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Plymouth, Minn.

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March 6-7

AHIP National Policy Forum
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June 11-13

Ohio Hospital Association
97th Annual Meeting
Hilton Columbus at Easton
Columbus, Ohio.

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the details of your event, or call
(877) 248-2360, ext. 3. It will be
published in the Calendar section,
space permitting.

Wyden and Ryan Pitch Medicare Fix *Former Program Heads Share Their Perspectives*

"I like it."
"My first reaction is caution."
"It's morally outrageous!"

Those are responses from three different people to the healthcare bombshell dropped in Congress last Thursday by a pair of policy wonks (or legislative provocateurs, depending on your point of view) who are trying to keep Medicare a going concern without bankrupting the federal government.

Democratic Sen. **Ron Wyden** of Oregon, a longtime deep-thinker on healthcare, teamed up last week with Republican Rep. **Paul Ryan** of Wisconsin, the House budget committee chairman, to unveil a bipartisan approach to reforming Medicare that caught party faithful on both sides of the aisle by surprise.

The concept behind the Wyden-Ryan proposal is to use competitive bidding to depress cost growth. Seniors would receive a voucher (sometimes referred to as premium support) to buy the health plan of their choosing on the

open market. The voucher would be worth the price of the second-least expensive plan in the local market. Premiums higher than that would be paid by the beneficiaries themselves. People would be allowed to stay in the present defined-benefit Medicare program if they chose. The plan would limit the growth of Medicare spending to nominal GDP growth +1%, although it's not clear how this cap would be enforced.

"Is Ron Wyden trying to elect **Mitt Romney**?" asked a blogger for *The Nation* magazine, a liberal publication. A conservative blogger wrote that "Ryan's timing and the nature of this plan will be viewed as a walk-back, one that weakens the hands of Republicans going into the presidential (election)."

All well and good in an election year, but what do Medicare's actual administrators think of the proposal? The three people quoted at the top of this article -- **Gail R. Wilensky**, **Don Berwick**, M.D., and **Bruce C. Vladeck** -- have each had a turn piloting the vast



Gail R. Wilensky
Former Medicare
Administrator

Continued on Next Page

Friday, January 20, 2012

Noon CST

C-Suite Hospital Compensation: How Much Is Too Much?

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In Brief

Permits for 2 New Hospitals Denied by Illinois CON Panel

The Illinois Certificate of Need panel definitively turned down two separate hospital projects in Chicago's far northwestern suburbs, citing a lack of need for either institution.

Mercy Alliance, based in Janesville, Wis., was denied permission to build a 70-bed hospital in Crystal Lake, at a cost of \$200 million. **Centegra Health System**, based in nearby McHenry, was told it could not build a 128-bed hospital in Huntley, for \$233 million.

The **Illinois Health Facilities and Services Review Board** had signaled in June it would probably vote no on both proposals. (*Payers & Providers*, June 28 and July 12).

The CON committee's staff reported an absence of need for the new beds, saying that six hospitals within less than an hour's drive were operating at less than capacity for surgery, obstetric, and intensive-care services. Building a new hospital "may result in an unnecessary duplication of service," the staff report concluded.

Hospitals in the area, including **Sherman Hospital** in Elgin and **Advocate Good Shepherd** in Barrington, had lobbied against the new construction.

Iowa Medical Society CEO Will Head Ohio Hospital Lobby

The **Ohio Hospital Association** has reached across the Midwest to find a new chief executive officer. **Mike Abrams**, executive vice president and CEO of the **Iowa Medical Society**, will take office in the Buckeye State in February.

Continued on Page 3

Wyden-Ryan Plan (Continued from Page One)

entitlement program.

Wilensky was administrator of what was then called the **Health Care Financing Administration** from 1990 to 1992, under the administration of President George H.W. Bush. Vladeck ran the agency for President **Bill Clinton**, from 1993 to 1997. And Berwick just stepped aside on Dec. 2 as administrator of the renamed **Centers for Medicare and Medicaid Services**, having served for 17 months as a recess appointment by President **Barack Obama**.

Although they are, respectively, a Republican and two Democrats, they offer a less politicized perspective, one rooted in a deep knowledge of the program's strengths and deficiencies, financial and operational challenges.

Payers & Providers interviewed the three of them on Thursday and Friday, just after the Wyden-Ryan plan had been released and before any of them had had an opportunity to study its details or think about it in any depth.

The concept behind the Wyden-Ryan proposal is to use competitive bidding to depress cost growth. Seniors would receive a voucher (sometimes referred to as premium support) to buy the health plan of their choosing on the open market. The voucher would be worth the price of the second-least expensive plan in the local market. Premiums higher than that would be paid by the beneficiaries themselves. People would be allowed to stay in the present defined-benefit Medicare program if they chose. The plan would limit the growth of Medicare spending to nominal GDP growth +1%. It's not clear how this cap would be enforced.

The new proposal marks an about-face by Ryan, whose original Medicare reform plan from last year has become a whipping post for politicians of both parties. Ryan proposed replacing the Medicare entitlement with a voucher for seniors to buy their own plan, but at a limited amount that put them at greater financial risk.

The Democrats planned to use it to campaign against the Republicans, and presidential candidate **Newt Gingrich** called it "right-wing social engineering."

Wilensky thinks the new proposal deflects the use of Medicare as a political whipping block. "The best part of it is, bipartisanship isn't necessarily dead," she said. "It recognizes we need more choices, we need to take care of the people who are already in existing Medicare. It's terrific that the two of them were willing in this most partisan time, to say, there are ways to get this done. I like it."

In some ways, Wilensky may be the intellectual godmother of the Wyden-Ryan plan. The proposal bears a resemblance to some suggestions she outlined in the May 19, 2011, issue of the *New England Journal of Medicine*: "Reforming Medicare—Toward a Modified Ryan Plan." Her three suggestions for modifying Ryan's original privatization proposal – allow a greater rate of cost increase, up to 1%; make the subsidy rich enough to purchase at least one health plan in each region; and let seniors continue to choose traditional Medicare – all appear as hallmark pieces of the new bipartisan plan.

Berwick, however, was deeply cautious about the implications of the new proposal. "There are so many ways to shift costs back to beneficiaries, including people who are not able to bear those costs," he said. "You have to be very careful with that dynamic."

His second concern is how insurance companies will behave. Wyden and Ryan "basically put the private sector insurance companies and Medicare in direct competition through this exchange mechanism. Does this reopen the opportunity for selective enrollment and gaming the private market insurance side? There are all kinds of ways for the insurance companies to cover only the people who will be low cost."

The **Department of Health and Human Services** right now is struggling how to define the medical loss ratio for purposes of the ACA. Insurers of large groups must spend at least 85% of premium revenue on medical care, and insurers of small groups and individuals must hit 80% under the new law. Insurance companies are pushing for a lower rate, or more liberal definitions of what may be considered medical costs, while consumer groups are lobbying for a higher MLR.

"By that measure Medicare is an extremely efficient system," Berwick pointed out. "The MLR would be well over 90%, whereas the insurance companies have trouble swallowing 80%." Under a consumer choice approach to Medicare, "You'd incur marketing and other costs that would raise the MLR for Medicare."

For Vladeck, the analysis is "very simple": If the goal is to cap the federal liability for the Medicare program, there are two ways to do it: You can keep the financial risk with the federal government, where it now is, "which means government has to figure out how to run the program with a budget constraint."

Or you can shift the risk to beneficiaries.

"To me that's outrageous. It's morally outrageous and practically stupid," Vladeck said.

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In Brief

Outgoing president and CEO **Jim Castle** is retiring Dec. 31 after 23 years leading the organization.

The OHA represents 167 hospitals, 19 health systems, and more than 350,000 employees.

"At a time when alignment with physicians and hospitals is critical, the OHA Board of Trustees is excited to bring in a new CEO whose background and reputation will help Ohio hospitals work even more effectively with physicians to improve care to the communities they serve," said **Mina Ubbing**, president and CEO of **Fairfield Medical Center**, Lancaster, and chair of both the OHA Board and the search committee for a new CEO.

Abrams, 50, has been CEO of the Iowa Medical Society since 1996. He and his wife, a physician, are natives of Ohio.

Illinois Hospitals Hire Firm to Fight on Tax Exemptions

The **Illinois Hospital Association**, facing aggressive moves by state officials to examine hospitals' tax exemptions, has hired a public relations firm to help preserve their tax-exempt status and lobby for Medicaid funding.

The IHA has engaged PR firm **Kathy Schaeffer & Associates**, of Chicago, to organize a campaign defending the tax exemptions of Illinois hospitals. Its clients include **Sherman Health System**, which just prevailed in an effort to derail two new hospitals in McHenry County (see first item, above).

In August the **Illinois Department of Revenue** took away the tax exemptions of three hospitals because they spent so little on charity care (**Payers & Providers**, Aug. 23). It announced it would review the taxation status of another 15 hospitals.

Gov. **Pat Quinn** has put that examination on hold pending negotiations between the hospitals and state authorities, which should be concluded by March 1.

Joint Efforts Paying Off in Ohio, Mich. Aetna, Michigan Blues Develop ACO Prototypes

Hospital groups in Michigan and Ohio are partnering with major insurers to explore alternative reimbursement strategies that should in theory provide better care at lower cost.

St. John Providence Health System in southeast Michigan has joined with the **Physician Alliance** to form **Partners in Care**, a physician-centered system created to manage the health of populations. The group has 2,300 physician members in southeast Michigan.

Together these entities are working with **Blue Cross Blue Shield of Michigan** to establish a pay-for-performance protocol intended to eventually replace fee-for-service.

"This is the first outcomes-based reimbursement arrangement between Blue Cross and a major Michigan hospital system," said **Susan Barkell**, senior vice president for healthcare value at Blue Cross. "We recognize the leadership and foresight of St. John Providence for partnering with Blue Cross on it."

The Blues will help pay for infrastructure upgrades that will integrate care services between the Physician Alliance and the five hospitals controlled by St. John Providence, which is a division of **Ascension Health**, the country's largest Roman Catholic health system. In 2013 the hospital group will include a performance-based reimbursement model in its next contract with Blue Cross.

Meanwhile, in Ohio, **Aetna Inc.**, the country's third-largest for-profit health insurer, has announced results of a prototype

accountable care plan partnership with **Central Ohio Primary Care Physicians**.

Since 2009 when the collaborative began, COPC achieved a 97% rate of preventive and follow-up visits for 3,200 Aetna Medicare Advantage members. The Aetna cohort experienced 30% fewer inpatient hospital days than the average traditional Ohio Medicare population, and 22% fewer hospital readmissions.

Aetna's model allows for a nurse case manager to be embedded in the COPC practice who coordinates care for the Aetna MA members. Research conducted by **The Commonwealth Fund** into this prototype found that this program decreased duplicate or unnecessary services and improved outcomes. In 2010, Aetna's MA enrollees in this program required 43% less acute hospital care, compared to unmanaged Medicare beneficiaries.

"By working more effectively and efficiently with outstanding health care providers like COPC, we have demonstrated that we can help improve the coordination and quality of care and reduce health care costs," said **Randall Krakauer**, M.D., Aetna's national Medicare medical director. "Aetna believes patient-centered collaboratives can serve as one stepping stone to the creation of accountable care organizations."

Aetna plans to expand the program across the country for its Medicare Advantage patients.

Basic Benefit Gets Tossed to States HHS Decides Against Setting One National Standard

The federal government has decided to punt the question of the basic benefit package under the Affordable Care Act to the states.

Last week Health and Human Services Secretary **Kathleen Sebelius** announced that her agency would allow states wide leeway in setting the terms of the basic benefit. Contrary to expectation, HHS will not set one national standard for what health insurance companies must cover under health reform. (**Payers & Providers**, Dec. 13).

Each state may choose an existing health plan to use as a benchmark for coverage. The benchmark can be the HMO with the largest

market share, or one of three biggest plans that covers small employers, state workers, or federal employees in that state. This will allow state regulators maximum leeway in figuring out what the local market desires.

"Coverage that works in Florida may not work in Nebraska," Sebelius said.

Starting in 2014, the ACA requires all small-group and individual insurance plans to cover a set group of services, known as an essential benefits package.

HHS said there will be limits on state flexibility to set benefit packages, and it will address those issues in the next few months.

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Getting Value for Healthcare Dollars

Employers Need a Rigorous Approach with Vendors

Employers could avoid a lot of frustration, disappointment, and unnecessary costs if they more effectively set expectations and performance guarantees with their healthcare vendors (i.e. health plans, providers, pharmacy benefit managers). **Warren Buffett** once noted, "price is what you pay, value is what you get." While he may not have been talking specifically about purchasing healthcare benefits, I think he would agree that employers need to focus not only on price, but on performance and value.

All too often, employers don't set expectations for levels of services, reports, and metrics early in their request-for-proposal process and overlook the need to outline specific performance guarantees in their vendor negotiations and contracts. They are often left with the performance deemed appropriate by the vendor, which may not meet their level of satisfaction or employee needs.

Employers are wasting millions of dollars on wellness and prevention programs that get little participation or may not even work. Many have no idea how many employees are engaged in their programs. To ensure value for every dollar spent, they must first set clear expectations and measurable deliverables.

While larger employers have been doing this for some time, small- to mid-size employers are moving toward hosting "vendor summits," meetings where all of an employer's partners can learn how the employer wants the vendors to work together and set the expectations for their relationship. This can reduce overlapping services and help the vendors understand the employer's bigger picture. Many employers are interested in having a more integrated understanding of what their data sources are telling them all together. Collaboration among vendors is critical.

Before this can be accomplished, however, they need to ensure they have the necessary data to make smart decisions, set expectations, and measure results. One initiative currently helping employers understand their data is the

Midwest Health Strategy Project. As a result of this effort, employers will be able to introduce a complementary array of employee health offerings and incentives that better align health promotion and prevention strategies with their medical and pharmaceutical plans, and other benefits such as disability and workers' compensation.

Another way to bring about positive change is for purchasers to work together to have a common ask and collaborate on what is most important to move the market. An example of this is the **BlueCross BlueShield User Group**, led by

the **Midwest Business Group on Health**, which brings together employers of different sizes and industries who share a common health plan. The user group allows them to not only share information and experiences, but to communicate as a collective group to the plan on areas of concern or improvement.

A second instance of an initiative that fosters required collaboration is eValue8™, an annual survey and evaluation used by healthcare purchasers to assess and manage the quality and efficiency of health plans.

eValue8 involves collaboration among the **National Business Coalition on Health**, the organization that

developed it, the regional coalitions that manage it, the employers that use it and the health plans that accept the challenge of accountability and motivation within their networks of doctors and hospitals. The health plan-customer dialogue leads to improvements in the plan's structure, process, and outcomes, and helps to answer the critical question: What are plans doing to improve quality and value?

It's no longer about asking a vendor "What can you do for me?" It's about going to a vendor and telling them what you need as an employer. Upi want your vendors to be partners. To do this, employers must first understand their population and then communicate their needs to ensure they are receiving value, and ultimately healthier employees, for their healthcare dollar.



By Larry Boress

Larry Boress is president and CEO of the Midwest Business Group on Health.



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