Healthcare Reform

GPO Role

November 15, 2013
“Changes aren’t Permanent, But Change Is”

Geddy Lee, Rush, Tom Sawyer
Drastic Situations Require Changes
Healthcare Landscape

History to Date
WAITING ROOM

HEALTH CARE REFORM

BEEN HERE LONG?

2009 OBAMA PLAN

1993 CLINTON PLAN

Source: Handelsman, Newsday; June 16, 2009
Elements of Reform

- Losing 7.2% on Medicare Cases, losing 14% on Medicaid*, **
  - Medicare Reimbursement rates declining**
  - Increasing Medicare & Medicaid population.
  - Value Based Purchasing – quality performance = reimbursement

- Hospitals will Never Be Paid as Well as They are Today

- Fee for Service versus Fee for Volume
  - Rewards chasing revenue, not margin/quality
  - Capitation payment encourages less volume
  - Evidence Based Care Plans are needed. Remove waste

- Care Silos Dismantled
  - Physicians, hospitals, other providers not aligned (incentives)
  - Coordination lacking inside/outside walls of hospital
  - EMR Adoption/MU requires new processes**

- Chronic Disease Patient Volume Management
  - Rapid increase in patients with multiple chronic diseases (CHF, COPD, Diabetes); 133M Americans have a chronic disease***
  - 5% patients = 55% of admissions, care at Medicare rates
  - Health Plans shift risk to provider. Bundled care, ACO.

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*Source: Modern HC 6-29-09, pg 16 MEDPAC. FierceHealthFinance, 12-15-09 **ObamaCare Impact this for Primary care Physicians. 1 – Appropriate Tort Reform when practice pattern reflects standard. ***CDC 2005 Chronic Disease Prevention and Health Promotion Report.
Legislation Timeline

2013
- Medicare Bundled Payment Demonstration Project begins
- Medicaid Primary Care Payment = 100% of Medicare Payment
- Readmission Penalty 1% for AMI, Pneumonia, and CHF

2014
- Independent Payment Advisory Board submits first recommendation
- Medicare DSH payments reduced by 75% & modified based on uninsured and uncompensated care
- Medicaid to 133% FPL
- Readmission Penalty 2% for AMI, Pneumonia, and CHF

2015
- Reduce Medicare Payments for Hospital Acquired Conditions by 1%
- Readmission Penalty 3% for AMI, Pneumonia, and CHF + two additional conditions (COPD)
HealthCare Reform

Certainty of Health Care Reform

• Forcing Innovation
• Acquisition Cost is not as relevant
• Total cost of care is now focus
• Utilization of resources is key
• Survivors will be able to communicate value in terms of quality and cost
Hospitals are no longer the center piece of healthcare
GPO Role

- No longer a conduit to lower pricing through Quantity purchases
- Must focus on value of products to clinical outcomes rather than continued cost reductions.
- New Contracting Strategy
New Contracting Strategy

• Products, Services, Devices, and agents
• Alter the Cost, Length, and Venue of care
• Customers that can drive clinically appropriate utilization
• Customers that have aligned ACO incentives
• Where appropriate work to define appropriate utilization
• Contract to incent these customers to utilize at clinically appropriate rate that medical evidence suggests will alter cost, length or venue of care
Key Components

• Define Participants
  - Significant utilization or need for relevant product
  - Aligned incentives across providers and facilities
  - Ability to drive utilization

• Outcome based requirements
  - Evidence driven utilization requirements designed to achieve product benefit
  - Example outcomes – LOS, readmissions, ICU stay, ventilator days, pressure ulcers, mortality, falls, all cause admissions, direct relational admissions, ancillary product or service use, venue of care, or cost of care
Key Components

• Incentive
  - Financial or otherwise
  - Used to break down the silo budget mentality

• Tracking
  - Consistently measureable
  - Easily measureable
  - Timely access to data
  - Quantifiable impact