The Evolving Value-Based Healthcare Landscape: Opportunities for the National Diabetes Prevention Program

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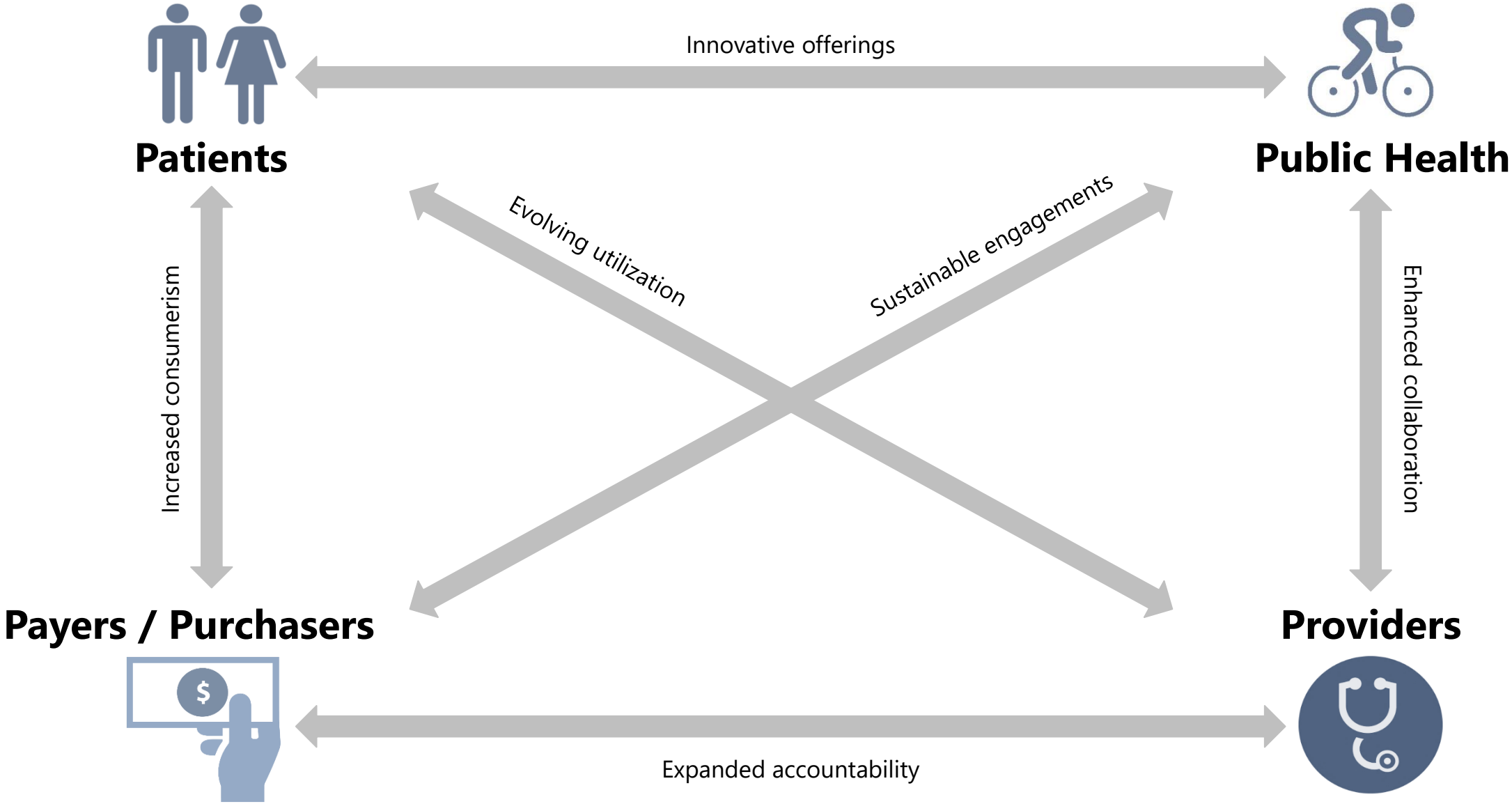
Objectives

1. Educate about the evolving relationships facing the value-based healthcare economy.

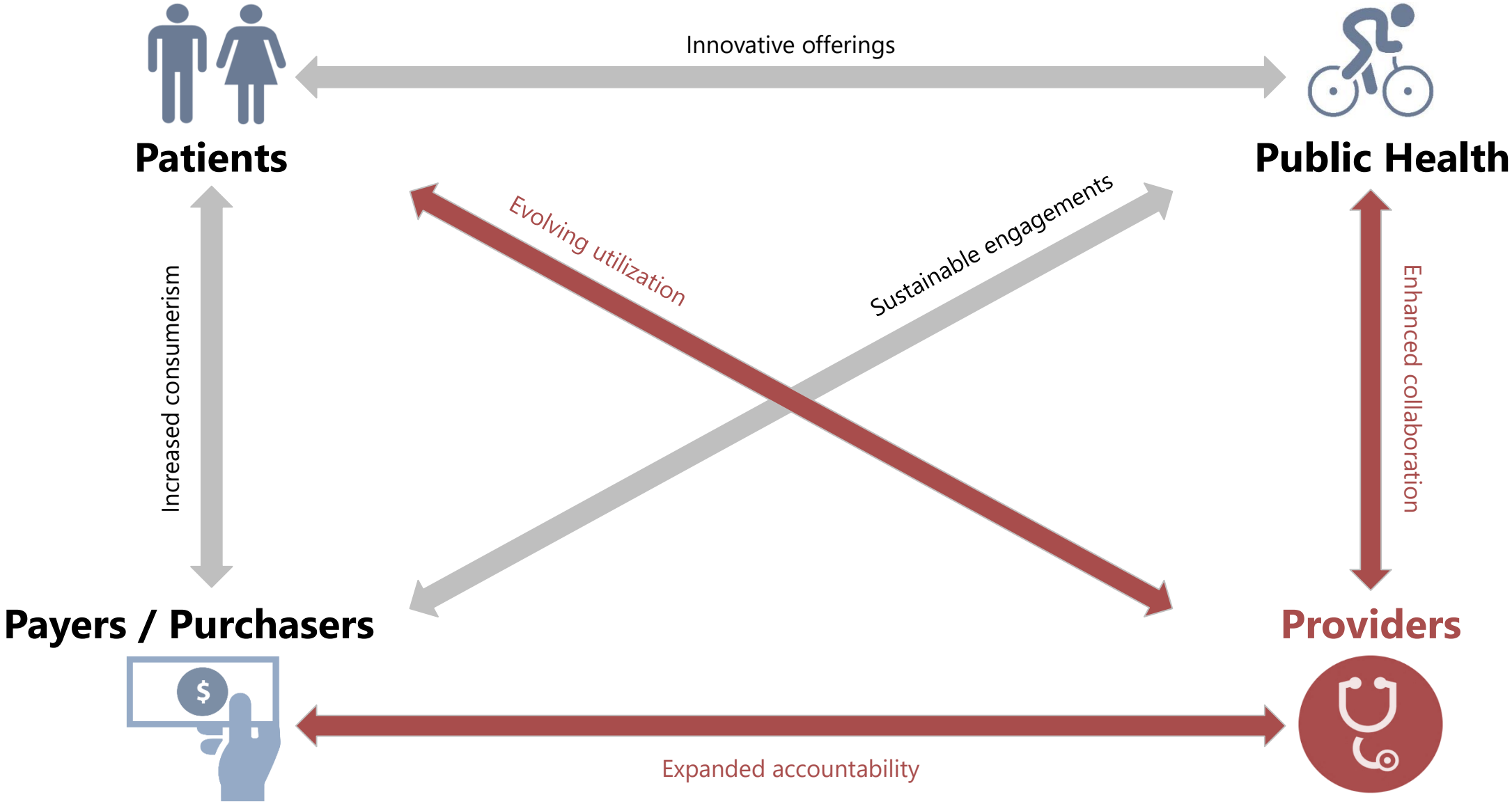
2. Increase understanding about accountable care concepts and the implications for provider organizations, particularly National DPP providers.

3. Provide insight on how payer and purchaser organizations can play critical roles in the National DPP moving forward, particularly financial coverage.

Evolving Relationships



Evolving Relationships



Medicare Announcement and Proposed Rule

Intersection between non-traditional providers and a public payer engaged in a value-based arrangement

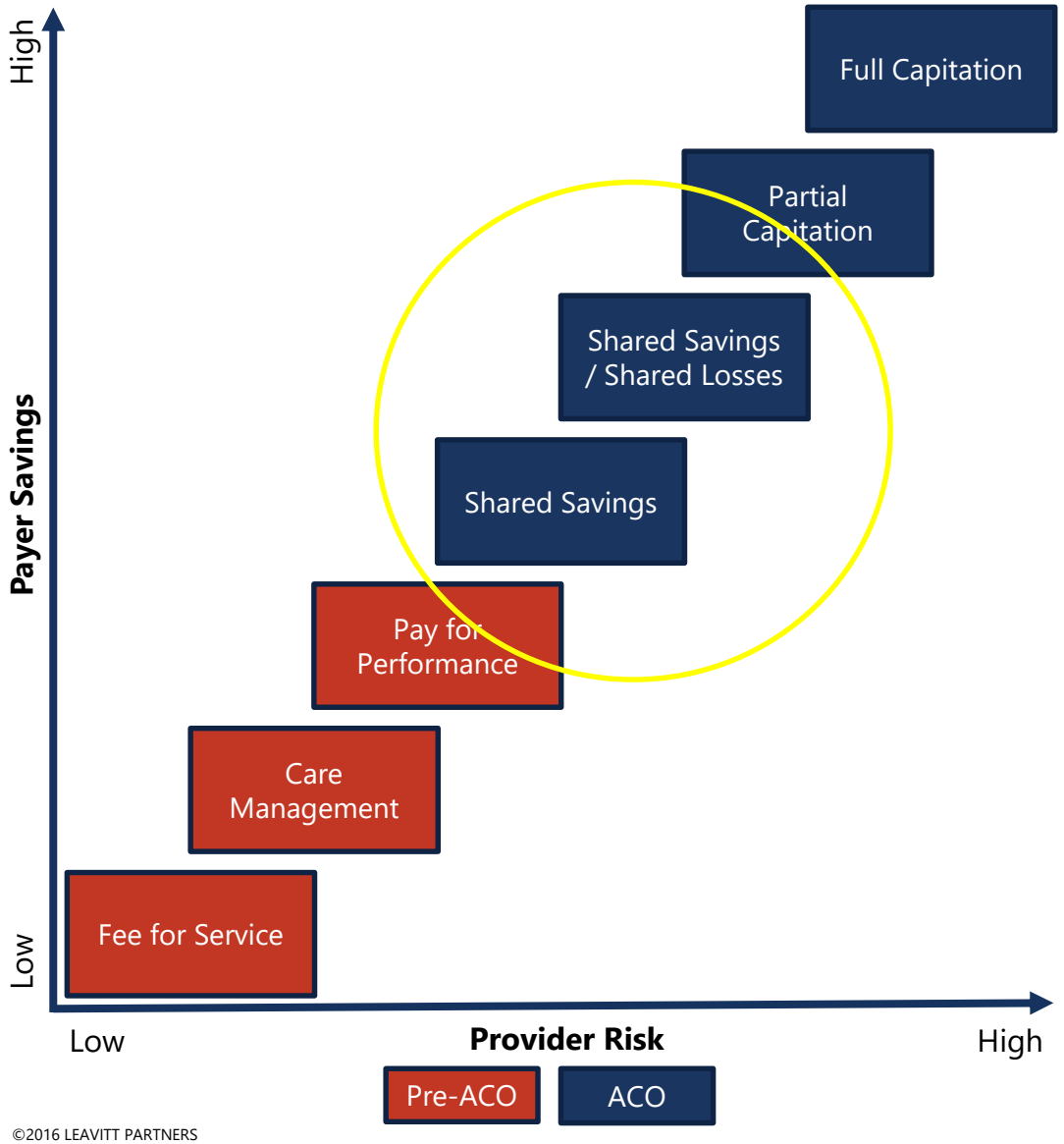
- CMS OACT certification based on data that demonstrates a reduction in medical cost for participating seniors
- Rigorous terms of this arrangement ensure that coverage will not increase net-Medicare spending
  - No payments after 6 months unless weight loss target is achieved

Unique care model and cohort of non-traditional providers to support disease prevention

Where does this lead?

- Bright light on the promise of the National DPP, which draws the attention of commercial and state payers
- Coverage for additional non-traditional models that demonstrably support prevention or management of chronic disease

The Accountable Care Movement



Pre-ACO

Fee for Service: A "traditional" payment system in which provider organizations receive separate payments for each individual service provided to patients

Care Management: A payment to provider organizations for certain non-face-to-face care coordination services furnished to patients with multiple chronic conditions

Pay for Performance: A payment approach in which provider organizations are rewarded or penalized based on adherence to predetermined quality metrics, such as meaningful use, patient quality, or value-based purchasing

ACO

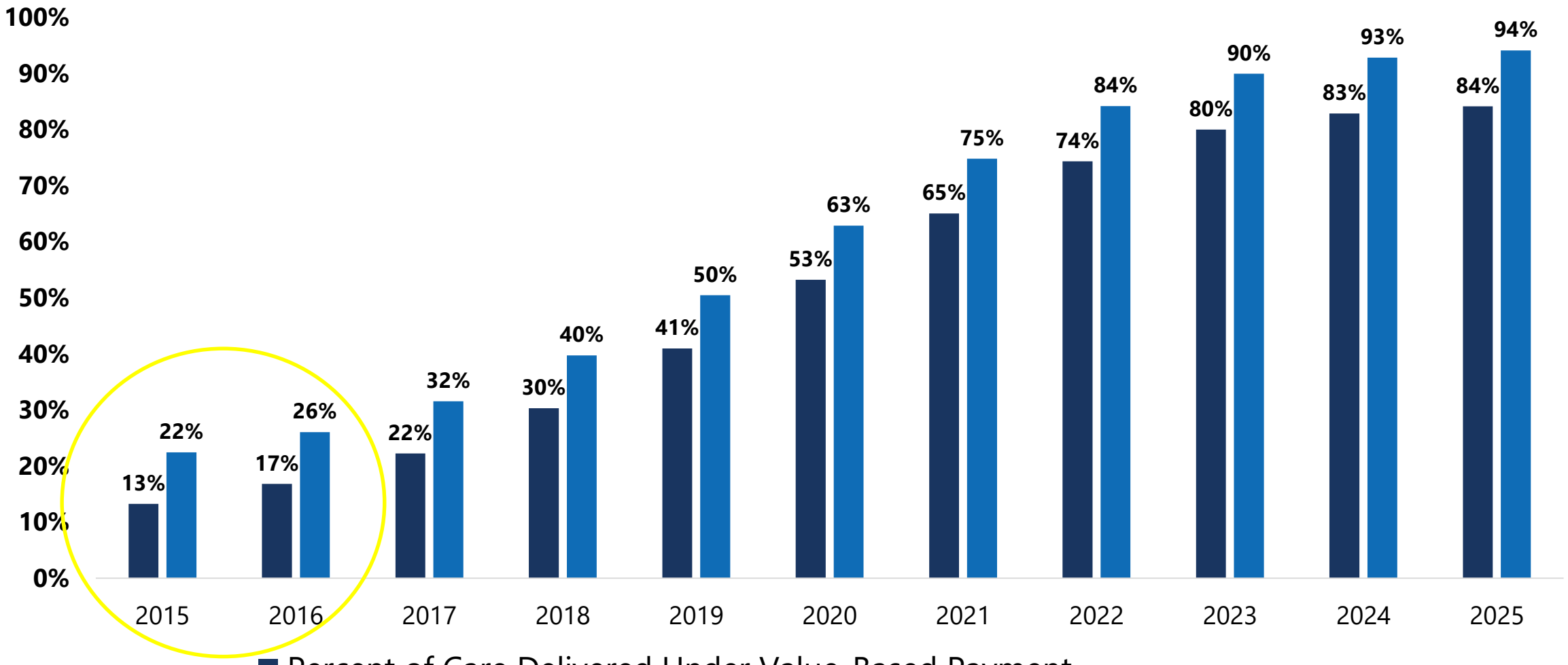
Shared Savings: A payment approach whereby a provider organization shares in the savings (but not in the losses) that accrue to a payer when actual spending for a defined population is less than a target amount

Shared Savings / Shared Losses: A payment approach whereby a provider organization shares in the savings and losses that accrue to a payer when actual spending for a defined population is less or more than a target amount

Partial Capitation: A payment approach in which only certain types or categories of services are paid on a capitated basis; typical examples of this include capitation for primary care services, specialty care or other services such as mental health

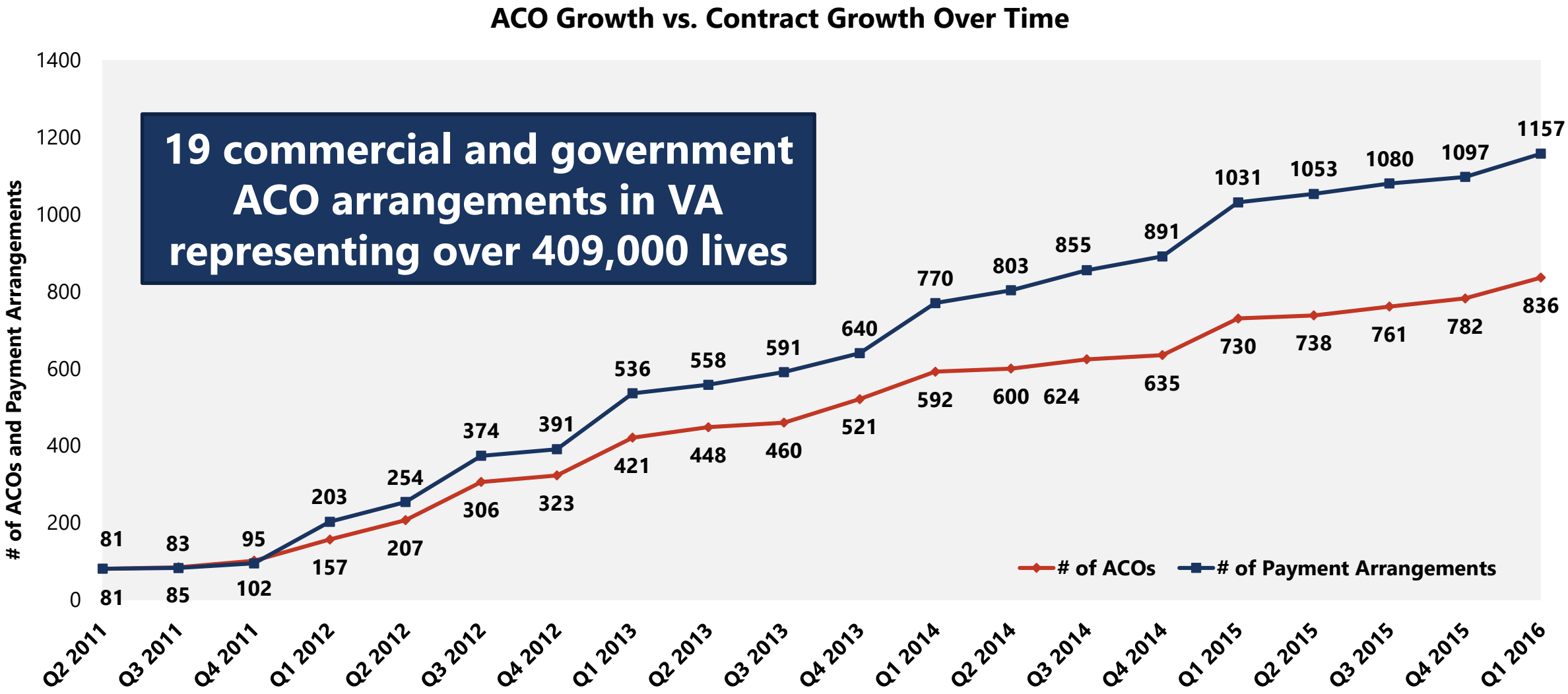
Full Capitation: A single payment made to a provider organization to cover the cost of a predefined set of services delivered to a patient

National Value-Based Payment Penetration



ACO Growth

Total ACOs: 836
Total Contracts: 1,157



Source: Leavitt Partners Center for Accountable Care Intelligence

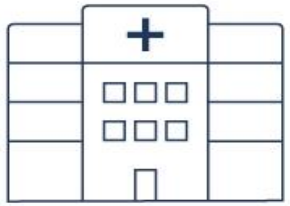
ACO Taxonomy

Total Covered Lives: 23.8 million

FULL SPECTRUM INTEGRATED

All services are provided directly by the ACO. May include one or multiple organizations.

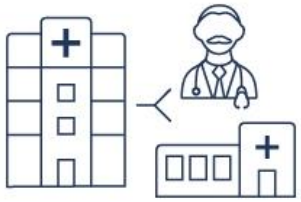
~ 108 ACOs ~ 6.5 Million Lives



INDEPENDENT HOSPITAL

A single organization that directly provides inpatient care.

~ 81 ACOs ~ 2.1 Million Lives



HOSPITAL ALLIANCE

Multiple organizations with at least one that directly provides inpatient care.

~ 89 ACOs ~ 2.6 Million Lives

INDEPENDENT PHYSICIAN GROUP

A single organization that directly provides outpatient care.

~ 177 ACOs ~ 4.8 Million Lives

PHYSICIAN GROUP ALLIANCE

Multiple organizations that directly provide outpatient care.

~ 120 ACOs ~ 2.2 Million Lives

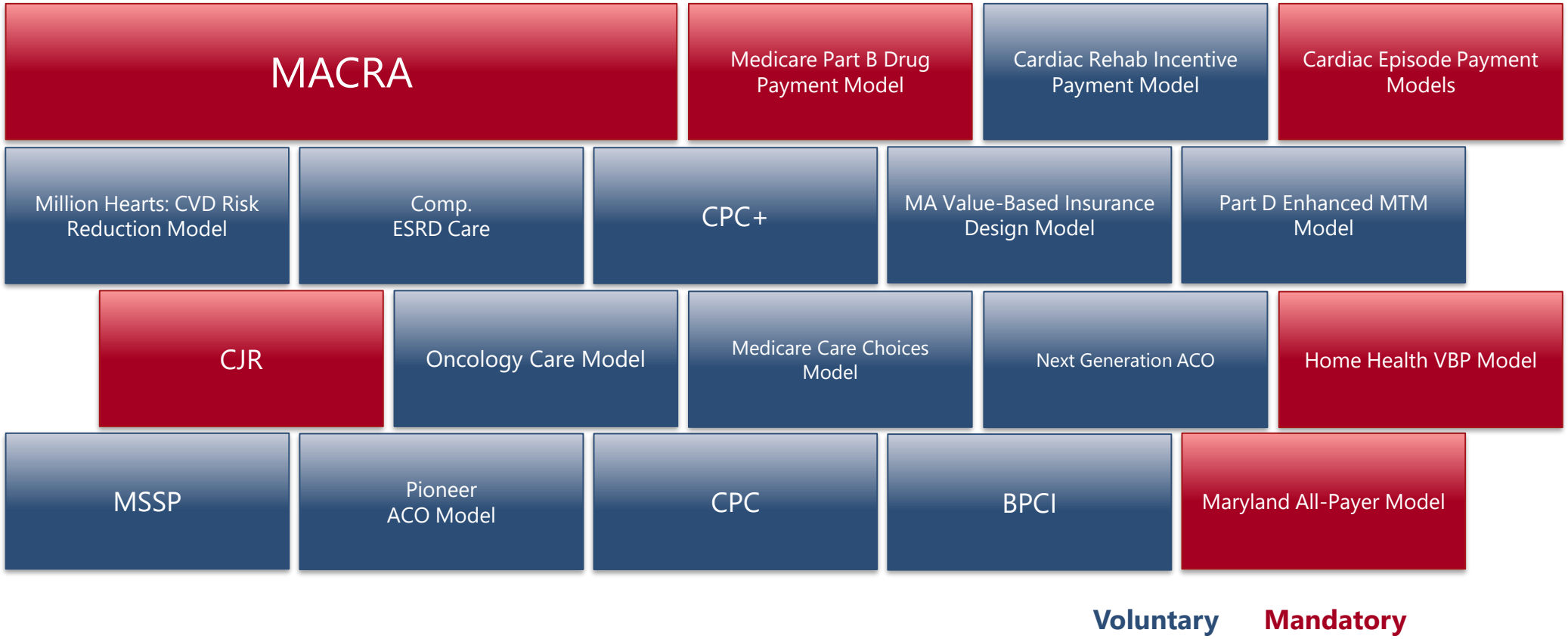
EXPANDED PHYSICIAN GROUP

Directly provides outpatient care and contracts for inpatient care.

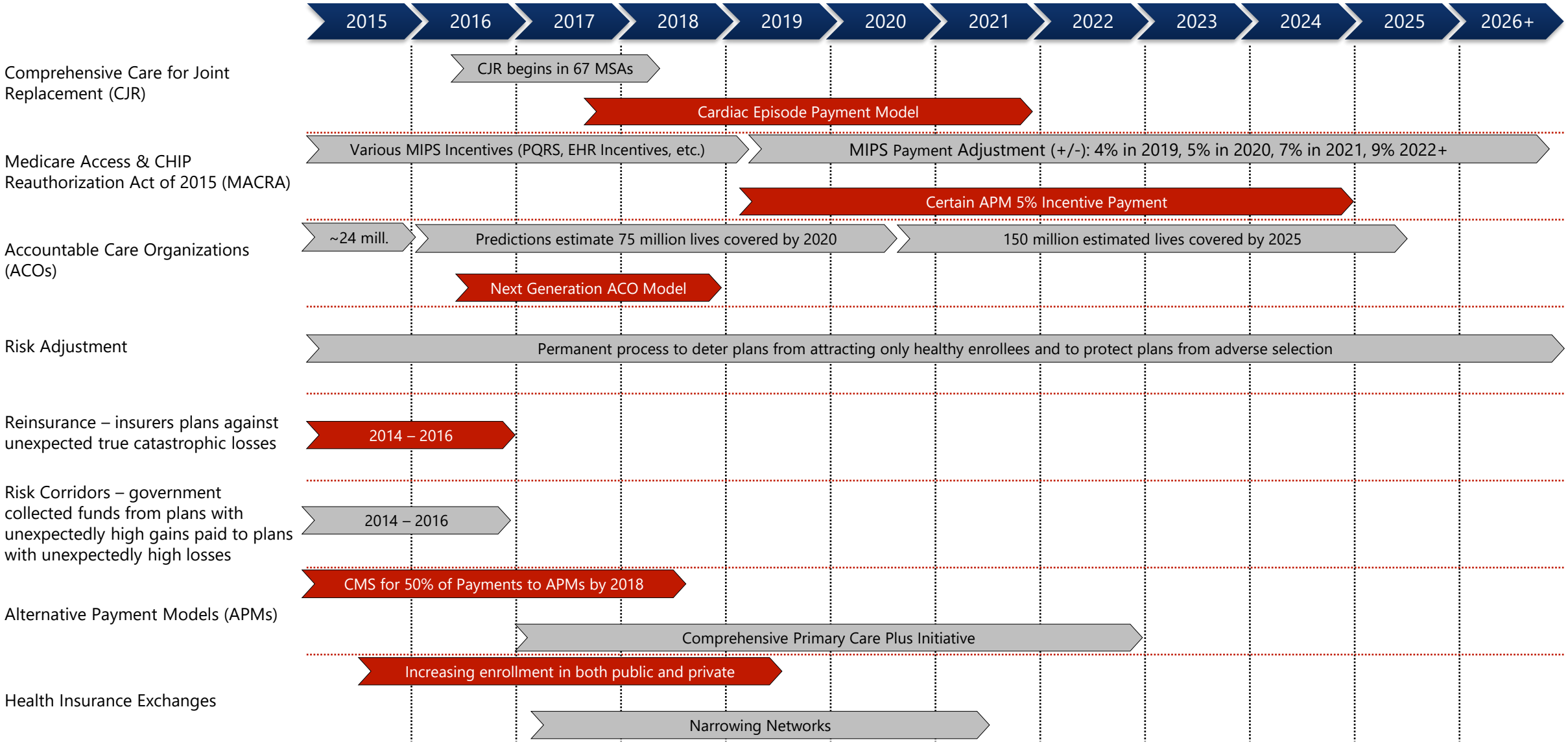
~ 169 ACOs ~ 5.6 Million Lives

***Total ACOs and covered lives do not include the most recent Medicare Shared Savings Program (MSSP) ACO cohort that added 92 additional ACOs in January 2016**

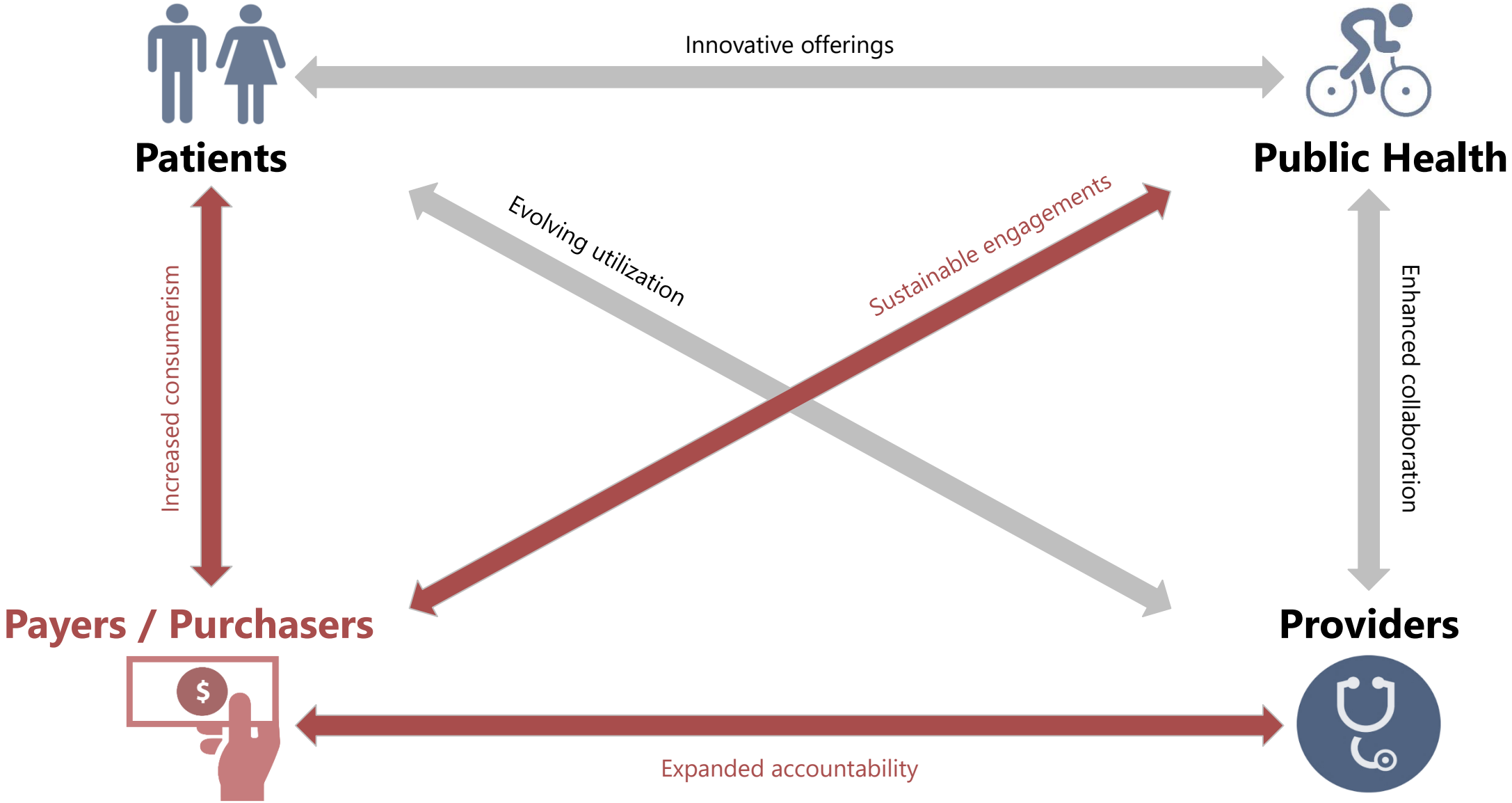
Policy Foundation For Value



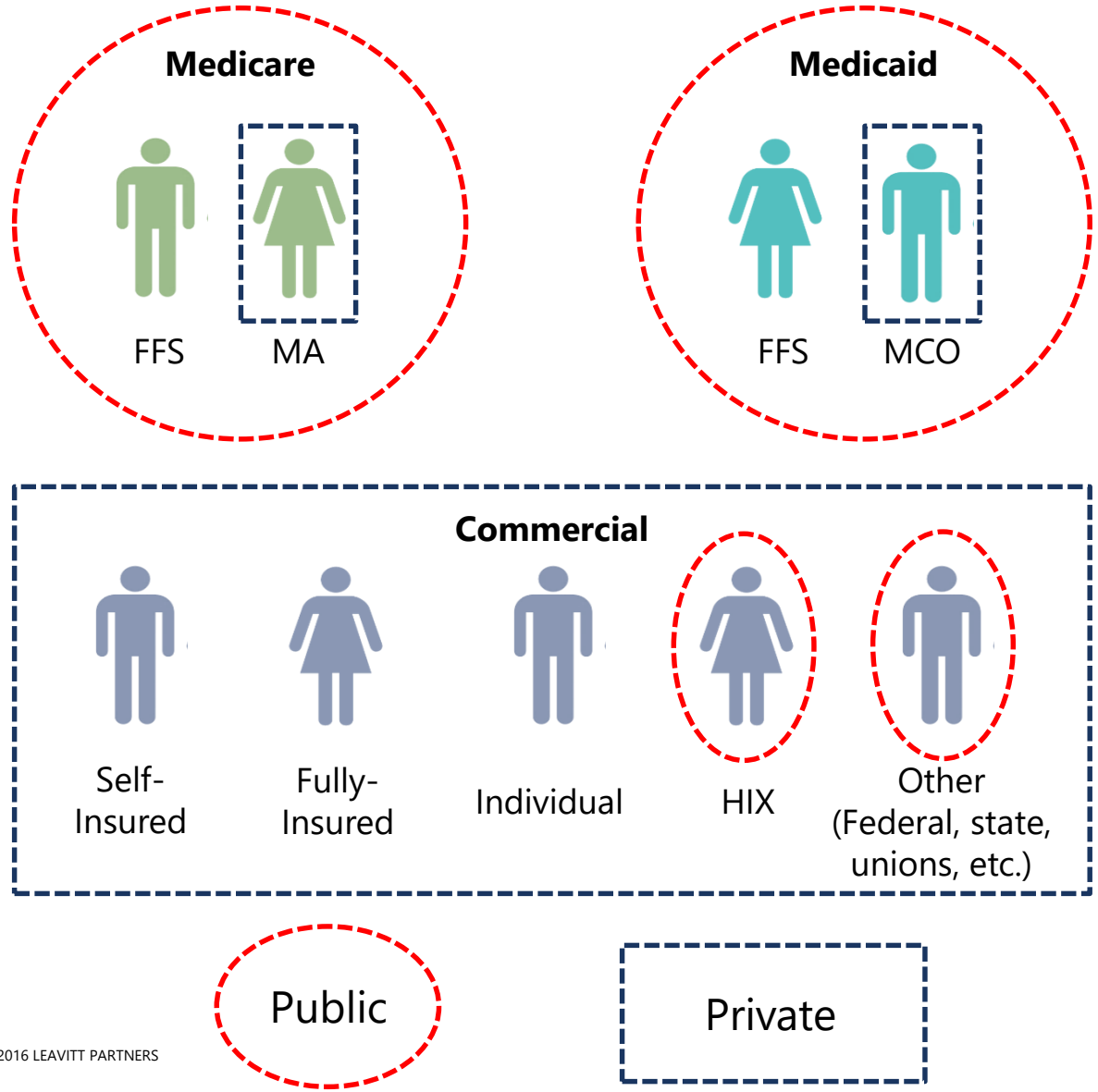
Market Signals Timeline



Evolving Relationships



Types of Insurance



Medicare

FFS: Hospital and Medical coverage administered directly through the federal government

MA: Medicare Advantage plans sold by private insurance companies that provide Medicare benefits

Medicaid

FFS: Insurance coverage administered jointly through federal and state governments to low-income individuals/families

MCO: Managed Care Organizations provide delivery of Medicaid health benefits via contracts with a state Medicaid agency

Commercial

Self-Insured: Employers accept financial risk and administers its own health insurance plan (82% of employers with 500+ employees self-insure*)

Fully-Insured: Employers pay an insurance company who assumes financial risk for their employees

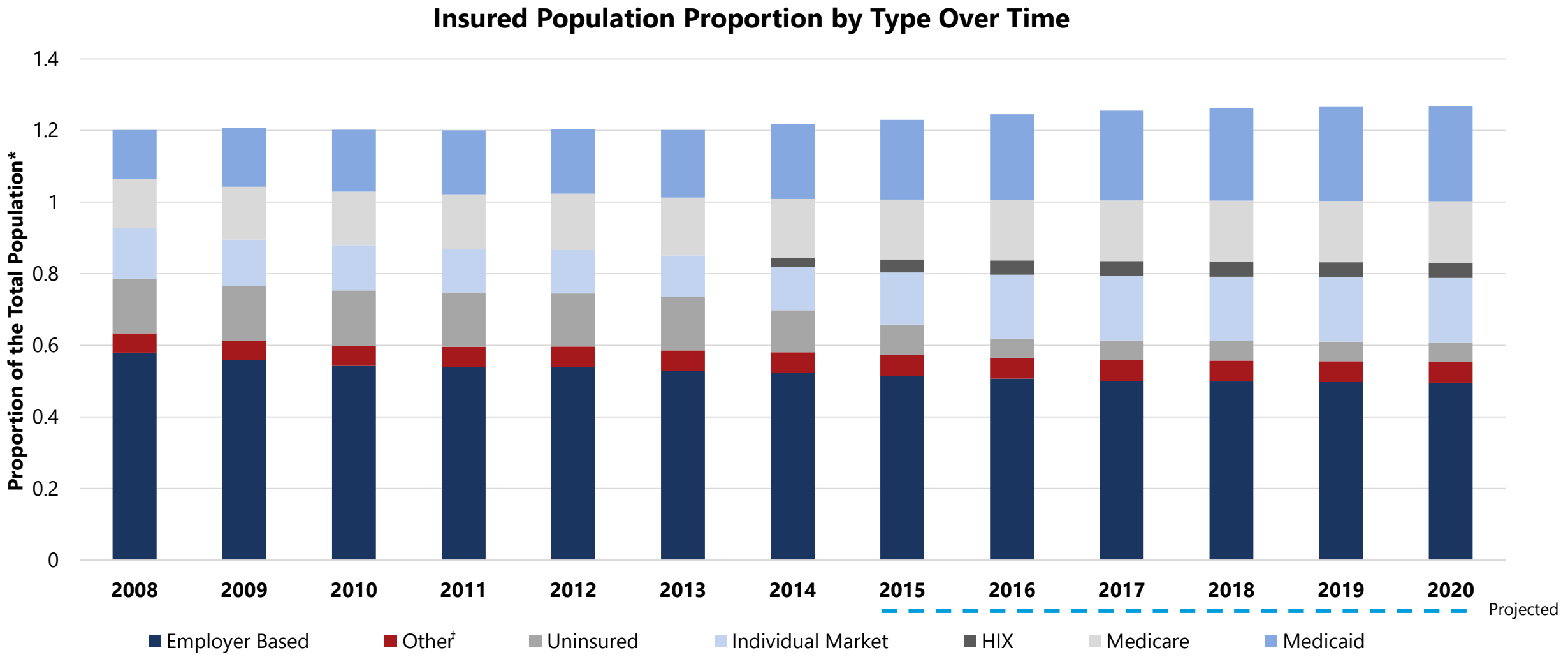
Individual: Consumers purchase individual/family plans from private insurance companies and pay full premiums out of pocket

HIX: Consumers purchase individual/family plans from the state- or federally-based insurance exchange; federal subsidies are available based on income to reduce monthly premiums

Other: Group coverage obtained through an option not associated with an employer, HIX, or individual plan; i.e., federal, state, or union plans, etc.

*Source: Department of Health and Human Services, 2015

Insured Population by Type



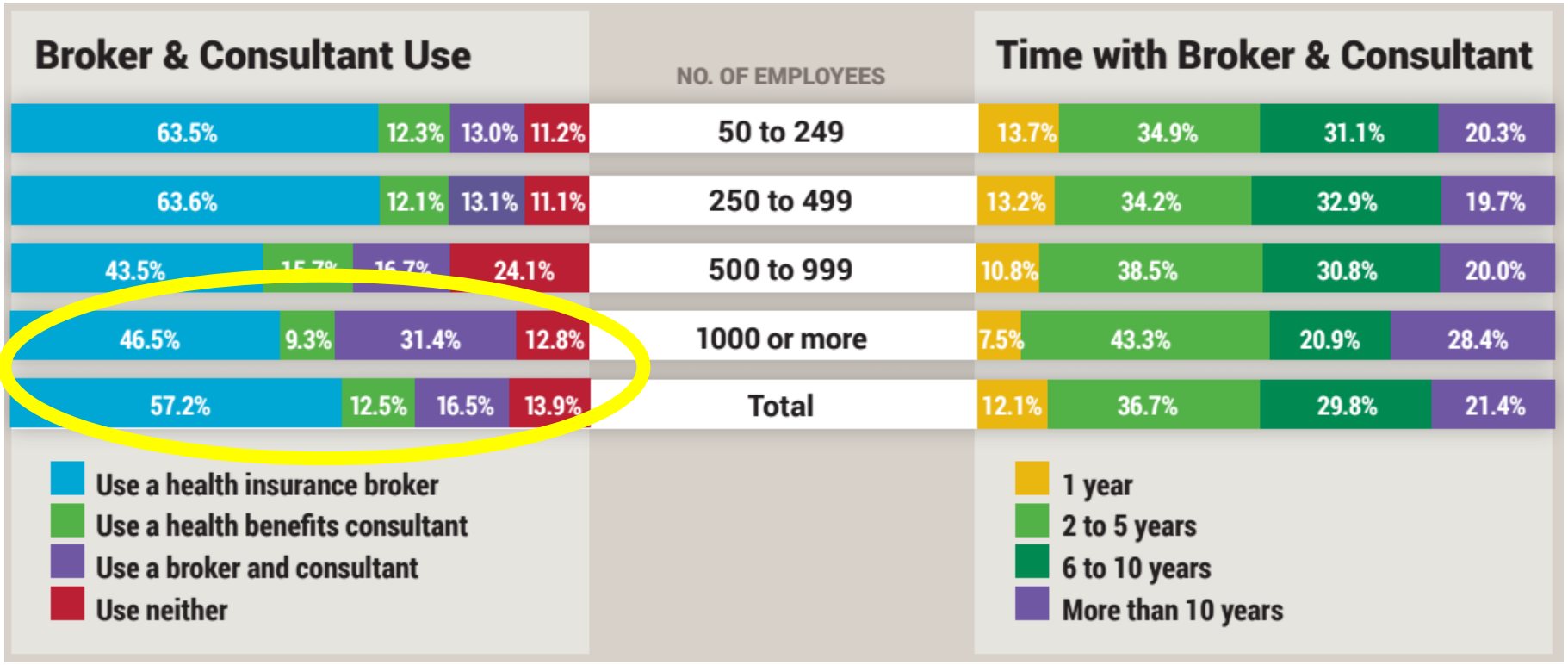
Source: Leavitt Partners Map, 2015

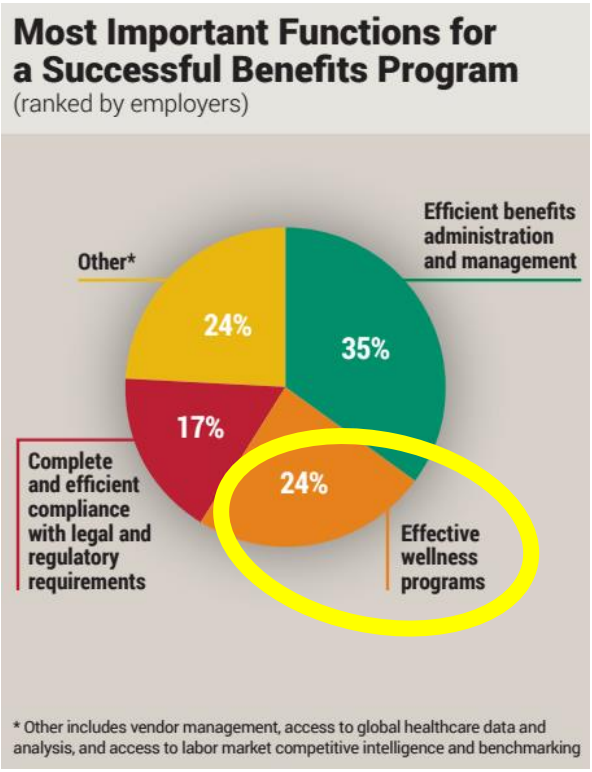
***Proportion totals greater than 1 due to Medicare and Medicaid dual-eligible recipients**
†Other includes any plan not employer-based or individual-based; i.e., federal, state, or union plans, etc.

Brokers / Benefits Consultants

An individual or firm that advises an employer or plan sponsor in matters relating to group insurance or employee benefits.

Benefit Consultants advise employers on an array of employee benefits – insurances, investing, legal, health/wellness, etc. **Brokers** match employers' needs (i.e. health insurance) to the right seller (i.e. payer) at the optimal price. Remember, self-insured employers bear financial risk for employee health, but still contract with a third-party payer for administrative capabilities. Fully-insured employers shift the financial risk and administration to a payer.





Source: Leavitt Partners' analysis for The Council of Insurance Agents & Brokers

Takeaways

1. The evolving relationships in the healthcare economy are driving value and chronic disease prevention is a high priority.

2. Accountable care is being tested in many ways, but is here to stay. The National DPP is positioned to succeed if clinical incentives move to value and away from volume.

3. Payer and purchaser organizations play critical roles in the National DPP moving forward, particularly financial coverage.

Thank You!
Questions?