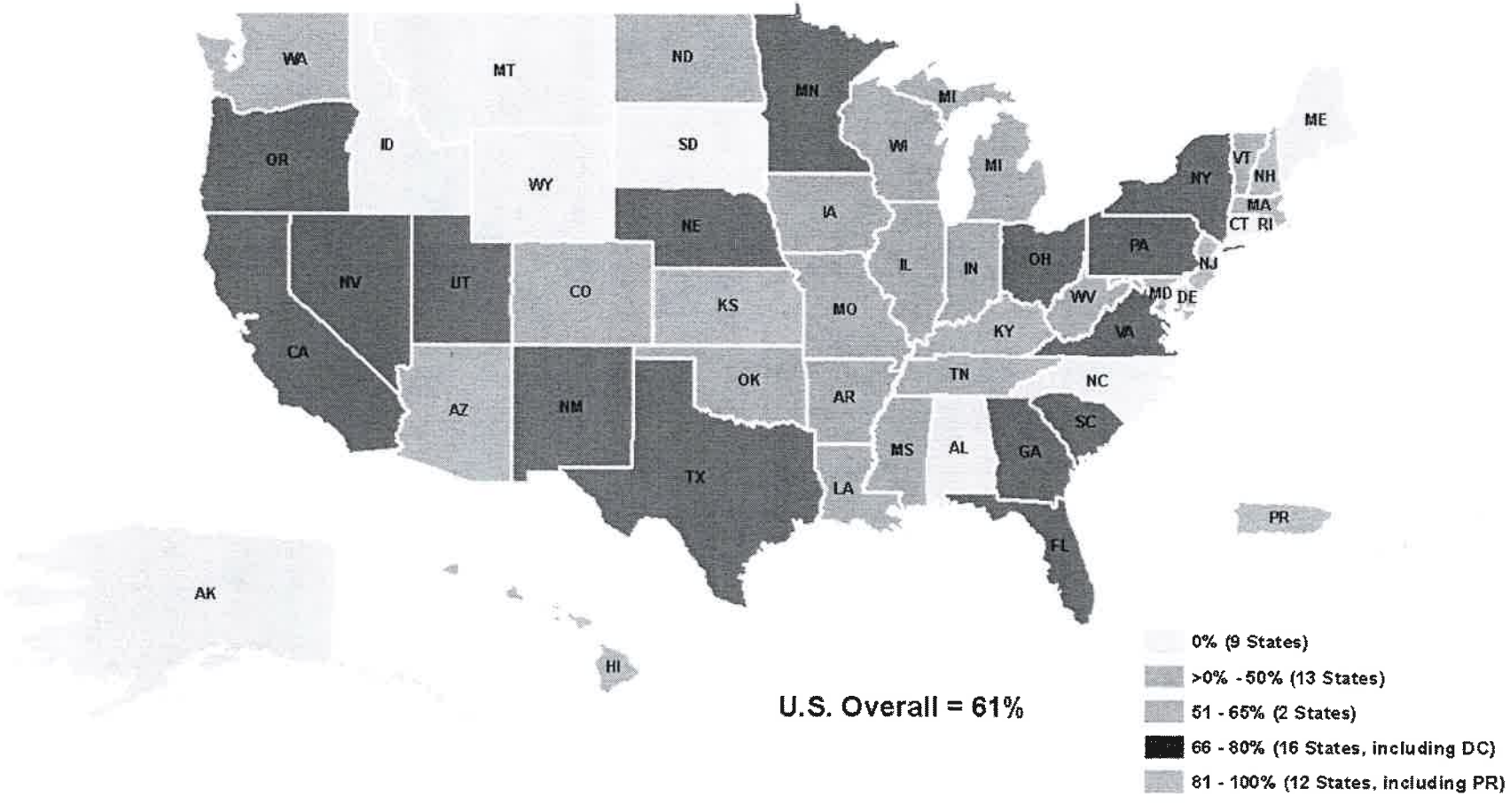


Changes in Medicare Readmission Rates 2007-2015



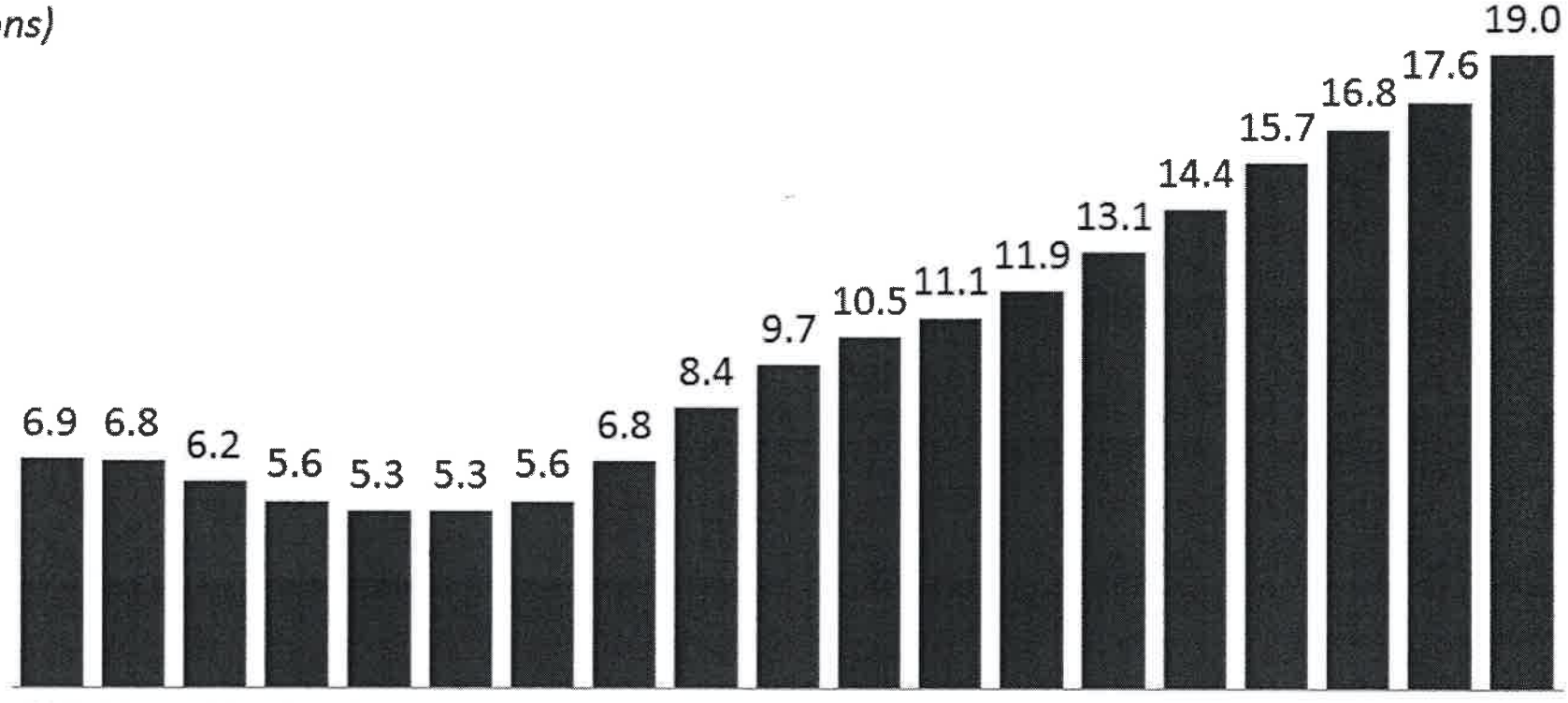
Medicaid Managed Care

State Comprehensive Managed Care Penetration, as of July 1, 2014



Enrollment in Medicare Advantage plans has steadily increased since 2004

Total Medicare Private Health Plan Enrollment, 1999-2017
(in millions)



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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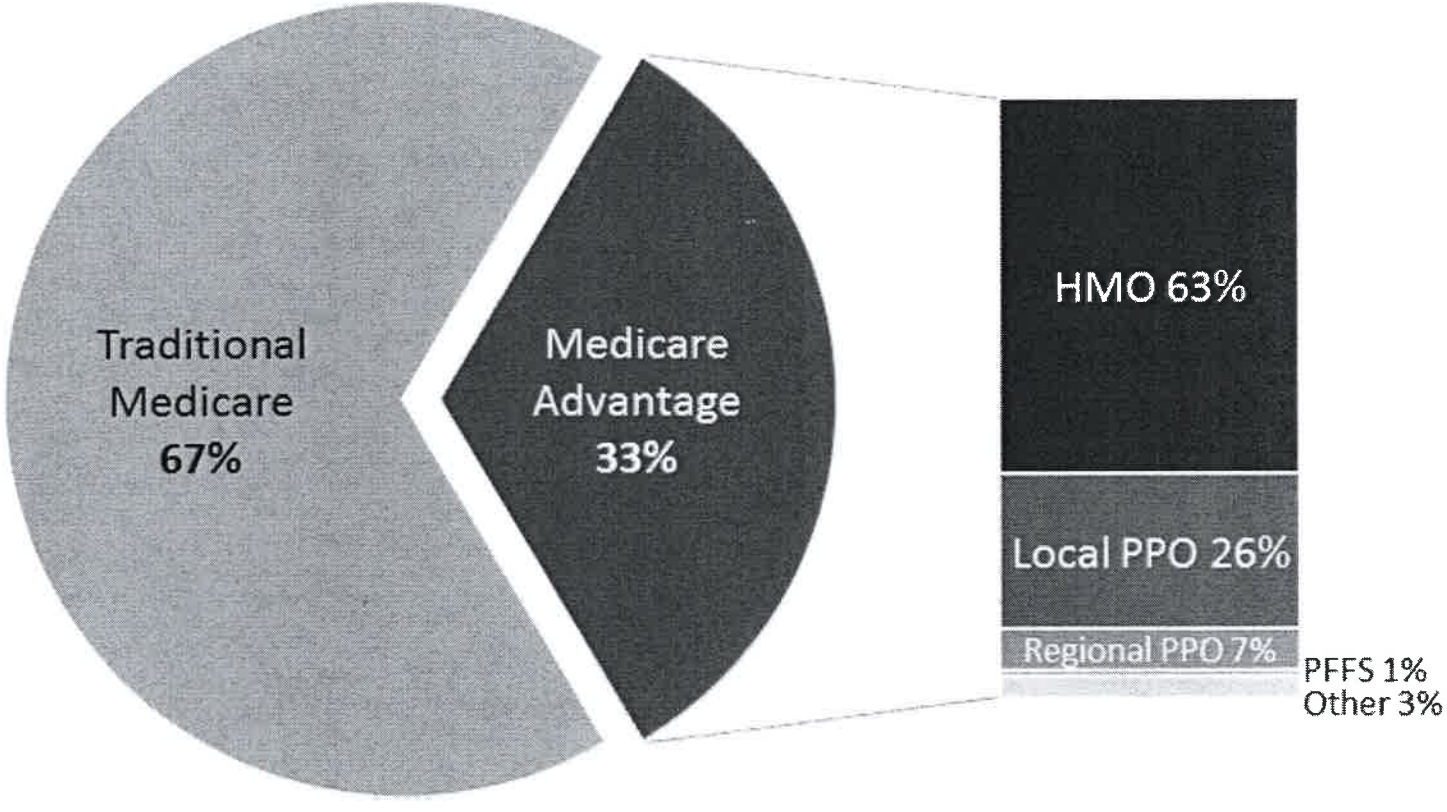
Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2017



Total Medicare Advantage Enrollment, 2017 = 19.0 Million

NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and in territories other than Puerto Rico.
SOURCE: Authors' analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage enrollment files, 2017.

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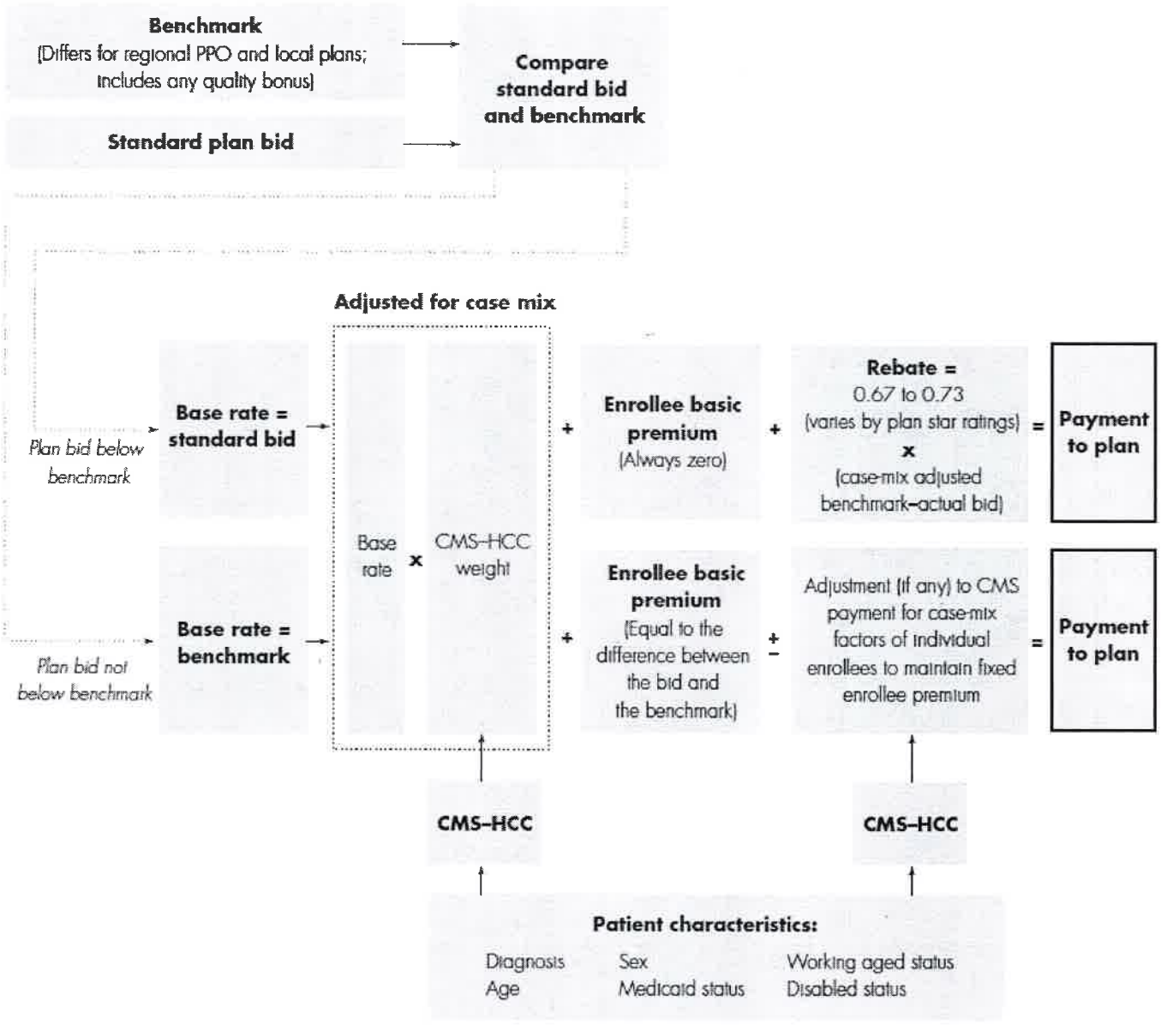


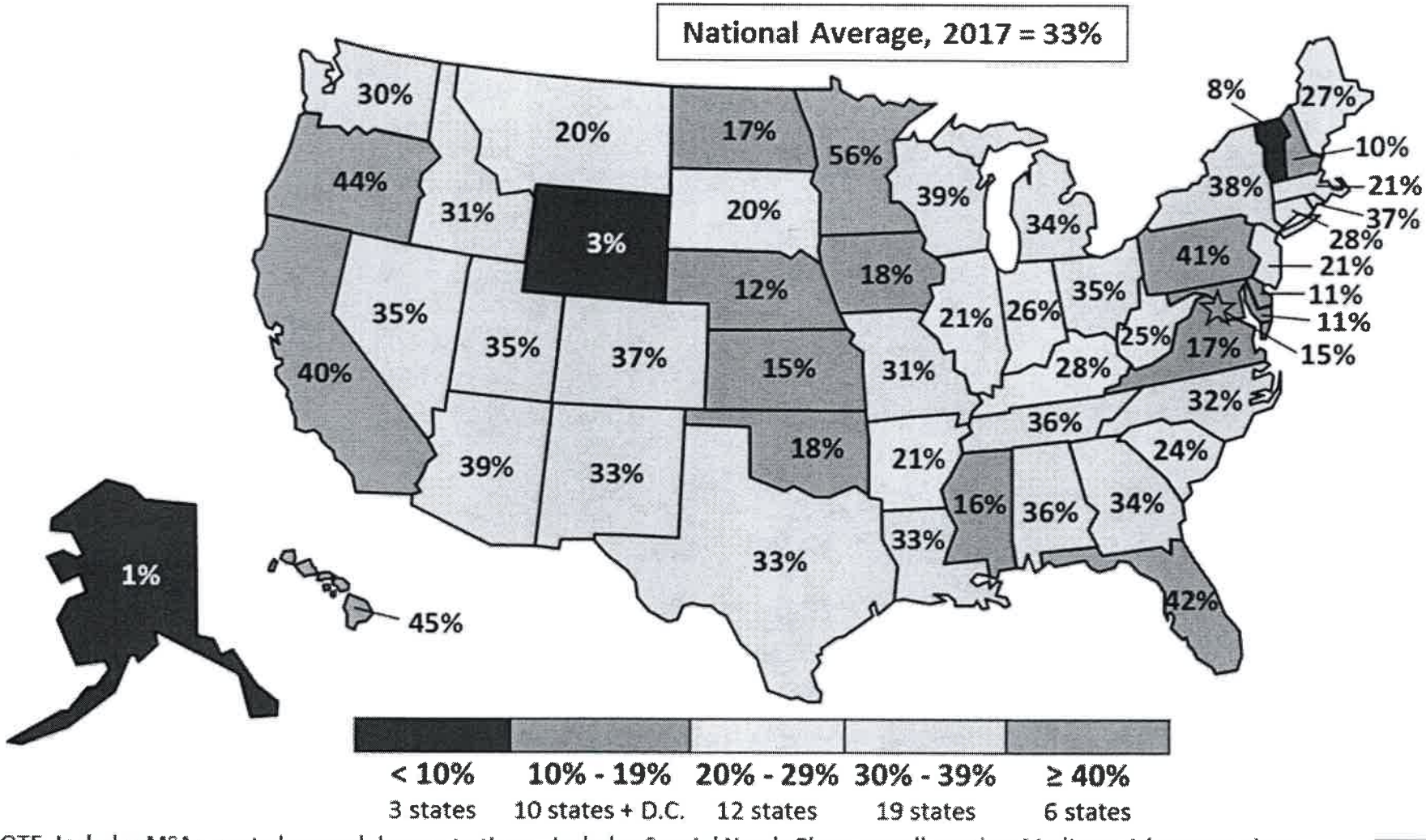
Note: PPO (preferred provider organization), CMS–HCC (CMS–hierarchical condition category). If the plan bid equals the benchmark, there is no enrollee basic premium. Medicare payments also reflect an intra-service area adjustment based on the county of residence of the enrollee.

Medicare Advantage Star Rating

1. Outcomes (30%)
2. Intermediate outcomes (30%)
3. Patient experience and complaints (15%)
4. Access (15%)
5. Process (10%)

Enrollment in Medicare Advantage plans varies across states

Share of Medicare Beneficiaries Enrolled in Medicare Private Health Plans, by State, 2017



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2017.

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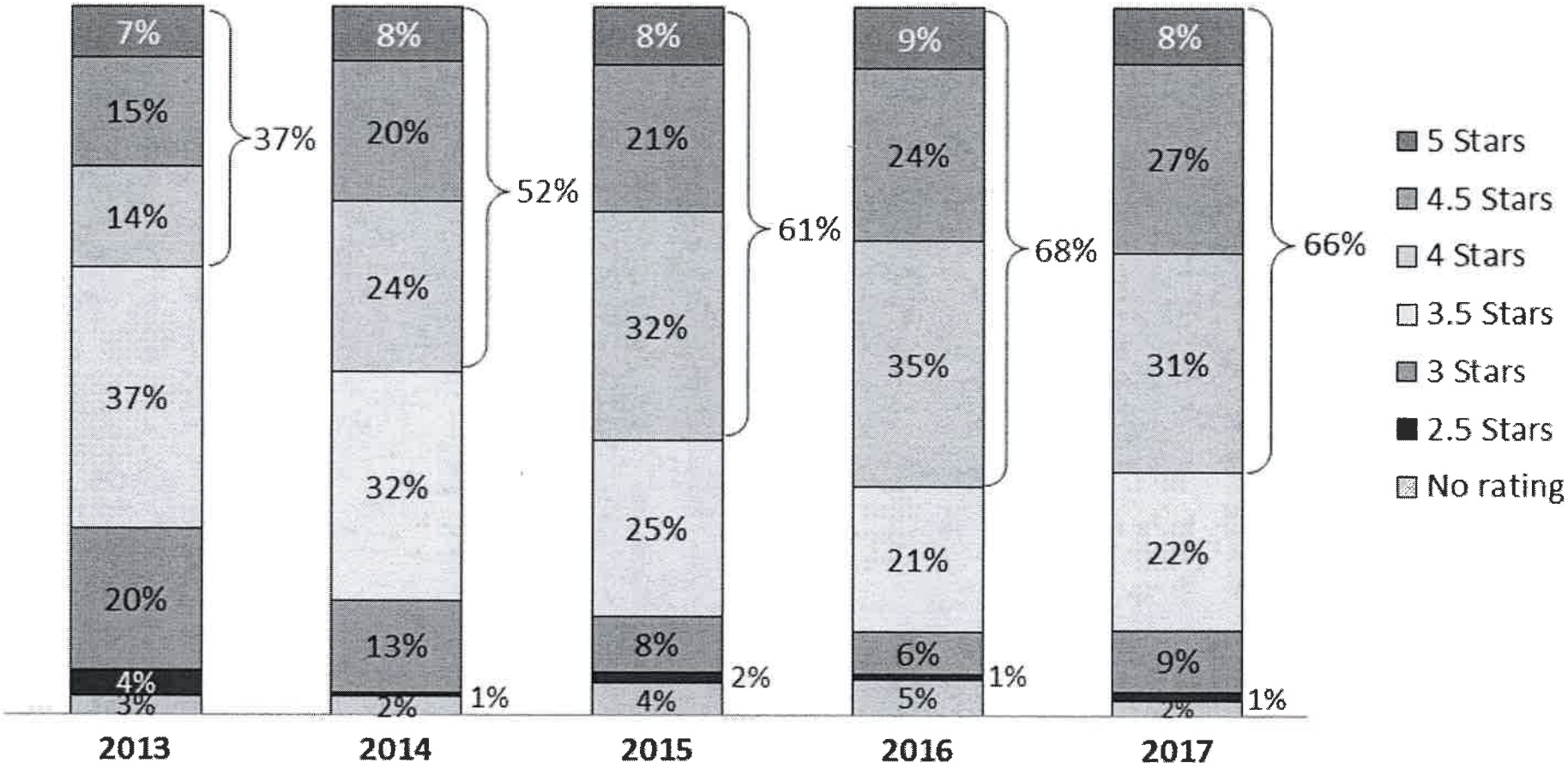
Almost two-thirds of Medicare Advantage enrollees are in contracts with ratings of 4 or more stars in 2017

Enrollment in Medicare Advantage Contracts, by Star Quality Rating, 2013-2017



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations. Totals may not add to 100% due to rounding. Less than 1% of enrollees were in plans with 2 stars in 2013 and 2014.
SOURCE: Authors' analysis of CMS's Landscape and Enrollment Files for 2013 – 2017.

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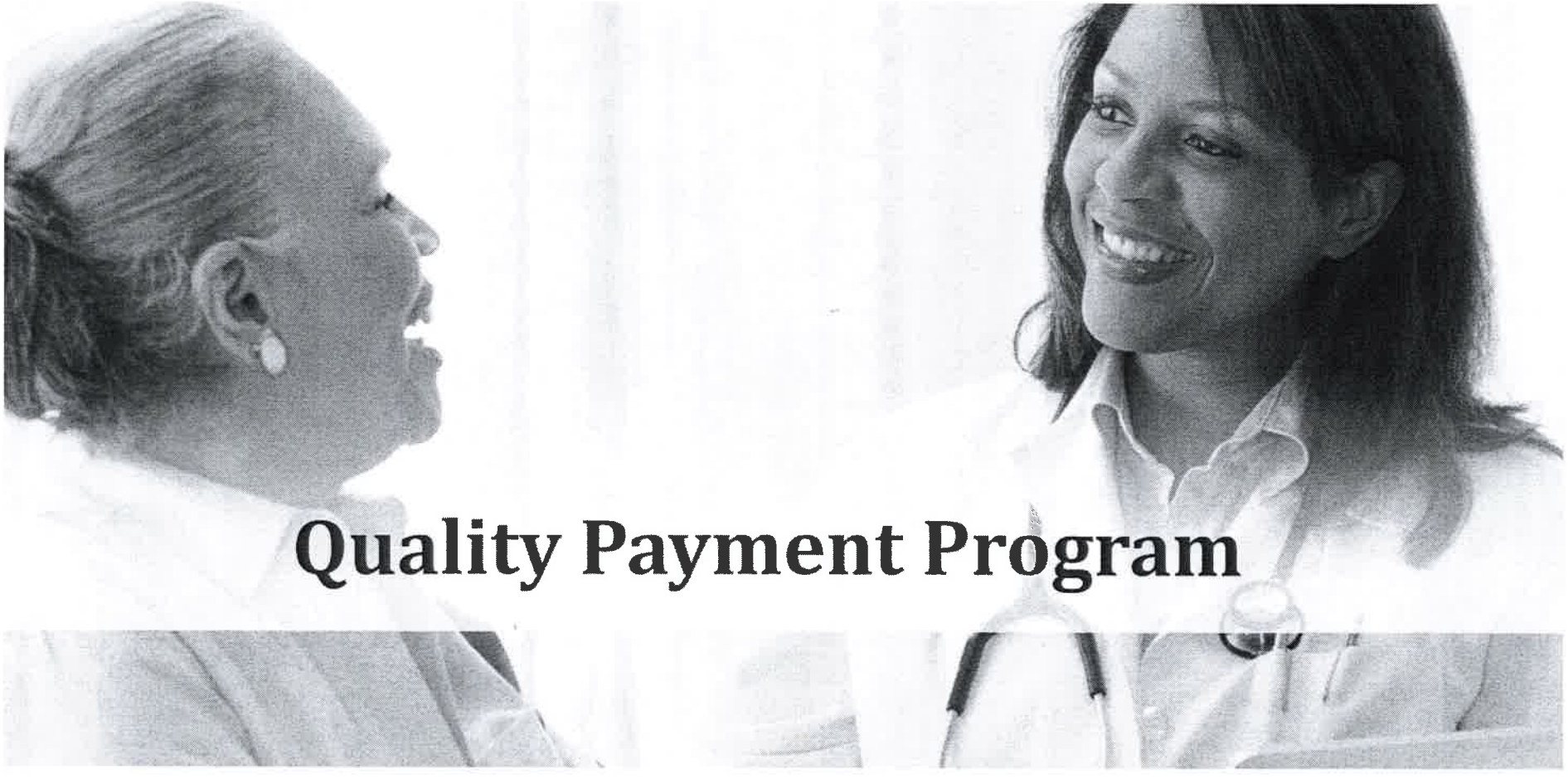
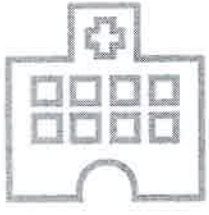
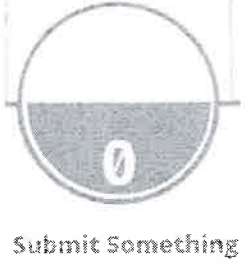
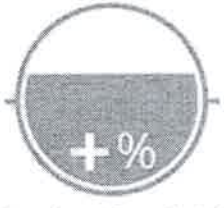


Quality Payment Program

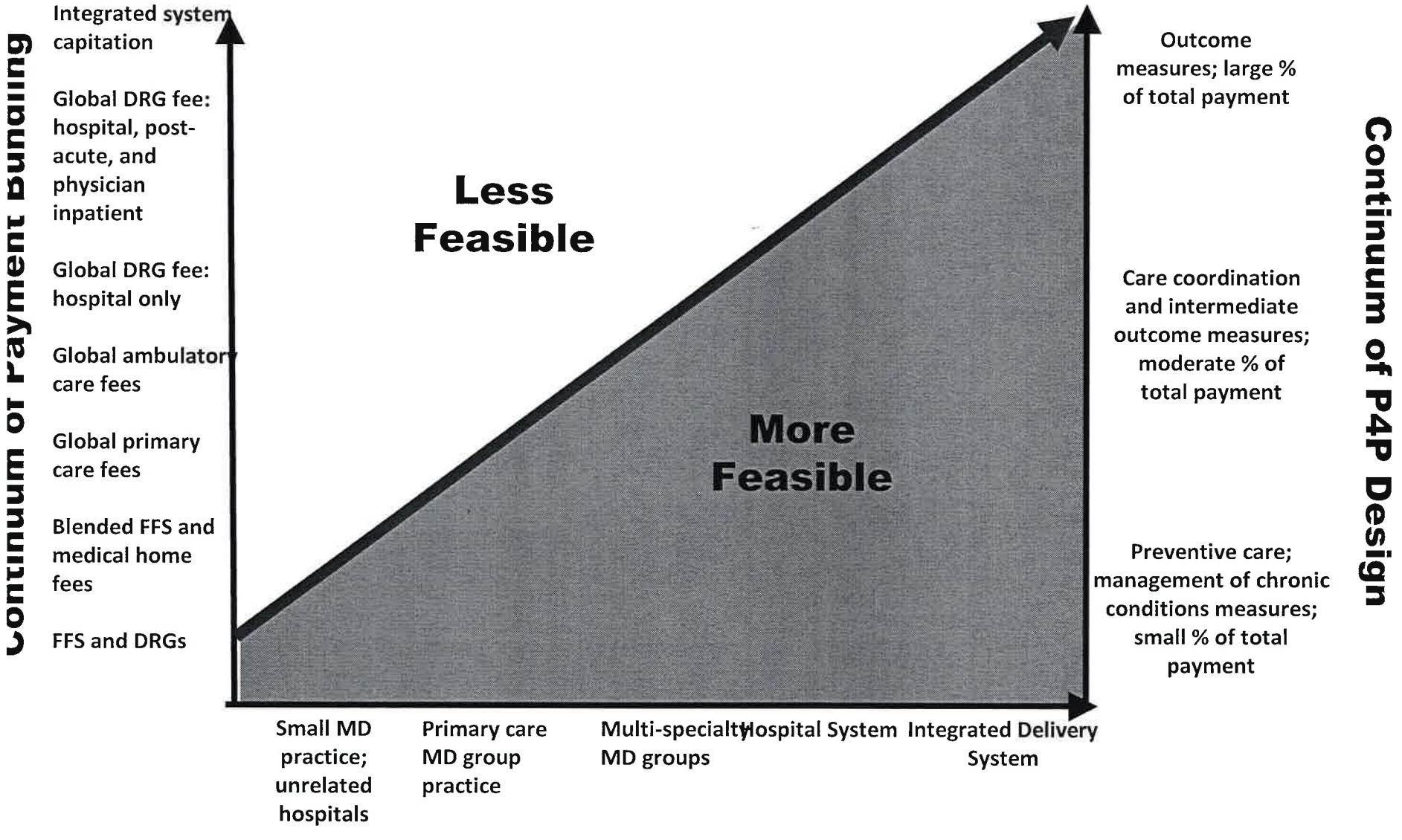
Pick Your Pace for Participation for the Transitional Year

MIPS

Participate in an Advanced Alternative Payment Model	**Test Pace**	**Partial Year**	**Full Year**
			
• Some practices may choose to participate in an Advanced Alternative Payment Model in 2017	• Submit **some** data after January 1, 2017 • Neutral or small payment adjustment	• Report for 90-day period after January 1, 2017 • Small positive payment adjustment	• Fully participate starting January 1, 2017 • Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

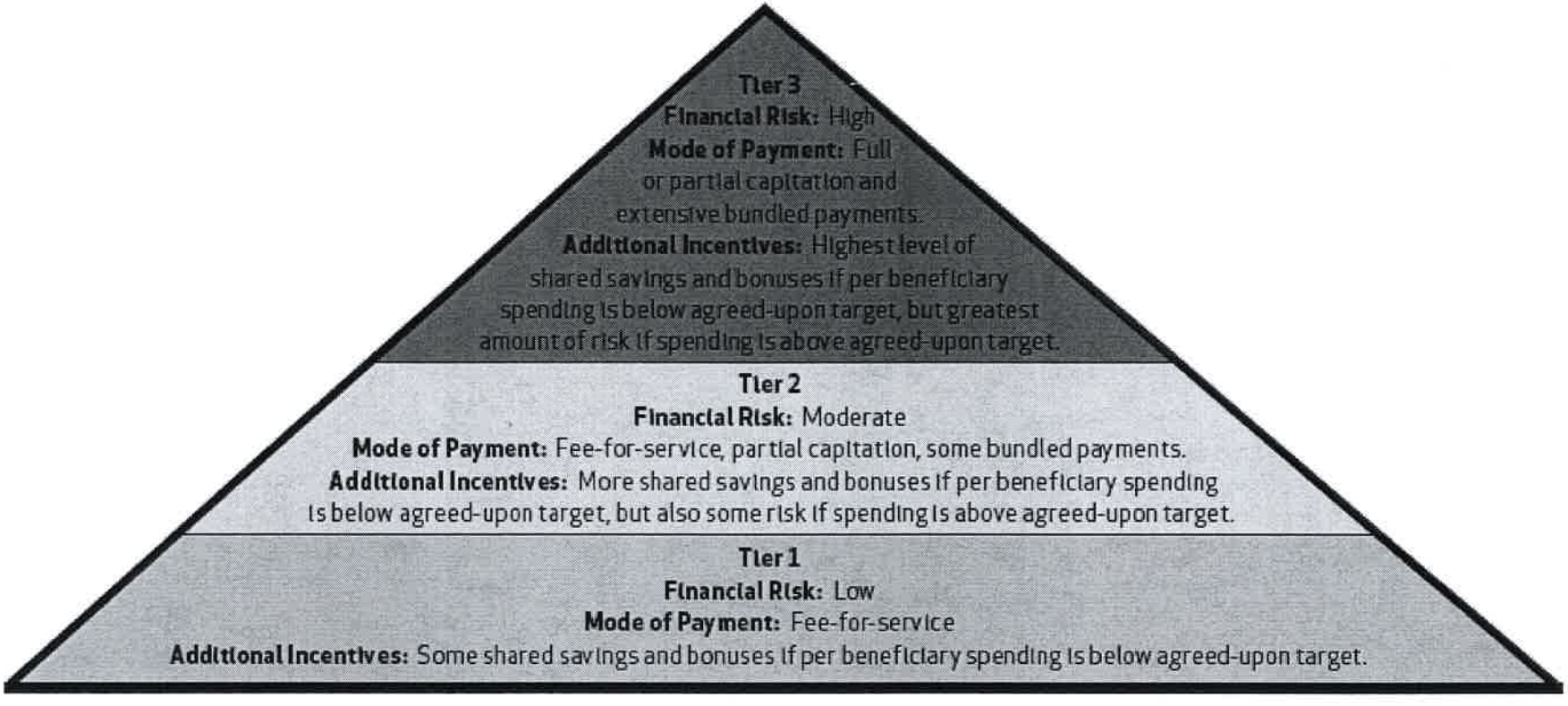
Payment Methods and Organization Are Interrelated
Need Incentives and Systems for Organized Care



ource: Shih et al. *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, August 008

Risk-Reward of ACO Membership

Three Tiers Of Accountable Care Organizations And Possible Characteristics



SOURCE S.M. Shortell, L.P. Casalino, and E.S. Fisher, "How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations," *Health Affairs* 29, no. 7 (2010): 1293-98.

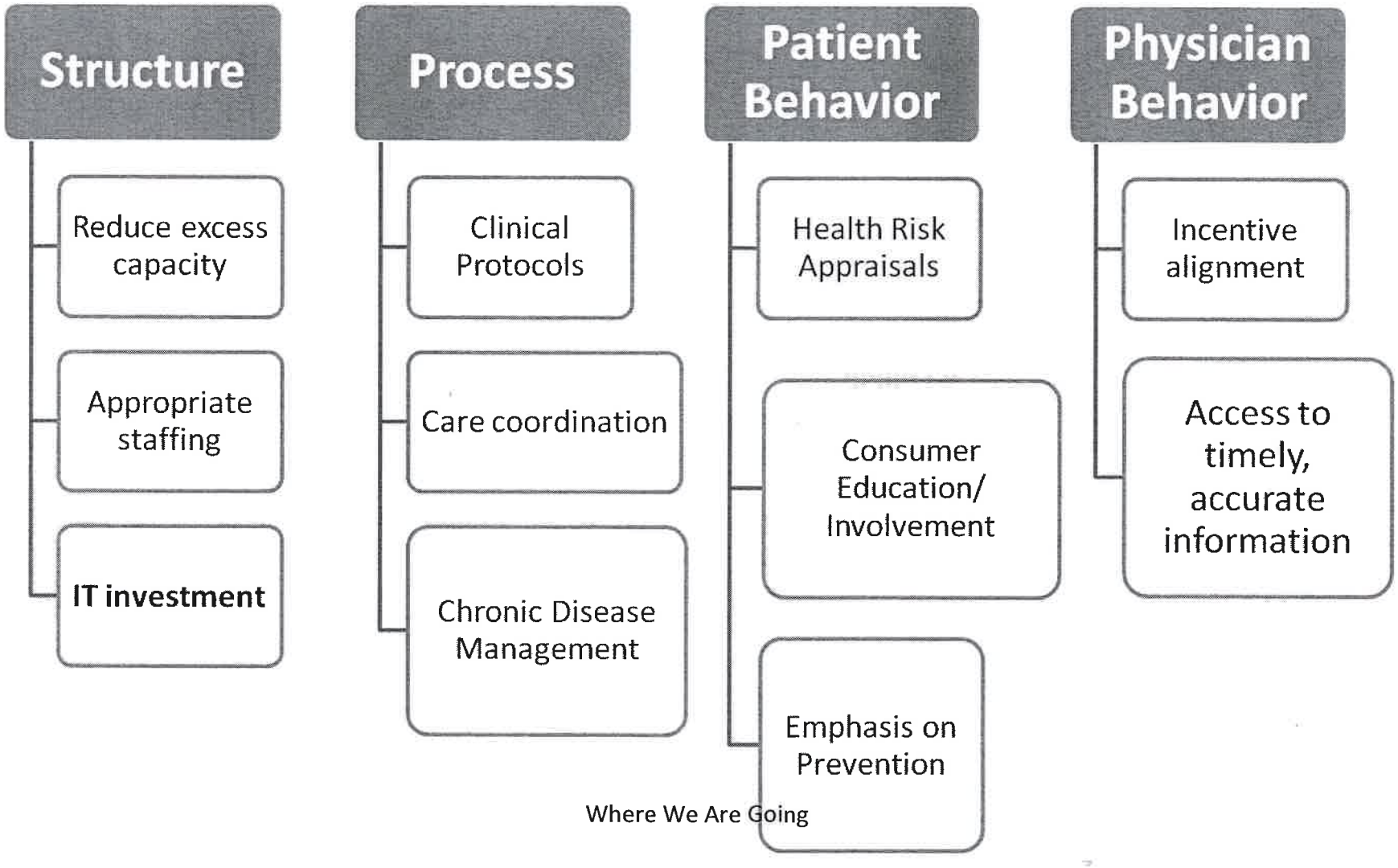
Where We Are Going

Models for ACOs

Model	Characteristics	Current Examples
Integrated delivery systems	• Own hospitals, physician practices, perhaps insurance plan. • Aligned financial incentives. • E-health records, team-based care.	Geisinger Health System Group Health Cooperative of Puget Sound Kaiser Permanente
Multispecialty group practices	• Usually own or have strong affiliation with a hospital. • Contracts with multiple health plans. • History of physician leadership. • Mechanisms for coordinated clinical care.	Cleveland Clinic Marshfield Clinic Mayo Clinic Virginia Mason Clinic
Physician-hospital organizations	• Nonemployee medical staff. • Function like multispecialty group practices. • Reorganize care delivery for cost-effectiveness.	Advocate Health (Chicago) Middlesex Hospital (Connecticut) Tri-State Child Health Services (affiliated with the Cincinnati Children's Hospital Medical Center)
Independent practice associations	• Independent physician practices that jointly contract with health plans. • Active in practice redesign, quality improvement.	Atrius Health (eastern Massachusetts) Hill Physicians Group (southern California) Monarch HealthCare (southern California)
Virtual physician organizations	• Small, independent physician practices, often in rural areas. • Led by individual physicians, local medical foundation, or state Medicaid agency. • Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care.	Community Care of North Carolina Grand Junction (Colorado) North Dakota Cooperative Network

OURCE S.M. Shortell, L.P. Casalino, and E.S. Fisher, "How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations," *ealth Affairs* 29, no. 7 (2010): 1293-98.

How does an ACO generate savings?



Basic Requirements for Success

- **Delivery infrastructure**
  - Manage flow of patients across continuum
- **Financial infrastructure**
  - Negotiations with payers
  - Shared savings methodology
  - Prospective budgeting and planning
- **Information infrastructure**
  - Technology
  - Data analytics
  - Performance metrics
- **Adaptive leadership**
  - Changing processes and culture

Patient-Centered Medical Home – Improved Coordination

- Ongoing relationship with a personal physician
- Physician-directed medical practice
- Whole-person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks
- Enhanced access to care
- **Payment appropriately recognizes the added value**

PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity		Pts
A.	**Access During Office Hours****	**4**
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20

PCMH2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	**Use Data for Population Management****	**5**
		16

PCMH3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	**Care Management****	**4**
D.	Manage Medications	3
E.	Use Electronic Prescribing	3
		17

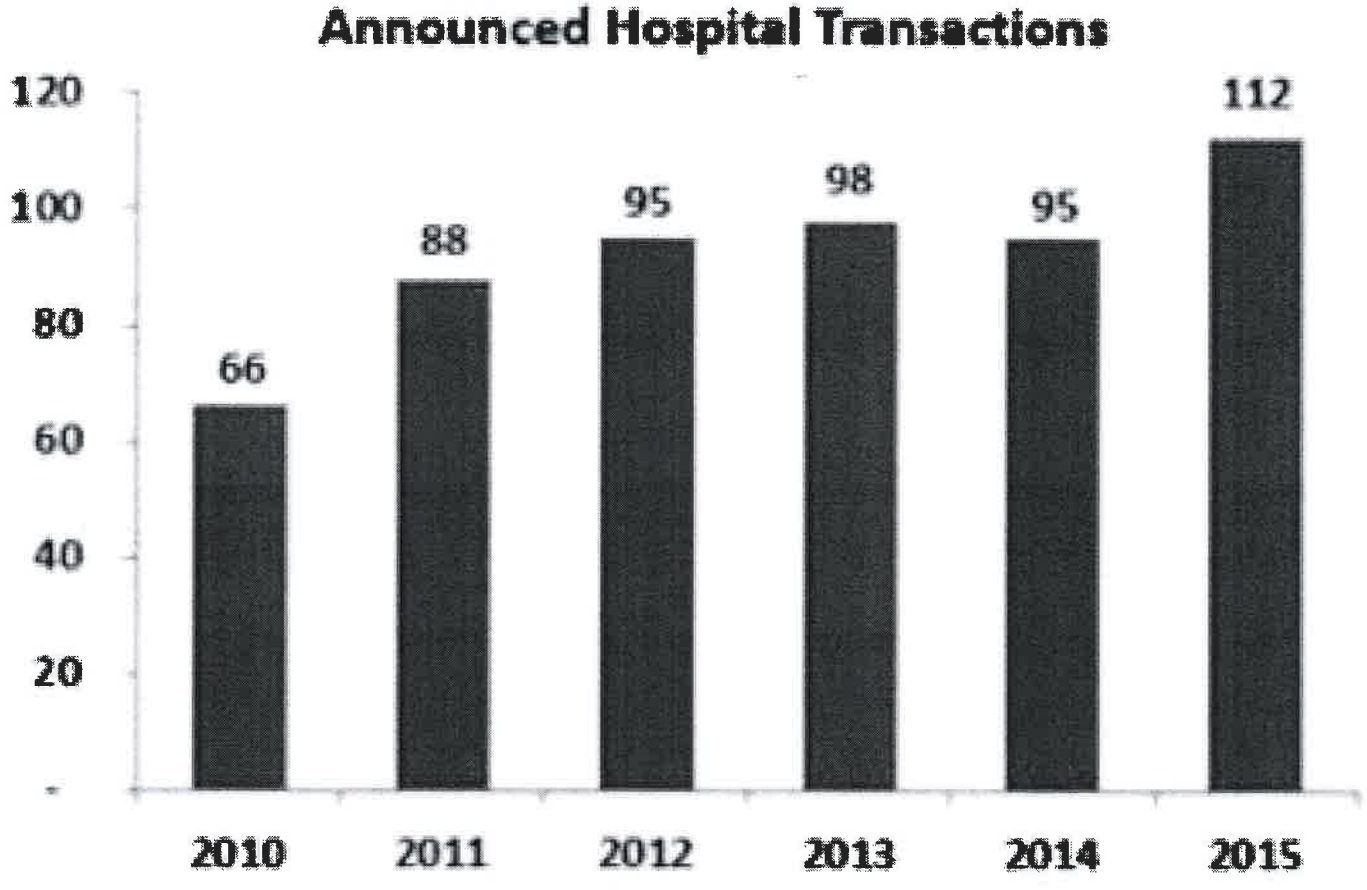
PCMH4: Provide Self-Care Support and Community Resources		Pts
A.	**Support Self-Care Process****	**6**
B.	Provide Referrals to Community Resources	3
		9

PCMH5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	**Referral Tracking and Follow-Up****	**6**
C.	Coordinate with Facilities/Care Transitions	6
		18

PCMH6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	**Implement Continuously Quality Improvement****	**4**
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
		20

****Must Pass Elements**

Health Care Is Consolidating and Integrating



Note: Includes reported combinations of acute-care hospitals in the U.S., including mergers, acquisitions, joint ventures, and member substitutions.