Volume 12, Issue 3

Payers & Providers California Edition is published every Thursday. An annual individual subscription is $119 a year (Bulk pricing: $219 for up to 5 sub-scribers; $319 for 6-10 subscribers). It is delivered by e-mail as a PDF attach-ment, or as an electronic newsletter.

Editorial inquiries:
editor@payersandproviders.com

Advertising Inquiries:
clairet@mcol.com
503-226-9850

Subscription and Administrative Inquiries:
mcare@mcol.com
209-577-4888

Mailing Address:
1101 Standiford Ave, Suite C3,
Modesto, CA 95350

Website
www.payersandproviders.com

Twitter
www.twitter.com/payersproviders

Despite Threats To ACA, It's Time To Plan For Long-Term

Health Plans Need to Focus on Stabilizing Provider Networks

The Affordable Care Act (ACA) has survived for a decade despite Congressional attempts to repeal it, executive orders to weaken it, and some Democratic Presidential candidates proposing to upend it in favor of a single-payer system.

Despite the political rhetoric and executive actions, participating ACA individual insurers experienced a highly profitable 2019. This resulted in the requirement to issue at least $743 million of excess premium rebates to individuals who make up the 2.7 million ACA customers. About 8.3 million people signed up for ACA coverage for 2020, holding mostly steady from 2019, and premium costs for most ACA products have slightly declined in 2020.

While enrollment has declined slightly, the positive profit numbers have some individual insurers appearing to be more optimistic about the ACA in 2020. Insurer participation on the ACA Marketplaces will increase in 2020, with an average of 4.5 insurers participating per state, up from 4.0 in 2019. Medicaid managed care organizations MCOs), which filled the gaps in 2018 left behind by major payers, continued to extend their reach in the federal health insurance marketplace. Specifically, **Centene**, **Oscar**, and **Bright Health** plan major expansions. The Blue Cross Blue Shield plans, **Cigna**, and **Anthem** have also staked out new areas to offer ACA health plans.

By Allen Miller and Cindy Ehnes

As individual enrollment through the marketplace stabilizes, the price sensitivity and historic health characteristics of enrollees in the individual market challenge insurers to create strong networks of high-impact healthcare providers. The number of Americans insured under a narrow network plan is likely to increase, as enrollees sacrifice provider choice for cost savings. While the ACA market has become more sustainable (at least in the short term) for participating insurers and consumers, excluded hospitals and medical groups/IPAs could lose a small to large portion of their individual or Medicaid patient population. Further, narrow networks threaten to exclude teaching hospitals, specialized care hospitals and small rural hospitals in areas dominated by a single insurer.

Payers in the individual market especially confront the challenge of identifying health systems and physicians capable of performing well under value-based care contracts that coordinate team-based, cost conscious care. These arrangements call for strong alignment and creative partnership between health plans, health systems and medical providers. Co-opetition will be key for both payers and providers, perhaps the deciding factor between successful and unsuccessful players.

Success will depend on both the providers and the health plans selecting partners to grow market share, reduce both medical and administrative cost and improve quality together. Health systems, medical groups and IPAs must be ready to negotiate value-based payment agreements with health plans. They must bring internal capabilities in population health management and closing quality care gaps to improve their value in collaborating with ACA insurers. To enable a mutually successful negotiation season, consider these best practices:

- **Do not look at the ACA marketplace population in a silo**. Align your ACA marketplace strategy with your value-based payment and population health management strategies, including your employee health plan is you're self-insured, Commercial Managed Care, Managed Medicaid, Medicare Advantage, possibly Medicare Direct Contracting (as the program takes shape) and any other managed care lines of business.
- **Evaluate what will make a good health plan partner for longer-term contracting.** Cultural fit, value-based payment and population health management capabilities, willingness to delegate care management and other key administrative functions, and financial strength are all critical factors in a successful partner-ship. Hospitals, health systems and medical groups should assess the strategic and cultural alignment, as well as tangible benefits the health plan provide after a risk agreement is in place.
- **Understand the federal and applicable state network ade-quacy requirements to under-stand potential network gaps.** For a health insurer to offer a plan on the Marketplace, the plan must be certified as a Qualified Health Plan ("QHP"). A QHP must meet the network adequacy standards of the exchange on which the plan is offered. While the federal standards and many state standards are vague (e.g., *"Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."*) some states, such as California, have expanded access requirements beyond the federal standards.
- **Strongly consider transitioning to value-based, coordinated care (VBP) contracting to improve patient satisfaction, overall quality, and profitability.** For medical groups, hospitals and health systems, VBP brings more opportunities to earn revenue for performing well on both quality metrics and reductions in total cost of care (medical loss ratio or MLR). Under risk arrangements and by proactively coordinating care, health systems can increase patient engagement, reduce avoidable hospital utilization, increase quality outcomes and increase profitability. Look for opportunities for clinical redesign, such as e-consult and co-management by high performing specialists with primary care.

(continued on page 5)

Santa Clara County Health Authority
Enrollment and Utilization Table as of 9/30/2019

QUARTERLY STATEMENT AS OF September 30, 2019 - Santa Clara County Health Authority

ENROLLMENT AND UTILIZATION TABLE

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Source of Enroll	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Grandfathered Enrollees (also included in Column 5)	Cumulative Enrollee Months for Period	Total Member Ambulatory Encounters for Period - Physicians	Total Member Ambulatory Encounters for Period - Non-Physicians	Total Member Ambulatory Encounters for Period	Total Patient Days Incurred	Annualized Hospital Days/1000	Average Length of Stay
1.	Large Group Commercial				0					0		0	
2.	Medicare Risk	8,022	172	0	8,194		24,404			0		0	
3.	Medicare Supplement				0					0		0	
4.	Medi-Cal Risk	237,697	0	3,219	234,478		706,445	98,062	12,593	110,655	20,951	356	3.00
5.	Individual				0					0		0	
6.	Point of Service - Individual				0					0		0	
7.	Point of Service - Small Group				0					0		0	
8.	Point of Service - Large Group				0					0		0	
9.	Small Group Commercial				0					0		0	
10.	Healthy Families				0					0		0	
11.	AIM				0					0		0	
12.	Medicare Cost				0					0		0	
13.	ASO				0		N/A	N/A	N/A	0	N/A	N/A	N/A
14.	PPO Individual				0					0		0	
15.	PPO Small Group				0					0		0	
16.	PPO Large Group				0					0		0	
17.	Aggregate Contracted from Other Plans	0	0	0	0		0	0	0	0	0	N/A	N/A
18.	Aggregate Other Source of Enrollment	0	0	0	0		0	0	0	0	0	N/A	N/A
19.	Total Membersh	245,719	172	3,219	242,672	0	730,849	98,062	12,593	110,655	20,951	N/A	N/A

Source: Quarterly Statement 9/30/2019 Santa Clara Health Authority, Enrollment and Utilization Table

Despite Threats To ACA, It's Time To Plan For Long-Term …*continued from page 4*

- **Integrate quality and total cost of care metrics across care delivery "enterprises" to focus on clinical outcomes, patient/member experience and accessibility of services.** As more payments are shifting to VBP arrangements, integrated delivery systems and health plans have significant revenue and membership tied to quality performance on key metrics – necessitating specialized resources and optimal coordination to manage credibly and effectively.
- **Determine the optimal "in-network" set of providers, including but not limited to, facility, physician, skilled nursing and other providers, behavioral health and other community-based organizations (CBO) configuration for each VBP arrangement.** To maximize opportunity to "repatriate" from current out-of-network providers, examine issues related to "leakage" to ambulatory care centers, with particular focus on physician-owned facilities.
- **Leverage data to identify the highest performing specialists in order to better manage referrals, total cost of care and network leakage.** Using validated and shared cost (including current data from payers) and quality data, rank system specialists per specialty by performance and make it easier to access these specialists for high panel primary care providers (PCPs) across the network, including federally qualified health centers (FQHCs).
- **Empanel like-minded PCPs, including hospitalists, to keep business within your defined optimal network.** Align physician compensation to incentivize performance based on credible individual physician data for their VBP attributed panels.
- **Explore FQHC look-alike clinic development, as well as improved alignment and coordination with existing local FQHCs**. Based on population mix and likely "churning" of lower-income patients on and off ACA coverage and into Medicaid, community clinics can help to align coordinated care with optimized "wrap-around" supplemental reimbursement.
- **Depending on your population, you will need to go beyond the traditional post-acute network and develop high performing community and home care, including hospital at home and hospice strategies.** The care model should be one in which care is accessible at the lowest level of acuity necessary and with home and community- based options in order to avoid hospitalization or skilled nursing facility admission when unnecessary.

To optimally serve enrollees in the individual market, payers should work alongside providers to create meaningful relationships that enhance the value-based contracting process and adoption of required capabilities and processes. "Co-opetition" is crucial for sustainable results and lasting partnerships in the ACA individual marketplace, along with other managed care lines of business.

Allen Miller and Cindy Ehnes are Principals at COPE Health Solutions in Los Angeles. Mr. Miller can be reached amiller@copehealthsolutions.com. Ms. Ehnes can be reached cehnes@copehealthsolutions.com.