Impact of AHCA on Children’s Hospitals: Preparing for the Road Ahead

by Raphe Schwartz, Mackenzie K. Horne and Anneliese Gerland

The first 105 days of the Trump Administration were an on-again, off-again story of dismantling the Affordable Care Act (ACA). While not a new challenge, the unaffordability of healthcare remains an important issue for consumers, employers and government at both the federal and state levels. Throughout the campaign and early administration, Trump promised to repeal Obamacare, and he is now one step closer after the recent passage of the American Health Care Act (AHCA) by the House. While there are still many unknowns and uncertainties about the next wave of healthcare reform, decreased funding for Medicaid will be a core component.

Throughout the debate these past few months, there has been little discussion about the impact of potential spending cuts and programmatic changes on pediatric care through Medicaid. The underlying premise of the reductions would be to roll back Medicaid expansion and reduce spending on newly insured adults who previously did not have insurance—without any specific eligibility implications for children. However, the sheer magnitude of expected funding cuts, coupled with the shift in responsibility to states that will exhibit variability in how they respond, increase the likelihood of consequences for children who need care.

Children’s Hospitals’ Reliance on Medicaid

For children’s hospitals, which disproportionately serve these children, there are a handful of options for how to react to the likely changes ahead:

In March, the Congressional Budget Office (CBO) estimated that nearly 24 million Americans on Medicaid would lose their insurance by 2026 under AHCA with the federal government reducing outlays to states for Medicaid by $880 billion over the next decade. Underlying this reduction in Medicaid spending are fundamental policy changes.

Survey Asks Healthcare Professionals About Repeal/Replace, ACA and Impact of 2017 Economy

MCON and Healthcare Web Summit jointly sponsored a survey of healthcare professionals on key health care business issues during 2017. The survey asked purchasers (health plans, third-party administrators, agents and pharmacy benefits managers); providers (physicians, pharmacists and hospitals); and vendors/other three questions:

1. Which of the following eight healthcare business trends (see page 7 chart) do you think will have the greatest overall impact for the rest of 2017?

2. Which of these ACA provisions (see charts on pages 7 and 8) do you think will generally survive upcoming repeal/replace measures?

3. Please project who you think the economic winners and losers for 2017 will be. Who do you think will be economically better off, the same or worse off by this time next year—consumers, employers, health plans, hospitals, physicians and/or pharmaceutical?

Types of respondents broke out fairly evenly: 31.7% are providers, 30.2% purchasers and 38.1% vendors/other.

Respondents clearly feel that ACA repeal/replace legislation/executive actions is the healthcare business trend that would have the greatest overall impact in 2017, with 68.3% of stakeholders indicating so. Value-based payment initiatives came in second with 9.5% of the votes. Government funding cuts and increased consumer cost sharing had the third highest number of votes with 6.3% each.

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Although it was treated by many at the time as utterly secondary to the main event, the June, 2012 decision in National Federation of Business (NFB) vs. Sebelius to make optional Medicaid expansion—a centerpiece of “Obamacare”—was a pivot point in American healthcare history. And now that a new administration, either directly or indirectly, is poised to capitalize on it, many fully formed or fledging networks might be in the right place at the right time.

In the NFB case, the U.S. Supreme Court made headlines when it upheld the constitutionality of the individual mandates contained in the Affordable Care Act (ACA) by a slender 5 to 4 majority. But by the same number (and using different players), Chief Justice John Roberts also declared that the expansion of Medicaid was a change to the program—not in scope but in kind—and thus forcing it on states was "coercive," in violation of the spending clause of the U.S. Constitution.

What people may not remember is that the remedy provided by the court for this constitutional problem—to make Medicaid expansion optional—carried the day with a strong majority of seven justices, making it the pronouncement in either Supreme Court case upholding the ACA that had the broadest support on the court.

At the time, the press treated the outcome as an oddity. There seemed to be an agreement of mainstream media thought on one important thing: As long as the federal government paid the full cost of expansion in the first three years and states would never pay more than 10% thereafter (as provided by the ACA), this remedy was a distinction without a difference—Medicaid expansion would be politically and fiscally irresistible to most every state in the union.

Of course, it didn't work out that way. Less than a majority of states took the deal immediately and later, the rest either ignored the opportunity to expand (leaving a sizeable number of their population without either covered care or access to ACA subsidies) or began immediately to consider making a deal with the administration. Today most of the remaining states that did eventually get on board, bringing the expansion state total to 31, did so through negotiating a Section 1115 waiver [which gives the Secretary of Health and Human Services authority to approve experimental, pilot or demonstration projects that promote the objectives of Medicaid and the Children’s Health Insurance Program (CHIP)] through traditional Medicaid rules with a politically weakened Obama Administration, which needed to put points on the board to spread its "coverage-for-everyone" philosophy.

Many of those waivers and waiver requests were significantly different than the minor waivers permitted over the past years of traditional Medicaid, mostly putting risk and consumer choice on the table. And now every state is going to get the opportunity to see just how far those waivers can go by negotiating them with the maestro of the waiver—Seema Verma, the new director of the Centers for Medicare and Medicaid (CMS) and the driving force behind the most far reaching of those waivers in the State of Indiana.

Her way of thinking is consistent with a great deal of Trump and GOP state-oriented regulatory policy, and is certainly central to the core Medicaid tenants embodied in the AHC replacement proposed by the Trump Administration. The AHCA would phase out Medicaid expansion and replace it with options for states to expand Medicaid as they wish but with more limited dollars. The core tenet of both is that states know how to cover their vulnerable population better than the federal government, that the choices Connecticut might make would vary greatly from those made in Mississippi.

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New U.S. Healthcare Plan Might Stir Medicaid Innovation ... continued from page 2

Bill or no bill, top Trump regulators have made it clear that they are open to states seeking waivers from delivering care in the same fashion they have since the passage of the first Medicaid regulations just after enactment in 1965, and that they have a marked preference for block grants, payment and delivery models that encourage what they view as responsible behavior in healthcare delivery and consumption. And that should be good news to fully formed networks—both those doing significant business already and those that are formed and looking for a purpose. The reasoning is that the type of block granting favored generally by the Trump Administration is hard to effectuate without a narrow network partner that can formulate a delivery model meeting quality standards and having the ability to manage risk.

Verma was the driving architect of the Healthy Indiana Plan (HIP), a state-funded program for vulnerable women and children developed under Governor Mitch Daniels. The state adopted it in 2008, two years before the passage of the ACA. The plan offered high-deductible coverage to its 52,000-person, covered population so long as a certain amount was contributed to a health savings account (HSA), motivating smart choices among the head of households but also providing a baseline of coverage for unavoidable, catastrophic events. When the ACA’s expansion option was made available, Indiana—among the reddest of the red states under its new governor and now vice president, Mike Pence—got in line to make a deal: We will expand Medicaid, they said, if you let us do so with a plan just like HIP.

The plan accepted by the Centers for Medicare & Medicaid Services (CMS), which Indiana calls HIP 2.0, takes those concepts to the next level. It permits the collection of up to 2% of recipient income (or up to $320 for an able-bodied individual making $16,000) in “premiums” to help defray the costs of care—otherwise paid for by the federal government—and puts typical managed care practices in place to motivate reasonable economic behavior.

A study produced by Indiana in 2016 found that 90% made their contribution (roughly the same amount that Obamacare subsidy recipients wound up paying for their first premium after signing up for private plans on the exchange) and remained in the program.

In addition, they were more likely to visit their primary care physicians, missed fewer appointments, went to the emergency room less often and took their medication as prescribed. Reports also indicate they chose generic drugs more often and were more likely to seek second opinions—all actions that, if followed by the Medicaid population at large, would likely bring down the overall cost of care.

Verma was a consultant while working for Indiana, and in that capacity she also worked on the waiver requests of Kentucky, Iowa and Ohio, which had even more extensive waiver requests in place before their modified requests were granted. Her bureau is now in a position to also grant the remainder of those requests.

This comes at a time when a Trump Administration proposal to change the ACA substantially has resurfaced, including a proposal to phase out Medicaid expansion and replace it with a per capita funding formulation—rather than just paying for all the passed on costs. It also promotes the use of block grants for states that wish to cover a more expanded population—a single budgeted amount for a state to spend on its covered population as it sees fit.

Because both these programs emphasize budgeting, it seems intuitive that care management will be required as a core component of any successful execution of a program. Provider networks with a sophisticated approach to population health management will be needed to succeed. And that need is likely to be there broadly whether or not legislation passes.

The 19 states that did not adopt Medicaid expansion will be under increased pressure, if an ACA replacement is not passed as they expected, to cover their populations. But because these same states also largely voted for Trump, they will only be able to find the political cover to do so if they institute programs similar to those championed under the proposed Trump legislation or advocated by Trump’s CMS.

In other words, the state of Kansas, an expansion holdout that went for Trump and has generally supported repealing the ACA, might ask for a block grant waiver—rarely given up until now—for Medicaid expansion based on close care management and principles similar to Indiana’s, declare victory and go home. Ironically, even a failure to pass an Obamacare replacement might spur Medicaid expansion, with federal regulators in charge who are quick to grant waivers for innovative programs.

This means network executives should be closely taking the temperature of state officials now that Washington has declared “game on” in Medicaid innovation. Whether the nature of Medicaid funding is changed radically—as proposed by the Trump Administration—or a new health bill fails to pass and Medicaid expansion remains in place overseen by regulators who believe in innovative thinking that might save costs, there will be an important seat at the table for network providers who know how to take risk, change behaviors and provide care in the most efficient manner over a large geographic area. In that way, it might be that real healthcare reform comes not from Washington, but from the trenches where it is delivered.

(This article should not be construed as legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult your own lawyer on any specific legal questions you may have concerning your situation.)


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While Republicans revised the bill to ensure House passage on May 4—although the CBO has not provided revised estimates—the latest version still includes a significant overhaul of Medicaid. Industry estimates suggest that reductions in funding will be substantial. Medicaid is currently viewed as an entitlement with a minimum standard of benefits for poorer Americans to ensure they have access to a range of healthcare services.

With the changes defined in the AHCA, the federal government would provide funding to states based on a per capita cap (or a state option to take a block grant for a period of 10 years), transforming the program and effectively limiting the federal exposure to spending growth. In addition, there would be an increased emphasis on the states’ role and authority on how funding should be spent for Medicaid.

Many states will need to reduce enrollment, benefits or reimbursement rates for children insured through Medicaid. States may or may not pursue explicit changes to children’s eligibility criteria, but any changes in benefits coverage that have the impact of reducing enrollment would result in an immediate impact to children’s health. With anticipated state budget pressures, states also might have to consider payment rate reductions. While a change in rates might maintain child enrollment, many physicians and other providers will limit access for lower paying patients or refuse to see them at all.

Finally, there might be other implications for children’s insurance coverage. Several studies have shown that children of uninsured parents often become uninsured themselves, even if they are eligible for coverage. In 2017, there are two important realities to Medicaid and the Children’s Health Insurance Program (CHIP) funding for children. First, while only approximately one-fifth of Medicaid spending is for children, about half of Medicaid and CHIP enrollees are children, even following Medicaid expansion for lower income adults in many states. In February 2017, 35.9 million of the 74.5 million Medicaid and CHIP enrollees were children.²

![Figure 1: Child Enrollment as a Percentage of Total Medicaid/CHIP Enrollment]

Secondly, Medicaid insures more than half of children’s hospitals’ patients, and this figure has been increasing steadily for nearly a decade.³ The nation’s children’s hospitals have become increasingly dependent on Medicaid as their primary payer. Given these realities, it is nearly certain that a meaningful reduction in Medicaid funding will reduce access, coverage and payments for children’s services.

Responding to AHCA

Assuming there is a federal reduction in funding for Medicaid and that states will not be able to compensate on their own, children’s hospitals will need to respond to anticipated Medicaid reimbursement constraints in one of two ways:

1. Change their patients.
2. Change the care delivery model.

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Change their patients. Children’s hospitals could respond to potential Medicaid funding cuts by seeking more volume—or revenue—from commercially insured children. However, growing commercial market share and reimbursement would be very difficult for many children’s hospitals because they have already expanded their ambulatory and facility networks in their attractive nearby geographies. Many children’s hospitals are already optimizing their commercial market share.

In addition, children’s hospitals could be challenged to raise commercial rates to compensate for Medicaid reductions because many children’s hospital and health plan leaders believe that reimbursement rates are already pushing up against a ceiling. If children’s hospitals raise commercial rates further, it may result in other health systems expanding their pediatric programs to intensify competition with children’s hospitals.

If children’s hospitals have difficulty growing commercial business and income, perhaps they can decrease Medicaid exposure by reducing care for Medicaid insured children. While children’s hospitals could limit Medicaid patients in their pediatrician or specialty physician panels and relocate their ambulatory services from lower to higher income geographic areas to ration Medicaid services, these efforts would defy their missions. Nearly all children’s hospitals have a commitment to serve all children in their service areas, regardless of payer mix. Rationing care for Medicaid insured children might be considered if rate reductions are severe, but clearly it will be a last resort.

Change the care delivery model. Assuming they will not change their patient bases sufficiently to compensate for potential Medicaid reductions, children’s hospitals will need to evolve their care models. There are three mutually reinforcing strategies children’s hospitals should consider to meet the financial realities of the future.

The particular focus and emphasis that children’s hospitals place on each of these three strategies should depend on the unique set of circumstances they face in regard to the competitive landscape, state economics, current cost position and the strategic direction of their organizations.

1. Reduce the cost base. Many children’s hospitals have and continue to focus on optimizing their cost base. Using advanced provider profiling and business intelligence, children’s hospitals will need to further reduce costs by tackling the more challenging drivers of costs, such as:
   - Reducing variability of care across their portfolio of providers.
   - Eliminating unnecessary care and activities, such as less valuable or non-value added diagnostics.
   - Ensuring care team members are operating at the top of their licenses.
   - Shifting care to lower cost settings in collaboration with partners (e.g., Federally Qualified Health Centers) and exploring new care modalities (e.g., virtual care) to offer convenient, accessible care at a lower cost.

2. Implement new care models. Many children’s hospitals have begun piloting new models of care oriented toward managing health. Children’s hospitals will need to accelerate design of these interventions and rapidly implement them to address total cost of care for Medicaid patients. These new models have the potential to sustainably address costs by reducing unnecessary emergency department (ED) visits and patient days.
Across the country, these interventions have been effective for:

- Highly prevalent chronic conditions (e.g., asthma and diabetes).
- Infants who spend significant time in the neonatal intensive care unit
- “Medically complex” children living with multiple, severe health conditions.
- Patients who are living with a combination of mental and physical health conditions.

Inherent in the success of these models is the ability to address the social determinants of health that might account for as much as 80% of health outcomes. While most children’s hospitals are already very connected in the communities they serve, innovative care models must integrate non-clinical resources as key members of the care team. In some instances, new business models and formalization of partnerships might be helpful in providing the appropriately integrated care required to more effectively manage the health of these vulnerable populations.

For example, children that receive sufficient asthma education, have a second inhaler at school with a nurse that is knowledgeable about their condition and live in houses where the vents are cleaned, mold is eliminated and pests are controlled will routinely have fewer ED visits and hospital admissions. Achieving innovative care models requires more than the clinical care team; it requires partnerships with schools and coordination with housing and other social services.

3. **Pursue global budget payment models.** Children’s hospitals will also need to evolve their reimbursement models toward global budget payment models. If children’s hospitals are successful with their new population health models described in the previous section, they will significantly reduce their fee-for-service (FFS) payments. Investing time, effort and resources to achieve population health goals under the current FFS model would result in continued Medicaid losses, just with a lower cost base. To be successful, children’s hospitals also would have to transition to global budget payment models. This is the only way children’s hospitals will be rewarded for their population health achievements and ensure sufficient funding for preventive and ambulatory services.

By assuming responsibility for the health and costs of children, children’s hospitals can better deploy available Medicaid funds to care for children in an ambulatory setting, addressing both clinical and social determinants of health before conditions are exacerbated and require acute care resources. In many markets, this transition will require children’s hospitals to pursue deliberate and concentrated efforts with payers to transition to new payment models.

### Figure 3: Changing Care and Reimbursement Models

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For many children’s hospitals, reimbursement for Medicaid services today does not cover direct cost of care, resulting in a negative contribution margin. If Medicaid spending declines, children’s hospitals will need to sustainably reduce their costs while locking in predictable reimbursement. This will allow them to reduce margin losses even if they receive reduced payments.

As the debate on the next wave of healthcare legislation moves on from the House and into the Senate, significant uncertainty remains. Yet irrespective of the specific changes to come, children’s hospital reimbursement is at risk. Children’s hospitals will have to wrestle with and balance these strategies and interventions to sustain performance and uphold their commitments to serve all children—regardless of income.

3 The Chartis Group Research.

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Survey Asks Healthcare Professionals About Repeal/Replace … continued from page 1

Impact of Healthcare Business Trends

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Although increased consumer cost sharing received only 4.3% of the stakeholder votes in 2013, the voting percentage for this trend rose in 2015 and 2016, more than doubling from (14%) to (31.5%). However, with the ACA repeal dominating the landscape, the percentage of responses dropped significantly this year (6.3%).

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When broken down by stakeholder category, provider, purchasers and vendors/other voted ACA repeal/replace legislation/executive actions as the Most important trend with 70%, 78.9% and 63.6%, respectively.

Repeal/Replace Survival

Accountable Care Organization Development

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Stakeholders rated which ACA provisions they believe will survive repeal/replace measures and gave ACO development the highest odds (48.4%), compared to other choices, while 40.3% feel they might survive, 8.1% say they would not survive and 3.2% are unsure. Broken down into stakeholder categories, 57.9% of purchasers, 45.8% vendor/other and 42.1% of providers agree that ACO development will survive.

As many as 85.2% of respondents say EHR development – Meaningful Use will or might survive, Vendors are the most optimistic with 83.3% holding onto survival. Health insurance guaranteed issue/elimination of pre-existing conditions got the nod from 81.7%, who expect it to survive or has a chance to survive.

Extension of dependent care coverage is expected to remain, according to respondents (74.6%).

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Survey Asks Healthcare Professionals About Repeal/Replace … continued from page 7

Federal Healthcare.gov Health Insurance Exchange

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Health Insurance Guaranteed Issue/Elimination of Pre-Existing Conditions

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The 2017 Economy

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Health Plans

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Hospitals

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Physicians

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Both health plan loss ratio regulation and state health insurance exchange options generated about a 54% chance of survival for each. Respondents are not so sure about the expansion of Medicaid coverage with 49.2% believing it will go away while 41% saying it will survive.

At the other end of the spectrum, mandated coverage provisions for businesses and individuals was given the lowest odds of surviving, with 68.3% stating it would not survive, and only 6.3% feeling it would. The next lowest chance of surviving was for the Federal Healthcare.gov Health Insurance Exchange, with 58.1% of the stakeholders stating it will not survive, and only 3.2% stating that it will survive.

When stakeholders were asked who they believe will be economically better off, the same or worse off by this time next year, stakeholders point to health plans as the winners (38.1%); however, an equal number of respondents say insurers will be worse off. Only 26.3% of purchasers chose plans as an option.

Based on responses, consumers are expected to be hardest hit in 2017, with as many as 58.7% saying they will be worse off. Stakeholders expect the pharmaceutical industry to be better off (29.5%), but more believe it will be worse off (39.3%).

Physicians appear to be the least affected by changes in the healthcare industry; 61.3% of respondents say their status will remain the same.

Both employers and hospitals have an equal chance of remaining the same due to the economy or becoming worse off (39.7%) and 41.3%), respectively.

Mari Edlin serves as editor of Accountable Care News. She invites you to submit bylined articles on accountable care issues and case studies illustrating successes with the model. She can be reached at MLEdlin@comcast.net.
thought leaders’ corner

each month, accountable care news asks a panel of industry experts to discuss a topic suggested by a subscriber.

q. will medicaid acos get off the ground?

yes, although this response is more complex than a simple “thumbs up” or “thumbs down.”

an aco framework is a wonderful way for participating providers to work together to meet the different needs of regional medicaid populations (say, rural indiana compared to downtown brooklyn). for example, as the importance of social determinants of healthcare, such as avoiding emergency room visits and readmissions, becomes more appreciated and understood, acos can adapt and grow to include additional resources.

in fact, many believe that failure is not an option. we need to keep improving our approach to patients who need medical assistance until we find workable solutions.

if the leadership team of a medicaid aco can be created to address the particular problems of a target population with adaptive strategies, success is possible. because there is no greater pressure on healthcare systems to be effective and efficient than in medicaid settings, innovation and adaptation will be cornerstones.

major efforts to use multi-level provider teams (e.g., advanced practice nurses); coordinate social services and social agencies in addition to traditional healthcare providers; and introduce better proactive disease management strategies for the chronically ill are just some of the new ways to address the perennial problems of low reimbursement rates and non-compliant patients. finally, information technology that shares critical patient information across the spectrum of care activity will also be an essential part of a solution.

Doug Moeller, M.D.
Medical Director
Change Healthcare
King of Prussia, Pa.

as many as 21 states could have medicaid acos by the end of this year. and if these programs are anything like the medicare acos they are modeled after, they are destined to fail before they even start.

acos were supposed to improve the experience of care and the health of populations, while reducing per capita costs of healthcare. but medicare acos have failed on all three fronts.

Take the care that individual patients receive. A sample of patient satisfaction scores collected by the Centers for Medicare & Medicaid Services in 2014 revealed that less than half of the acos scored at the 70th percentile or above.

Doctors seem to be equally unimpressed by medicare acos. A recent health affairs article reports that less than half of physicians participating in the medicare shared savings program—the largest medicare aco—says that acos are effective models for offering high-quality or cost-effective care for patients.¹

Medicare acos have also failed to improve the health of communities and cut overall costs. Only 32% of facilities have adequate resources to meet the challenge of improving community health.² And less than 30% of physicians say that the tools and resources provided by acos reduce the costs for care management.

If states don’t walk away from medicaid acos now, they will only face the same meager results that medicare acos have.


Sally Pipes
President/CEO
Pacific Research Institute
San Francisco, Calif.
The goal of ACOs is to shift from fee-for-service to integrated care. ACOs place financial responsibility on providers in hopes of improving care management and limiting unnecessary expenditures. ACO participants have an opportunity to share in savings if their assigned patient population uses less expensive healthcare resources.

On balance, ACO providers share the risk of providing more costly services, in which case they would have to reimburse a state for overruns. Significant challenges confront ACOs; for starters, a robust electronic health record (EHR) system that is capable of advanced reporting, disease registries and patient population care management is a must.

Unlike Medicare, which is solely a federal program, Medicaid is a joint federal/state program. Each state operates its own Medicaid system and must conform to federal guidelines in order for the state to receive matching funds and grants. Medicaid funding has become a major budgetary issue because on average, it consumes about 17% of state budgets. If the federal match expenditure is included, the program, on average, takes up 22% of each state's budget.

While Medicaid ACOs are a new phenomenon, some state programs (Colorado, Minnesota, Oregon, Vermont) have shown promising results using metrics, such as decreased emergency room visits, hospital admissions and general overall cost savings. Currently, 10 states have active Medicaid ACO programs, and at least 11 more are pursuing them. These early efforts demonstrate the value of linking physician reimbursement to patient outcomes and cost savings (value) rather than the volume, as in the traditional fee-for-service model.

Jose Almeida, M.D.
Endovascular Surgeon
Founder
Miami Vein Center and International Vein Congress
Miami, Fla.

CPSI Reports Strong Interest in Rural ACO Program

MOBILE, Ala.—(Business Wire)—CPSI, a community healthcare solutions company, has chosen its first round of charter members for the CPSI Rural Accountable Care Organization (ACO) Program. CPSI is bringing its leadership and experience to the value-based care arena through a strategic partnership with Caravan Health, a leader in rural ACOs and value-based payments. More than 50 healthcare facilities have signed letters of intent to be the first members of the CPSI Rural ACO Program, while more than 100 other facilities have expressed interest.

“We believe this program will help small, rural communities in their drive to manage the health of their populations through value-based care,” says Boyd Douglas, president/CEO of CPSI. “By working together, CPSI and Caravan Health are helping to remove the barriers rural providers face in participating in an ACO. We are minimizing upfront costs while providing the tailored tools and training needed to transform healthcare delivery in their communities.”

“This program is a great opportunity for rural providers to transition to value-based care with minimal risk," says Lynn Barr, CEO of Caravan Health. Barr adds that Caravan Health was able to achieve shared savings that were 257% greater than the national average based on 2015 Centers for Medicare & Medicaid Services data.

Primaria Health Expands Network of Primary Care Physicians

INDIANAPOLIS—(Business Wire)—Primaria Health, a primary care management services organization, has expanded its network of primary care physicians (PCPs) to become the largest in Central Indiana. It also formed a Medicare ACO to expand its portfolio of value-based, reimbursement contracts offered to physicians. In addition to contract access, Primaria provides physicians with data, clinical care models and resources to enable them to improve patient outcomes and patient satisfaction, lower the total cost of care and perform successfully in the new value-based, reimbursement environment.

“Primaria’s rapid growth is demonstrated by the desire of primary care physicians to adopt an enhanced delivery model that offers high-quality, coordinated care and personalized services that extend beyond the exam room, which ultimately improves care delivery, the patient experience and total cost of care," says Doug Stratton, chief executive officer, Primaria.

In the past year, Primaria has grown the number of patients under its model to 130,000 and added more independent physicians to its network, which now totals more than 375 PCPs.
A practice in Arkansas reached out to a patient and encouraged him to come in for an AWV. During the visit, the primary care physician determined that the patient had a significant risk of falling. The ACO installed a handrail at the patient’s home, which prevented a serious injury and possibly even a hospitalization.

The most common refrain we hear from our doctors is: “Show me the rules of the road, help me take the wheel and let me focus on keeping my patients healthy.” Most of the time, that’s how you get a successful ACO.

**Accountable Care News:** How does Aledade support physicians in their mission to form an ACO? What part does health information technology play?

**Mat Kendall:** I’m a huge fan of the world-changing power of health IT. Previously, while in New York, my job was to help more than 1,500 primary care doctors in underserved areas get connected to electronic health records (EHRs). Health IT can make measurable differences in the lives of patients, keeping them from unnecessary visits to the ER or easing their transitions from a hospital stay. And, a key part of our ACOs’ success comes from the technology platform Aledade provides.

But for me, health IT is just a means, not an end, to better health and better care. Much of my work here at Aledade involves visiting hundreds of primary care practices around the country and explaining our partnership ACO model and how we help doctors navigate the changing landscape of healthcare. Through them, we see how health IT augments a doctor’s work, but by no means replaces it.

Let me illustrate this using a little story. Let’s say an accident happens on a farm. A man is taken to the nearest hospital, a tiny critical access hospital, the only urgent care facility in the area. The medical team stabilizes the patient and then sends him by helicopter to the nearest tertiary care hospital.

If you’re that man’s primary care doctor, you might not even find out that your patient had been hospitalized until days or weeks later. With admission discharge transfer data that Aledade has in our app, not only do you know that your patient has been hospitalized, you also know when to reach out to him once he leaves a hospital. And that first phone call a patient gets right after they get home from the hospital can dramatically reduce the chance they are readmitted to the hospital.

That’s the power of effective health IT.

**Accountable Care News:** What have you found to be the primary challenges of forming and sustaining an ACO?

**Mat Kendall:** Healthcare is local so the challenges are usually different for each ACO, but we’ve seen some common threads.

In fact, Donald Fisher and Chet Speed from the American Medical Group Association did a recent survey of primary care doctors1 and saw some of the same things we’ve heard. First, it’s often tough for practices to get the right data at the right time. Secondly, some providers worry that commercial payers aren’t moving as aggressively toward value-based payments—especially in their local markets. And finally, reporting requirements are still too burdensome.

There are also some deeper policy challenges. CMS could help adjust the way it calculates whether an ACO achieves savings so that ACOs don’t get penalized for serving in a high-need and thereby, a high-cost, area. CMS could set up “stop-loss” so that smaller practices can take two-sided risk—for which there can be greater savings, as well as losses—without risking so much loss that they could doom their practice.

If you’re a small practice, it can also be challenging to get started. You might lack the technology to track your patient population and identify the highest risk patients. You might not have regulatory expertise or familiarity with the quality measures you’d need to report.

But it always comes back to the doctors. The best sustaining force in an ACO is the physicians and the team they have behind them.

That same survey by Fisher and Speed2 also found this fact: In practices with 1,000 or more employees, a solid majority was ready to take a risk with value-based payment; in practices with fewer than 50 employees, 86% percent were ready for the value-based future.2 The obstacles we might see today don’t stand a chance against that level of commitment.

**Accountable Care News:** What do you see as the future of ACOs in today’s healthcare environment?

**Mat Kendall:** The stars are aligned, and the course is set. ACOs are a key part of the future of healthcare—where the care you get is based on value, not volume. But as we say around the office almost every day, our work has just begun.

If you look around healthcare today, you see some promising signs. The ACO program is growing in leaps and bounds. Commercial payers are jumping into this model. Through Aledade, we’ve brought in about 70,000 covered lives in our commercial contracts alone. And while a lot of people are focused on a partisan debate about the future of healthcare, a massively bipartisan health reform bill passed in 2015 called MACRA, and advanced alternative payment models such as ACOs are an essential part of that.

And here’s where we think that future leads—to a place where independent primary care doctors can redesign their practices and reimagine their futures; a place where primary care is finally back in control of healthcare, using cutting-edge data analytics and technology tools; a place that will finally reward hardworking healthcare professionals for the value that they uniquely can bring—in coordinating care, managing chronic diseases and preventing disease and suffering. In six words: lower costs, better care, better health.


2 Ibid.
Catching Up With ….

Mat Kendall is the cofounder and executive vice president of provider networks at Aledade, a Series B start-up that provides independent physicians nationwide the tools and support they need to form and operate accountable care organizations (ACOs). He has developed a network of independent primary care providers, covering more than 240,000 lives who participate in new payment models through the Medicare Shared Savings Program and commercial contracts. Mat also supports the development of technology and analytics that assist providers in proactively managing their patient populations.

The impetus of founding Aledade was, to put it simply, this particular moment in time. Healthcare in America is at a juncture where opportunity and pressures are meeting. Doctors know the shift towards value-based care has arrived, and it’s accelerating across both the private and public payer markets. Many of them are eager to lead the way and take advantage of the opportunities value-based care offers.

They know that this is good for doctors who want to practice the best medicine possible, the way they always wanted to. They know it’s good for their patients, who get to see their trusted primary care doctors with additional incentives and support to keep them healthy. And they know it’s good for the country as higher quality, lower cost care will help lessen the strain on our budget and our economy.

But today, doctors face some unique pressures. I worked with rural practices when I served at HHS—small independent care practices, Federally Qualified Health Centers, rural health centers and many more so I’ve seen and heard it firsthand. Financial strains and anticompetitive practices are forcing many independent practices to cut back or look toward joining bigger hospital systems. Many are worried they lack the technological, regulatory and financial expertise to succeed in this brave new world.

That’s where an organization such as Aledade can play a huge role. We partner with independent primary care physicians to make it easy and inexpensive for them to form and join ACOs. Our goal is to make sure doctors get paid to practice medicine the way they want, which often requires innovative technology, as well as support from people on the ground working side by side with practices.

Accountable Care News: What was the impetus behind founding an organization that offers the services that Aledade does?

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Accountable Care News: What does it take to be a successful ACO?

Mat Kendall: It depends on how you measure success, of course. For example, our ACOs in their first year decreased 30-day, all-cause readmissions by 13% and 15%, compared with national benchmarks. Rates of emergency department visits that led to hospitalizations also fell by 5% and 4% in our first two ACOs.

The question is: how do you get there? The first steps are often, as we like to say, mind-bogglingly common sense. The most successful ACOs we’ve seen start with two things: knowing their patients and building relationships with those patients.

There are tried-and-true tactics you can build to complement those two principles. You can employ annual wellness visits (AWV), which offer an easy way to identify and connect with your highest risk patients. You can bring a care manager on staff to help reach out to patients during transitions in care, keep track of referrals and make sure patients with chronic conditions are getting the support they need.

Here’s an example of what success looks like: A practice in Delaware prevented four unnecessary emergency room (ER) visits in one week—simply by offering patients same-day visits.

To help prevent hospital readmissions, a practice in Maryland has been ensuring that patients who visit an ER are seen in the practice the next day.

(continued on page 11)