WHITEPAPER:

AN OPTIMAL MODEL FOR WORKSITE HEALTH CARE AND WELLNESS CLINICS

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Health Care Reform - the threat

Historically, regulatory and economic circumstances have played a major role in shaping the health care environment for physicians and hospitals. In the mid-70s, the HMO Act of 1973 was heralded as a major federal reform effort designed to fundamentally change how health care was rendered and reimbursed. Through that initiative, the concepts of provider networks, physician gatekeepers, care coordination, quality of care, as well as capitated risk, were first introduced and still have a continuing effect on how health care is delivered in both the insured and self-funded markets. This transformation also brought with it a wave of newly formed physician and physician-hospital based alliances designed to share in the both the risk and profit embodied within a capitated health delivery system. The success or failure of such entities were realized in the ability of such alliances to effectively manage organizational differences, divergent practice philosophies, coordination of care and assumption of risk while affording an appropriate level governance and management.

With the passage of the Patient Protection and Affordable Care Act of 2010, we are seeing a resurgence of many of the challenges first introduced into the marketplace 40 years ago; only this time the stakes have been upped.

Through the passage of the Patient Protection and Affordable Care Act, commonly known as the ACA, the federal government is once again attempting a regulatory overhaul of the US health care system. Unlike the HMO Act of 1973, the ACA establishes a regulatory structure that impacts the provision of care across the insured, self-funded, Medicare, Medicaid and military product platforms. As its goal, the ACA purposes to increase the quality and affordability of health care, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs

of healthcare for private insureds and the government. To accomplish these goals, the ACA uses its sweeping authority to fundamentally change how health care is delivered and financed in America.

Using the broad authority afforded under the ACA, one critical key to the engine of change is the role of the health care provider. Nationally, providers can be expected to experience increased pressure to enter into capitated and other risk sharing agreements, to coordinate care across a continuum of service providers, to reduce costs through best practices, to electronically communicate health care records and outcomes through a national electronic network and to meet heighten standards for identifying abuses within the system.

Health care providers can also expect third party payors and managed care networks to seek out those entities and practices that are best able to fit within this practice and reporting frame work. With the advent of insurance exchanges, all insurers essentially must offer the same products, providing what the ACA defines as essential health care services – much like insurers that offer Medicare Supplement products. With all other things being equal, consumers shopping the Exchange will purchase coverage through the health plan with the lowest price.

That downward pressure on price has required third party payors and managed care networks to rethink the both the composition and reimbursement methodology of their contracted providers. Providers who have demonstrated their ability to manage risk, coordinate care, reduce costs and electronically communicate health care records are now being selected for participation in "narrow" or "nested" networks. Such networks are a subset of the entire network and will be used to offer the purchaser the same services at a lower price. In turn, the narrow or nested network provider will be promised more volume through either exclusive network agreements or through lower out-of-pocket costs for the consumer.

Whether in integrated delivery, quality outcomes, electronic reporting, risk diversification or strategic partnering, the ACA is purposed to change the way in which health care is rendered and financed in the United States.

Health Care Reform - the impact

What does this mean for a Wisconsin-based specialty medical practice? Within the evolving health care theater, health care providers who receive revenue through insured, self-funded, Medicare, Medicaid and, military product platforms or participant in a managed care provider network, will experience increasing pressure to participate in risk based contracts and through selected networks.

Under Medicare, Wisconsin has one Pioneer ACO (Bellin-ThedaCare Healthcare Partners) and four Medicare Shared Savings Program ACOs (Accountable Care Coalition of Southeast Wisconsin, Aurora Accountable Care Organization, Dean Clinic and St. Mary's Hospital Accountable Care Organization, ProHealth Solutions, LLC). Each use specific risk sharing initiatives, through a unique alliance of contracted providers.

In a survey of several Midwestern states (Michigan, Indiana, Ohio, Iowa, Missouri and North Dakota), half of those states are exploring/moving to Medicaid demonstration risk contracts through accountable care entities.

Further, both third party payors and managed care provider networks are seeking to form unique networks within their contracted network with select providers demonstrating leading quality outcomes and competitive pricing structures profiles. Providers meeting these standards will be rewarded with increasing patient volume through what is being called "narrow" networks that are able to meet these contract metrics. Currently, Anthem and Aurora are either exploring or enrolling providers into these propriety networks that are able to demonstrate quality care and competitive pricing. In other states MultiPlan (Health EOS) have already establish such networks call "nested" networks. Narrow networks are being considered in Wisconsin.

Other considerations:

- WPS Health Plan, Inc. (Arise) and Security Health Plan of Wisconsin have expressed their intent to participate on Wisconsin's federally facilitated Health Care Exchange. These plans cover 65% of the state's counties. Further, UnitedHealthCare Insurance Company and Humana Insurance Company have publicly stated that they are considering exchange participation despite earlier announcements to the contrary.

- In February of 2013, Governor Scott Walker turned down money to expand Wisconsin's BadgerCare Medicaid program. At year's end approximately 92,000 Wisconsin adults that make from 100 to 200% of the Federal Poverty level will be sent to the private market (Exchange) for insurance.
- Effective December 31, 2013, Wisconsin's State Legislature voted to transition 22,000 Health Insurance Risk Sharing Plan (HIRSP) members to the State's federally facilitated Exchange.

To continue to serve these markets, requires provider participation within an authorized health care delivery program.

Health Care Reform - the opportunity

Given the delivery model transformation driven by both the ACA and the federal government, providers are considering both their fight and flight options.

Many physicians/practices have decided to join with hospitals as employees, focusing on the practice of medicine rather than the business of medicine. Other align themselves with networks which in turn negotiate provider contracts with Accountable Care Organizations (ACOs), Preferred Provider Organizations (PPOs), Physician Hospital Organizations (PHOs), Independent Practice Associations (IPAs), and numerous other entities which in turn contract with third party payors, government payors and self-funded employers. Still others decide to remain independent and continue as a private pay or fee-for-service provider.

Each of these approaches has its merits based upon the goals of the practice, the strength of their market share, their view of the future, strategic alignment with other providers/networks and the desire/ability to profitably render quality care under a risk based reimbursement methodology.

It is our belief that the worst thing that a provider could do is to delay their response in hopes that the future will revert things back to the way that it was. The market is changing. It is our further belief that integrated delivery, evidence based care, quality outcomes and risk management are hallmarks of where the market will be in the future. Providers who critically position themselves

and/or their practice now, will be the drivers of future programs that are now in the beginning and transitional stages.