CONTAINING MEDICARE COSTS AND SAVING THE MEDICARE PROGRAM

EXECUTIVE SUMMARY OF PROPOSED SOLUTION

STRUCTURE

1. Congress must mandate that all Healthcare Entitlement Programs (Medicare, Medicaid, and CHIP Programs) be privatized through empowerment of the private sector (Health Plans and ACOs) to establish Coordinated and Integrated Risk-Sharing Healthcare Delivery systems (IDS). This new legislation must place the independent physicians in control of healthcare decisions through an IPA Care Coordination structure or through a single TIN integrated group of physicians. Physicians employed or under control of hospitals will not be able to participate in IPA/ACO/Health Plan risk sharing/reward systems except through a single TIN group of physicians or an IPA. Hospital control of physicians has proven to be dysfunctional and costly to the healthcare system and should be minimized and disincentivized by the government.

    1. Health Plans/ACOs must be required to contract with local Independent Physician Associations (IPAs) or an integrated group of physicians under a single TIN which perform Care Coordination services and which are experienced in sharing risk and reward with their participating physicians. Expansion of the Health Plan/ACO into rural areas must be in tandem with an IPA. IPAs may reimburse participating physicians through FFS or through capitation arrangements.
    2. Hospitals must not be allowed to assume a control position relative to physician participation in Care Coordination. In order to participate in risk sharing and shared savings programs, hospitals must agree to support the IPA/ACO/Health Plan Care Coordination program and Case Management Program. This means that hospitals participating in Entitlement Programs must allow IPA/ACO Hospitalists to manage their member hospital admissions and discharges.
    3. Hospitals will continue to be paid through the DRG system or they can substitute a contracted Case Rate system that is bundled as a part of the global Capitation paid to the Health Plan when the hospital agrees to participate in the Integrated Delivery System formed by the Health Plan in concert with the IPA/ACO. MAPD Plans currently typically pay hospitals under the DRG system of reimbursement. Hospitals may elect to participate in risk sharing systems through their contractual relationship with ACOs, IPAs, or Single TIN physician groups.

2. This new legislation should take effect in the fiscal 2014 year and the development years for formation of these private sector ACO/IDS should be 2012 and 2013.

FINANCING

1. CMS to pay Health Plans or the ACO/IDS a **base global capitation rate** equal to the 2012 risk adjusted rate in affect for the members assigned to the Health Plan or ACO/IDS.

    a. Plans/ACO's that achieve Four Star status in 2013 or earlier should be paid at 2012 risk adjusted CAP rates plus 2% in the first year of this program (2014).
    b. Plans/ACO's that achieve 4.5 Star status or better in 2013/2014 should be paid at 2012 risk adjusted CAP rates plus 3% in the first year with one percent increases each year thereafter up to a maximum of a 5% increase over 2012 rates.
    c. Plans/ACO's that achieve four and five star status within three years of formation should also receive these same CAP rate increases in order to incentive them to focus on quality of care delivery.
    d. Plans/ACO's that fail to achieve four star status or better within three years of formation should receive 2012 CAP rates less 2% each year.
    e. No risk adjusted rate increases or decreases will be allowed beyond the 2012 risk adjusted rates except as detailed above for Plans/ACOs that achieve four or five star status. However, inflationary increases will be allowed each subsequent year so that Plans can keep up with labor and supply related cost increases each year. In this way, rate increases will be capped at 2012 rates through 2030 so that shared savings captured by these integrated groups will contribute to the continued viability of the Medicare system during the 20 year period (2011-2030) while the Baby boomers enter the system.
    f. IPA's and Single TIN physician Groups that are contracted with the Health Plan or ACO must receive a minimum admin fee equal to 1%-2% of global monthly CAP rate paid by CMS to the Plan/ACO for their Care Coordination activities, depending on the extent and quality of these care coordination activities. <u>These Care Coordination activities to include physician network development and management, Wellness and Health Risk Assessment programs, Credentialing, Utilization Management, Inpatient and Outpatient Case Management, MLP or nurse home visit programs, patient navigator programs, medical home certification programs, PCP and Specialist Care Coordination programs, clinical integration activities, palliative care programs, and P4Q bonus programs.</u>

2. Shared Savings that result from the Care Coordination programs within the ACO/IDS must be shared in accordance with the following formula:

    a. 25% to the government for continued funding of the Medicare Program; not to be used for the general budget.
    b. 75% to the Health Plan/ACO. The Health Plan/ACO must be required to share this 75% Savings with the IPA and its physicians in an equitable manner, not to be less than a 50/50 split between the IPA and the Health Plan. The IPA physicians who meet their P4Q criteria standards must receive at least 50% of the IPA portion of the total Shared Savings.

3. Penalties and rewards for relative achievement of Shared Savings: These rewards are in addition to the Four and Five Star rewards.

a. Plans/ACOs that do not achieve any Shared Savings first year will receive 2012 CAP rates less 2% in second year of program. Continued failure to deliver Shared savings in year two and three will result in additional decreases of 1% per year. If no Shared Savings results after year three, then the Plan/ACO contract will be terminated by CMS. This will compensate for the Plans/ACO's that fail to deliver viable Care Coordination savings.
b. Plans/ACOs that achieve a 1%-2% Shared Savings first year will receive the same 2012 CAP rate in second year as first year.
c. Plans/ACOs that achieve a 3%-5% Shared Savings first year will receive the 2012 CAP rate plus 2% in year two. The same formula to be used in subsequent years as well.
d. Plans/ACO's that achieve a Shared Savings first year of 6%-9% will receive the 2012 CAP rate plus 3% - 4.5% in year two, respectively. The same formula to be used in subsequent years as well.
e. Plans/ACOs that achieve a Shared Savings first year of 10% or more will receive the 2012 CAP rate plus 5% year two. The same formula to be used in subsequent years as well.

This is An Executive Summary of the Proposed Solution to our healthcare delivery and financing crisis. I am happy to elaborate on the many details necessary to accomplish the Triple Aim goals through this proposed solution. The actual years described in this Proposed Solution can be modified based upon the time of implementation.

Respectfully submitted,

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