

The Potential Impact of Health Care Reform on Critical Access and Rural PPS Hospitals

How to Develop Long-Term Strategies for Success



1:30 p.m. to 3:00 p.m. - Session 7
January 19, 2012

WIPFLi^{LLP}
CPAs and Consultants

Presenter: Jane Jerzak, RN, CPA

Agenda

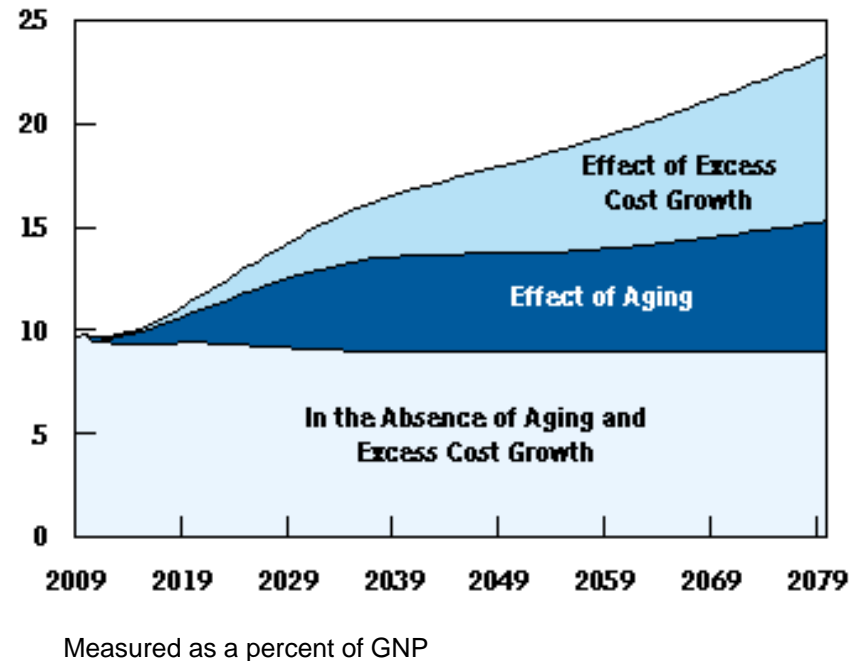
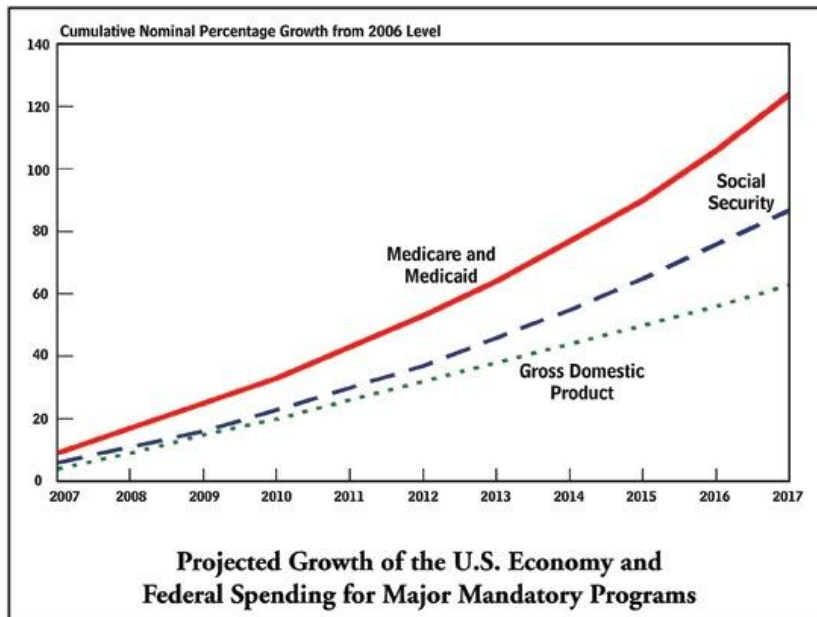
- Setting the Stage for Health Care Reform
- Overview of Health Care Reform Bill Concepts
- New Care Delivery Models Emerging Under Health Care Reform
- Potential Impact of Health Care Reform on Small Hospitals (Critical Access and PPS)
- Preparing for Reform - A Multifaceted View

Learning Objectives:

- Understand key concepts of the Health Care Reform Bill
- Understand the drivers of new delivery models and the specific approaches addressed in reform
- Recognize the critical success factors needed under these emerging models
- Understand potential implications of health care reform on small hospitals

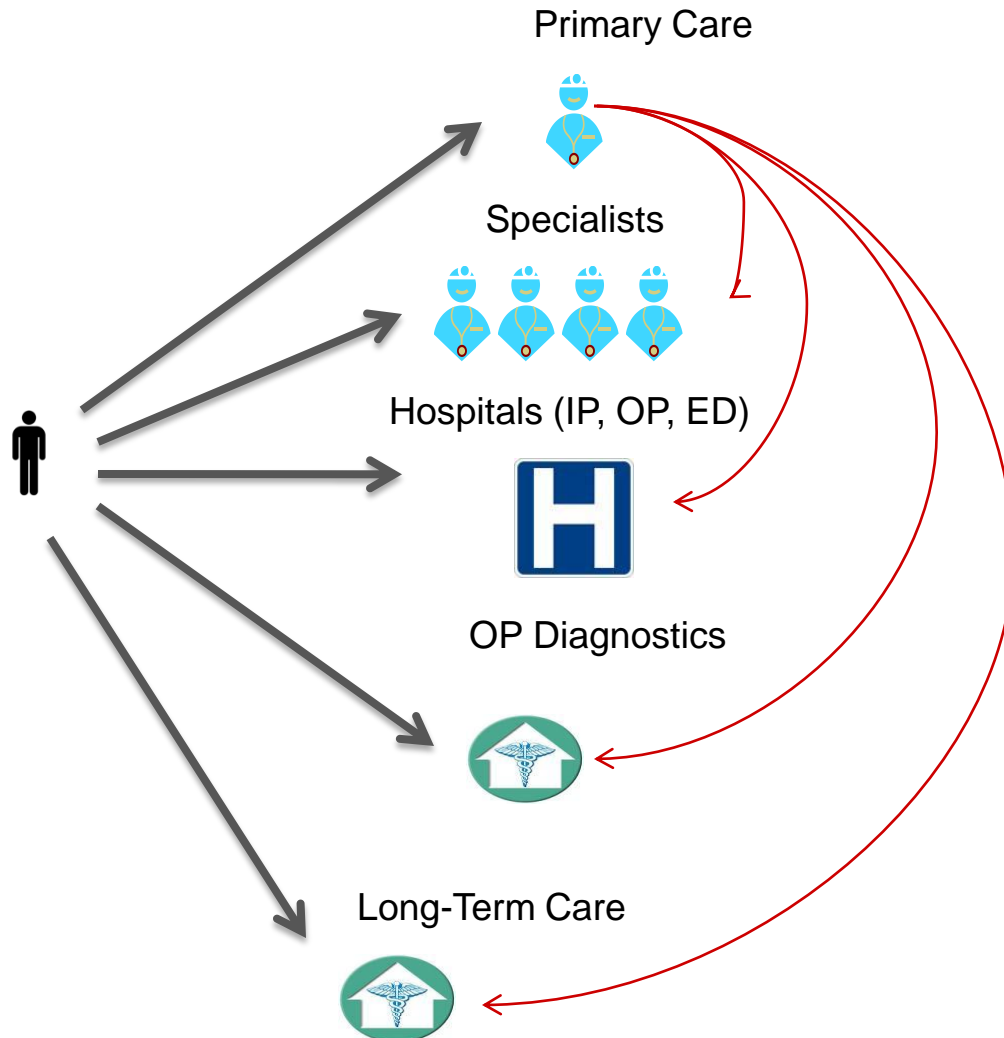
Setting the Stage for Health Care Reform

Bending the cost curve? We cannot continue our current level of spending on health care!



Setting the Stage for Health Care Reform

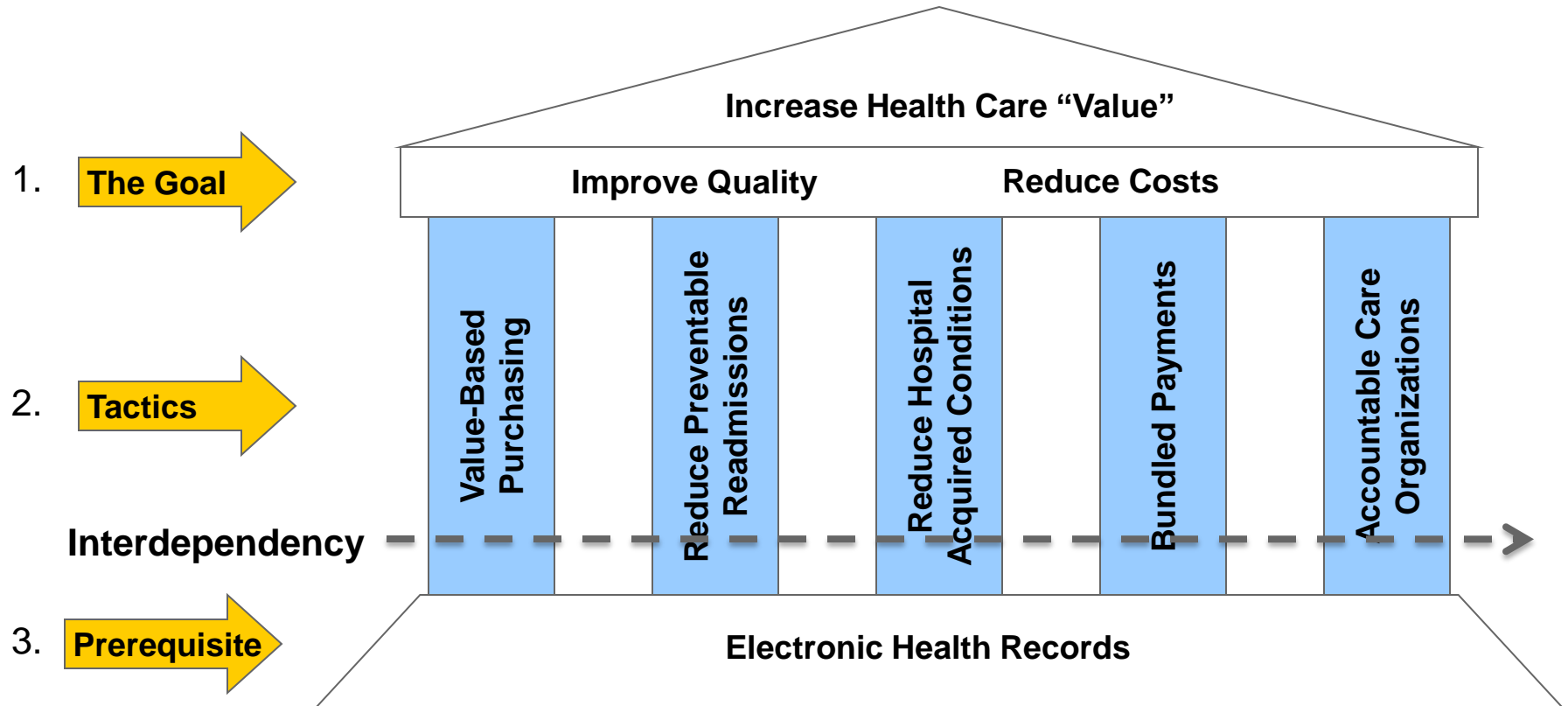
Current Payment



Each unit of service is paid without constraint:

- Coordination may not exist.
- Poor quality can be rewarded.
- Incentives do not exist to reduce utilization or find optimal care location.
- Incentives do not exist for quality outcomes.
- Prevention not emphasized.
- Variation based on insurance coverage.
- Industry experts - “Approximately 50% of our nation receives less than optimal care, the wrong care, or care that does not impact outcomes.”

Setting the Stage for Health Care Reform



Source: HFMA 2009

Overview - Major Points From Legislation

Aspects of Reform:

- Funding
- Coverage Expansion
- Insurance Reforms
- Reimbursement
- Transparency
- Delivery System Changes
- Work Force Incentives
- Tax-Exempt Reporting



Required Responses:

- New Delivery Models
- Operational Performance
- Quality Enhancement
- Physician Alignment

Overview: Major Points From Legislation

- Full impact of newly insured will be felt in four years; however, providers will begin seeing some changes immediately (particularly those in reform states).
- The new law presents providers (all - PPS and CAHs, physicians, and long-term care) with many challenges and opportunities:
 - Emphasis on “primary care driven” care continuum across all delivery modalities
 - Fee for service moving to “bundling” and “outcomes based” payment
 - Reduction in payments, movement toward a lower cost-of-care model
 - Pilot programs and demonstration project funding for development of “new care delivery models”
 - Targeted, consistent, and transparent quality and outcome measures across the care continuum
 - Patient-centered, alternate models of care will grow in all provider areas
 - Alignment, collaboration, and consolidation across the traditional care continuum and related clinical providers
 - An increase in the number of insured (at Medicaid rates)

Overview - "Initial" Health Care Reform: Implementation Timeline

High-Risk Pools		Medical Device Manufacturer Taxes	Tax on Insurers
Dependents Covered to 26 Years	Pharmaceutical Firm Taxes	Increased Medicaid PCP Payments	Individual/Business Mandates
Small Business Tax Credits	Report Health Care Benefits on W-2	Administrative Simplification	Exchanges and Subsidies
Ends Rescissions and Limits/85% MLR	Community Health Center Funding	Co-Ops Established	Medicaid Expansion

FFY: 2010					2011					2012					2013					2014				
MBU Productivity Reductions Begin					Hospital Pricing Transparency					Value-Based Purchasing					Bundled Payment Pilot					DSH Payment Cuts				
Expanded NFP Requirements					No Federal Matching for Medicaid HACs					Penalties for High Readmission										Reduced Payments for HACs				
					CLASS Implementation					ACO Pilot										Independent Payment Adv. Board				
					10% Bonus - PCP + Gen Surg in HPSA																			

Overview - “Initial” Health Care Reform: Areas of Reform Through 2014

Direct changes to current fee-for-service reimbursement models...doing more with less?

Hospitals:

- Hospital market basket updates reduced .025% (2010-2011)
- \$800M total to providers in low-cost counties (2011-2012)
- Financial penalties imposed with “excess” readmissions (2012)
- Reduction in payments to Disproportionate Share Hospitals (2014)
- Restructure (lower) Medicare Advantage rates (2011)
- Meaningful use impact on organization reimbursement (2013)

Physicians:

- Ten percent bonus payment for five years to all primary care physicians (PCPs) for Medicare patients (2012)
- Productivity adjustments applied to market basket (2012)
- Ten percent incentive payment to general surgeons in shortage areas (2011)
- Reestablish national average “floor” on Medicare’s Geographic Price Cost Indices (GPCI)

Overview - “Initial” Health Care Reform: Areas of Reform Through 2014

Payment pilots/demonstrations...incentives to change the model?

Medicare:

- Hospital value-based purchasing (2012)
- Home medical demonstration project for chronic illness (2012)
- Expand bundled payment to include 3 days pre-30 days post admission (2013)
- Health risk assessments and incentives for behavior modification (2011)
- Grant funding for prevention programs

Medicaid:

- Bundled payment and global capitation for wide range of providers
- Ability for pediatric accountable care organizations (ACOs) to share in cost savings
- Prevention coverage

Overview - “Initial” Health Care Reform: Areas of Reform Through 2014

Rural Health:

- Extension of rural health demonstration program
- Extension of outpatient hold harmless provision
- Extension of the Medicare-dependent hospital (MDH) program
- Temporary improvements to Medicare’s inpatient hospital payment adjustment for low-volume hospitals
- Extension of and revisions to Medicare’s rural hospital flexibility program
- Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under Medicare’s Physician Fee Schedule
- Improvements to the demonstration program on community health integration models in certain rural counties

Overview - “Initial” Health Care Reform: Areas of Reform Through 2014

Long-Term Care Providers:

- Pilot on payment bundling to include post-acute care, including home health, skilled nursing, inpatient rehab, long-term care hospital, and other (30 days after discharge)
- Additional disclosures regarding:
 - Ownership
 - Quality
 - Direct care staffing
- Class Act - Reform financing of long-term care and supports a voluntary long-term care insurance plan (subsequently terminated)
- Focus on home-based and community-based services
- Funding for technology and work force training

Overview - “Initial” Health Care Reform: Areas of Reform Through 2014

Health care work force...supporting “shortage” areas:

- **Increase the supply:** Increasing loan amounts; loan repayment programs; nurse-managed health clinics
- **Education and training:** Grants to develop family practice, internal medicine, physician assistant training; funding for direct care long-term care training; rural physician training grants
- **Strengthen Primary Care (PC):** Funding for PC extension program; additional funding for PC and general surgery in shortage areas, redistribute graduate medical education slots

Revenue offsets...“taxing others”...will they in turn pass it on?

- \$2.3B annual fee to Pharma manufacturers and importers
- \$2B annual fee to medical device manufacturers
- \$6.7B annual fee on health insurance providers
- Excise tax on indoor tanning...repercussions?

Overview - “Initial” Health Care Reform: Areas of Reform Through 2014

Expanded insurance coverage...drive more consumerism, attention to price?

- Individual mandates (2014) (Will this happen?)
- Employer mandates (2014)
- State insurance exchange (American Health Benefit Exchange 2014)
- Transparency for health plans

Medicare Payment Advisory Commission (Med Pac):

- “Study” the program in rural areas
- Are adjustments needed?
- Is there appropriate access to needed services?
- What is the level of service quality received?

“Change is a matter of time”

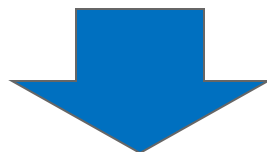


Overview - “Initial” Health Care Reform: What Does the Future Hold?

Future Not Limited to Current Reform Initiatives:






The Center for Medicare & Medicaid Services (CMS) Innovation:




































- In existence by January 1, 2011, with funding through 2019
- Tasked with establishing pilots to reduce Medicare and Medicaid costs and lead to quality improvements within the programs
- Able to implement new pilots and expand existing pilots
- Can contract directly with providers



- More opportunities to participate in pilots aimed at cost/utilization reductions, improved quality, and clinical collaboration

Overview - "Initial" Health Care Reform: Areas of Reform Impacting Providers

Negative Impact	
Potential Negative Impact	
Uncertain	
Potential Positive Impact	
Positive Impact	
Not Applicable	

Change	Impact				
	PPS Hospitals	CAHs	Home Health/Hospice/Palliative	Primary Care Physicians	Specialty Physicians
Reimbursement: Market Basket Update Changes					
Decrease in Self Pay (Expanded Coverage)					
Workforce: Primary Care Bonus (10%)					
No Cost Preventive Care					
New Delivery Systems - ACO, Bundling					
Value Based Purchasing - Quality					
Transparency - Pricing					
Insurance Reforms					
Tax Exempt Status					

Overview - “Initial” Health Care Reform: What Does the Future Hold? - Uncertainty

“...criteria specified by the Secretary”

“The Secretary shall establish...”



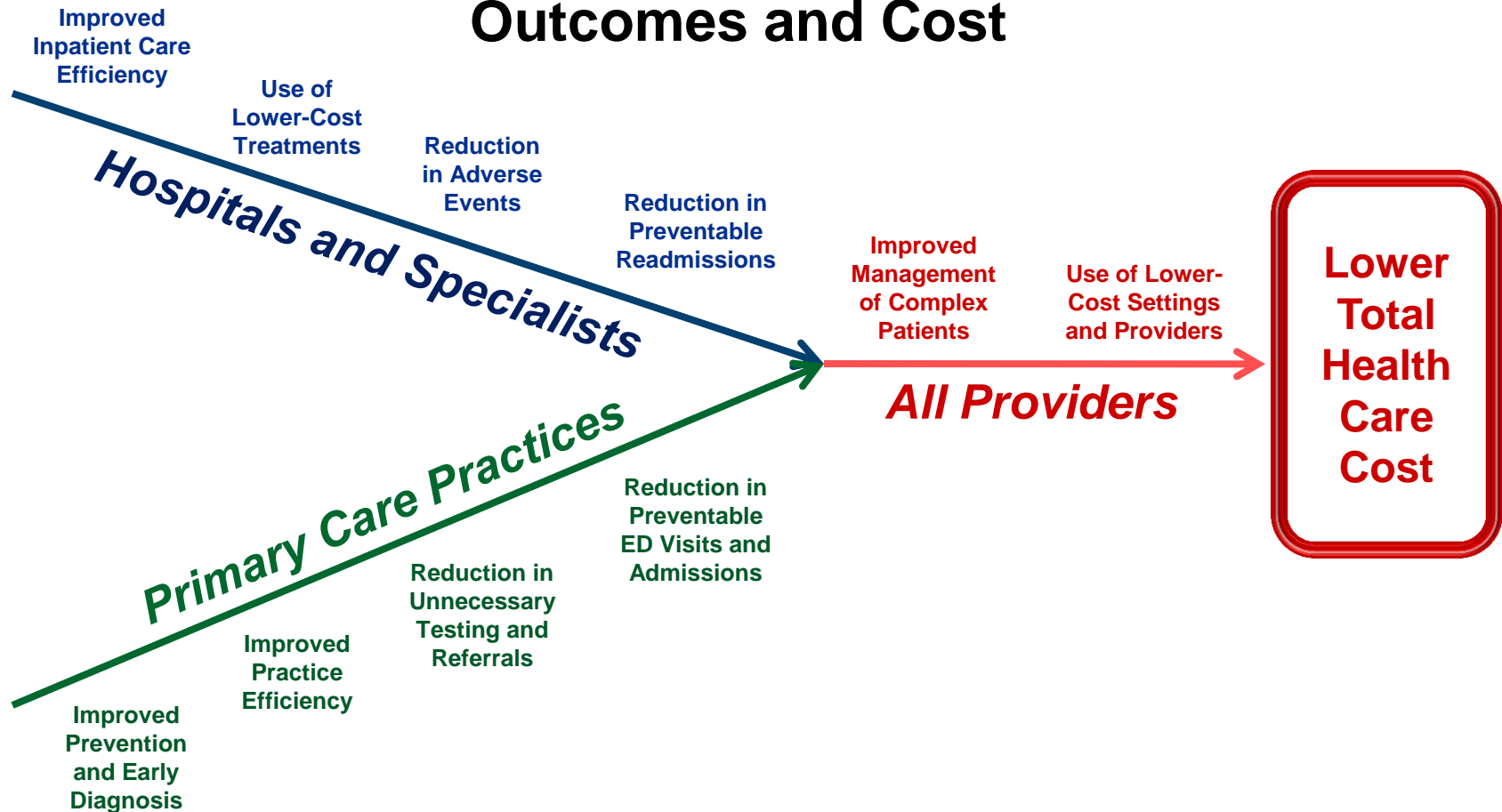
New Care Delivery Models Emerging Under Health Care Reform

New Care Delivery Models - Common Requirements:

- Requires coordination of care, aligned incentives, lower cost model:
 - Capitation
 - Value-based purchasing
 - Comprehensive payment for all inclusive service
- Interdisciplinary teams of care providers
- Defined and proven care practices - Primary care driven
- Access to patient information at various stages of care delivery
- Quality and outcome metrics tracking at various stages of care
- Various levels of service and management integration
- Structures and defined relationships allowing transfer of payment

New Care Delivery Models Emerging Under Health Care Reform

Operational Improvement Opportunities: Outcomes and Cost

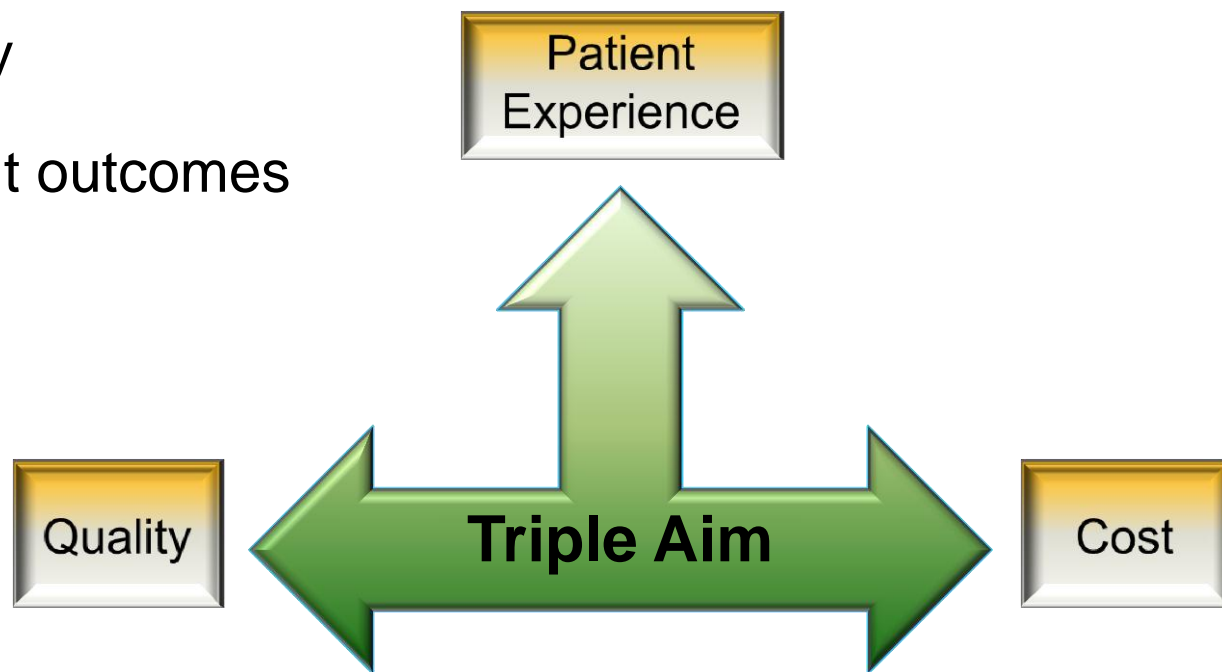


Source: "How to Create Accountable Care Organization, First Edition, September 7, 2009; 2009 Center for Healthcare Quality and Payment Reform

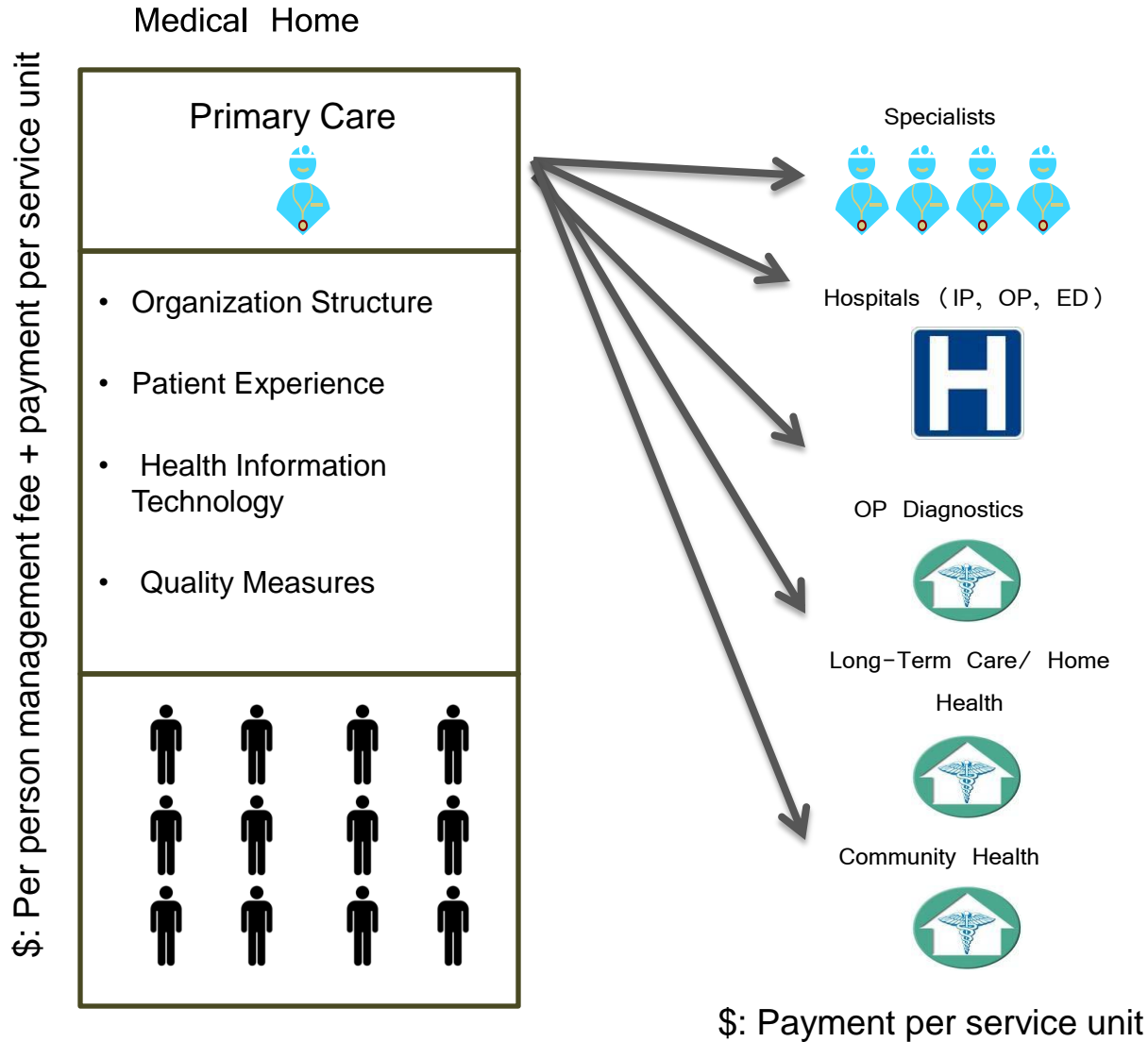
New Care Delivery Models Emerging Under Health Care Reform

New care delivery models will likely come with some type of bundled payment. Bundled payments provide incentives to delivery networks to:

- Integrate
- Improve quality
- Improve patient outcomes
- Lower costs



New Care Delivery Models Emerging Under Health Care Reform: Patient Centered - Medical Home

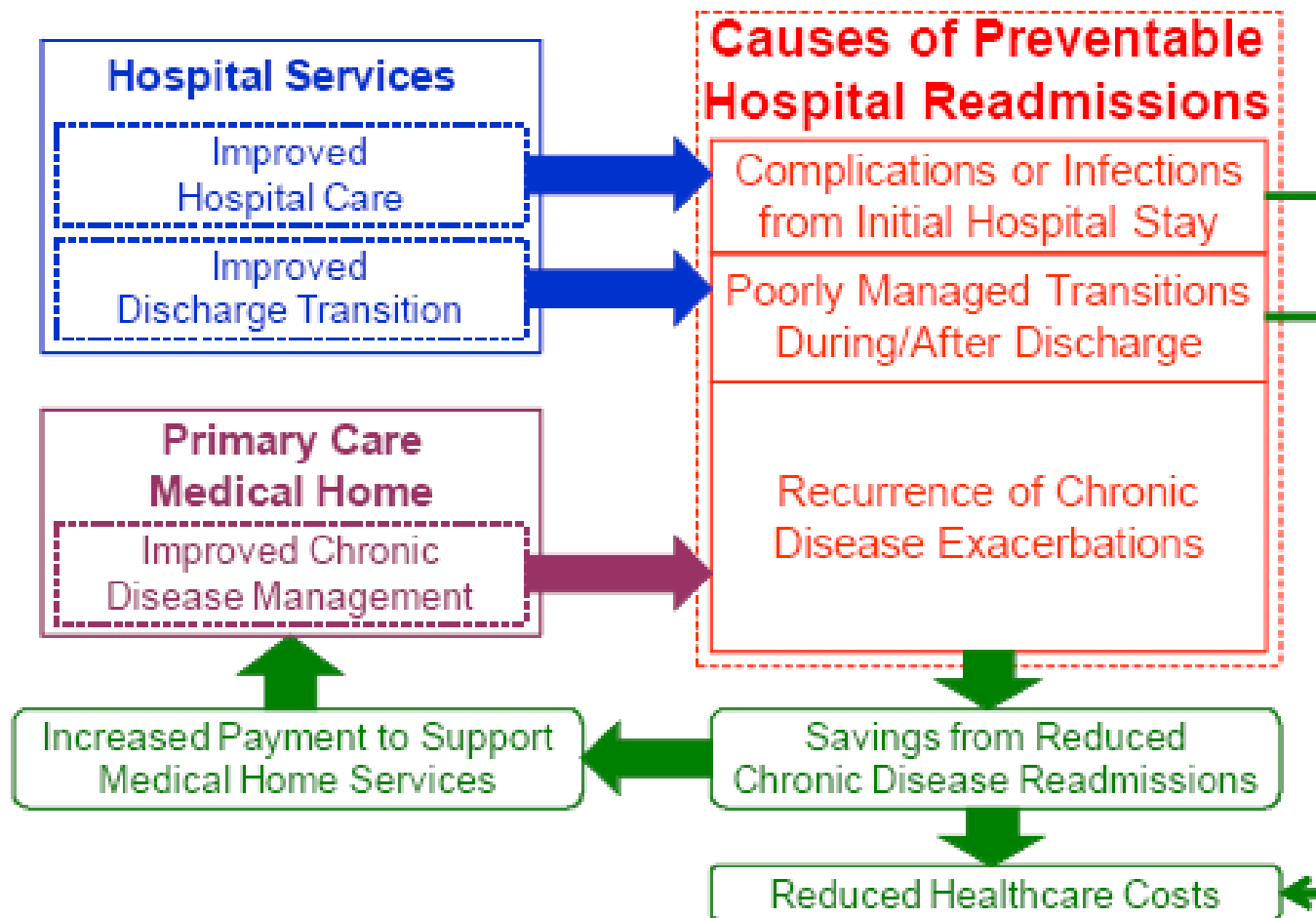


Quality IS primary outcome - Costs are not managed:

- Primary care coordinates population care
- Health care managed to optimize outcomes
- Prevention and patient self-management emphasized
- May focus on unique population
- Outcome measurement requires sufficient covered population

New Care Delivery Models Emerging Under Health Care Reform: Patient Centered - Medical Home

Will the Medical Home Better Coordinate Care?

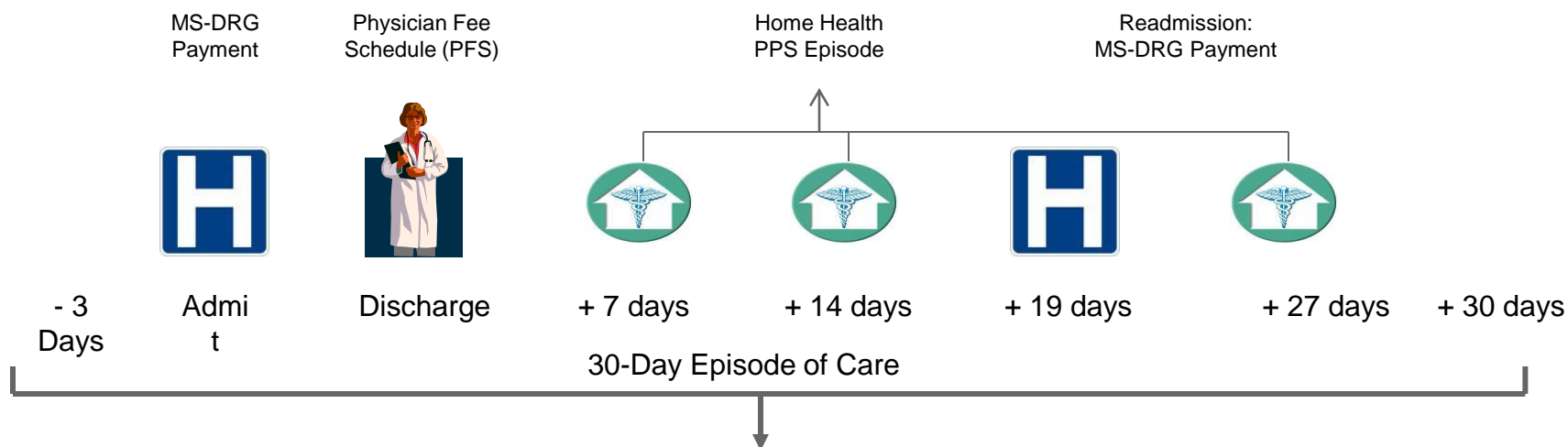


New Care Delivery Models Emerging Under Health Care Reform: Bundled Payments Concepts

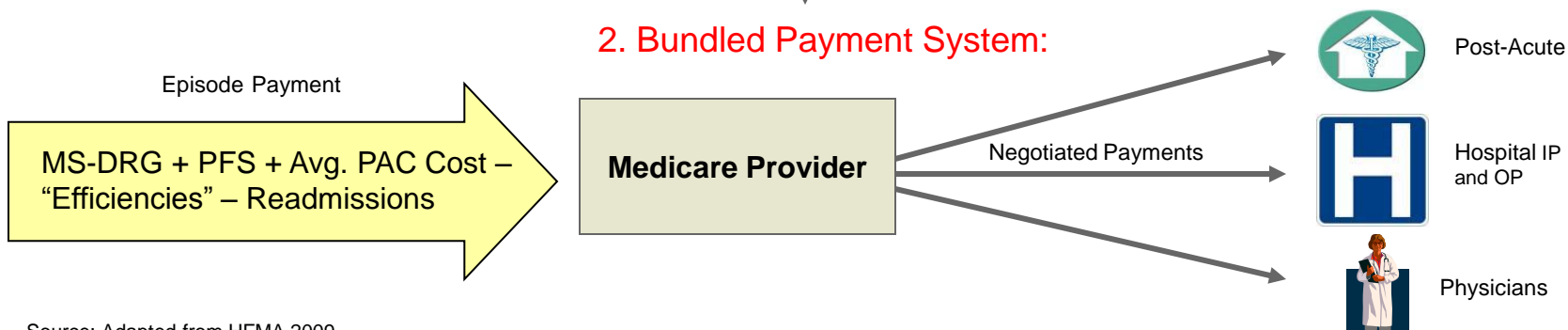
Legislation Expands the Bundled Payment Demonstration Project - Beginning in 2013

Sample Inpatient Stay

1. Current Payment Methodology:



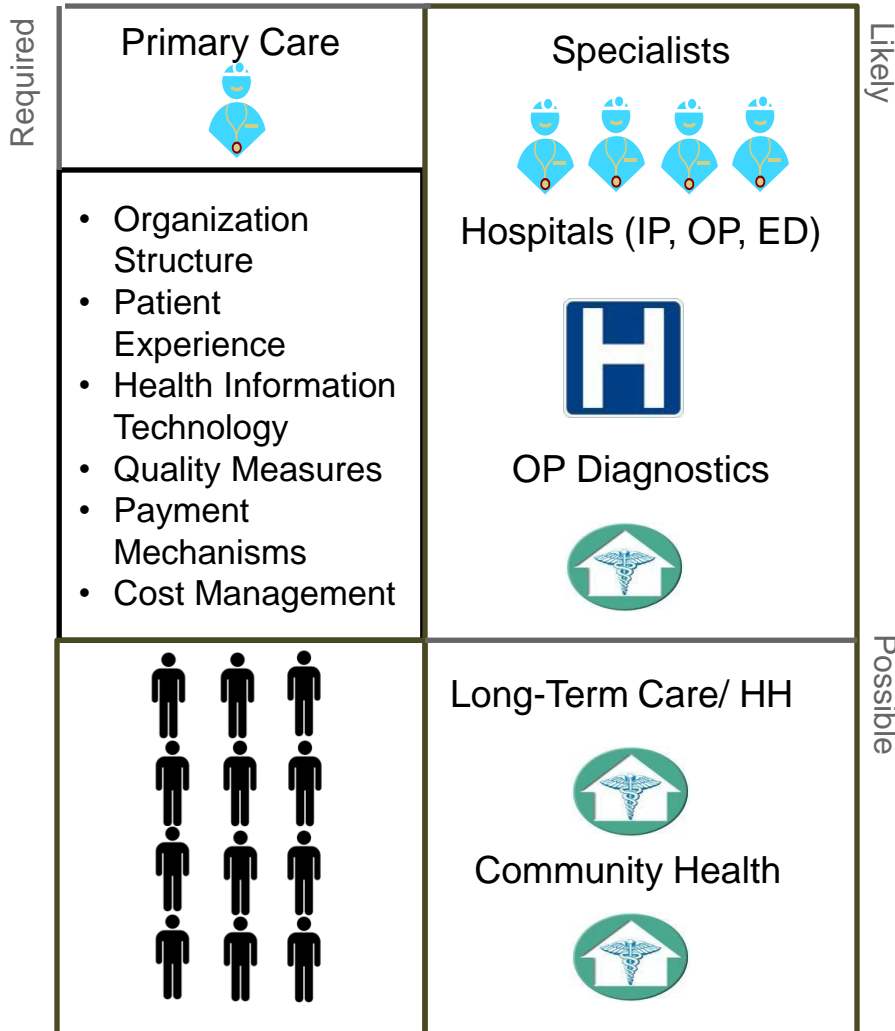
2. Bundled Payment System:



Source: Adapted from HFMA 2009

New Care Delivery Models Emerging Under Health Care Reform: Bundled Payments Concepts

Managing Bundled Payments Through Accountable Care Organizations



Cost and quality are primary outcomes:

- Primary care coordinates population care
- Health care managed to optimize outcomes
- Prevention and patient self-management emphasized
- Many options for payment including:
 - Shared savings
 - Partial per-person fee
 - Global fee

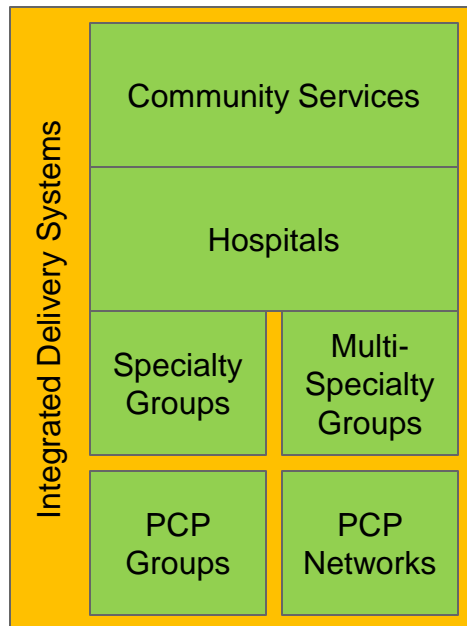
New Care Delivery Models Emerging Under Health Care Reform: Bundled Payments Concepts

Managing Bundled Payments Through Accountable Care Organizations (Continued)

On October 20, 2011, CMS issued the final rule outlining the framework for implementation of ACOs. The rule provides insight for hospitals and other providers as they strive to develop new patient care models.

The new ACO regulations:

- Provide a framework for facilitation of patient centric, quality, cost-effective, coordinated care across the patient care continuum through a legal entity that is responsible for ultimately managing the care of assigned Medicare beneficiaries.
- Support these efforts with a Shared Savings Program that would provide payment to the ACO for distribution to ACO participants.
- Require ACO reporting on ACO participants, 33 performance measures (reduced from the initial proposed 65 measures) for assigned Medicare beneficiaries among other requirements.



Ability to manage cost increases with participation, but complexity in managing payments and relationships also increases. IDS would be an exception.

New Care Delivery Models Emerging Under Health Care Reform - Summary of Final Rule

Accountable Care Organization:

- A legal entity that is responsible for establishing a mechanism for shared governance (provides ACO participants an appropriate proportionate control over ACO decision-making process).
- Responsible for receiving and distributing shared savings.
- Responsible for repaying shared losses and performing other ACO functions under a three-year participation agreement.
- Governance - ACO participants are required to have 75% or more control—beneficiaries are also required to be involved in the governance process.
- Eligible entities to form ACOs:
 - ACO professionals in group practices
 - Networks of individual practices of ACO professionals
 - Partnerships/joint venture arrangements between hospitals and ACO professionals
 - Hospitals employing ACO professionals
 - CAHs that bill under Method II, rural health clinics (RHCs) and federally qualified health centers (FQHCs)

New Care Delivery Models Emerging Under Health Care Reform - Summary of Final Rule

ACO Participant:

- Medicare-enrolled provider of service and/or supplier with TIN (during the three-year participation period cannot add ACO participants).

ACO Provider/Supplier:

- Provider of service and/or supplier (with TIN) that bills items and services it furnishes to Medicare beneficiaries under a Medicare billing number.

ACO Professional:

- ACO provider/supplier who is either a physician, physician assistant, nurse practitioner, or clinical nurse specialist

Goal:

- Fifty percent or more of ACO primary care providers are to be meaningful use electronic health record (EHR) users by year two.

New Care Delivery Models Emerging Under Health Care Reform - Summary of Final Rule

Beneficiaries are assigned to ACOs on the basis of primary care services rendered by physicians based on “plurality of allowed charges” based on a set of HCPCS codes including:

99201-99215

99304-99340

99341-99350

GO404, GO438, and GO439

Beneficiaries are assigned during baseline years to establish historical per-capita-cost benchmarks.

ACO threshold of assigned beneficiaries > 5,000

New Care Delivery Models Emerging Under Health Care Reform - Summary of Final Rule

ACOs will need to demonstrate and document:

- Processes to promote evidence-based medicine and patient engagement
- Ability to report on quality and cost measures (33 initial measures)
- Coordinate care (through telehealth, remote patient monitoring, and other enabling technologies)
- Patient centeredness:
 - Beneficiary experience of care (via survey)
 - Patient involvement in governance
 - Evaluation of population health needs and consideration of diversity
 - Implementation of individualized care plans
 - Integration of community resources

New Care Delivery Models Emerging Under Health Care Reform - Summary of Final Rule

- Aggregated data will be made available to the ACO (unless beneficiary has chosen to opt out of claims data sharing).
- The 33 performance measures address:
 - Patient/caregiver experience
 - Care coordination
 - Patient safety
 - Preventative health
 - High-risk population/frail elderly health needs

Data will be publically reported. Year one requires only reporting of performance measures.

Performance Measures Collected From:

- 7 Patient survey
- 3 Claims data
- 1 EHR incentive
- 22 GPRO data collection survey tool
- 33 Measures

New Care Delivery Models Emerging Under Health Care Reform - Summary of Final Rule

Provisions for Antitrust Consideration:

Antitrust agencies issued a final Statement of Antitrust Enforcement policy regarding ACOs participating in the Medicare Shared Savings Program (no longer includes a mandatory antitrust review).

New Care Delivery Models Emerging Under Health Care Reform

Summary of Potential Impact Compared to Current State

Requirements	Medical Home	Bundled Payments	Accountable Care Organization	Your Current Position
Infrastructure				
• Clinical integration - Technology to collect and report necessary information	High	High	High	
• Technology to coordinate patient care	High	High	High	
• Performance management tools that can cross multiple organizations	Medium	High	High	
• Alignment (or contracts) between providers	Medium	High	High	
Culture				
• Teamwork among ALL members - Are you a collection of providers or truly one organization?	Low	High	High	
• Clear leadership	High	High	High	
• Accountability	High	High	High	

New Care Delivery Models Emerging Under Health Care Reform

Role of Governance in This Period of Change

The governing board will need invest in significant planning efforts to navigate a changing health care marketplace.

- How should we best serve the community?
- What services do we do well; should we divest others?
- Do we have sufficient capital to support needed technology?
- What is our physician strategy? Is it supporting our quality plan?
- What are the top strategic initiatives to address in the next three to five years?
- Do we have financial and operational plans to support these initiatives?

New Care Delivery Models Emerging Under Health Care Reform - Operational Imperatives

Update the Operating Model - Focused Areas

Financial

- Lower cost model:
 - Service line portfolio: Understand all aspects of operations.
 - Care settings: Are they appropriate from a cost perspective?
 - Performance: Understand variability within and across service lines.
 - Impact: Assess the “various risk” models by service line.

Patient Care

- Service offerings:
 - Are there gaps in the desired care continuum?
 - Market position by service - Where does it need to be ?
 - Is the appropriate delivery modality being used?
 - Is the variability of outcome understood? Improvement needed?

New Care Delivery Models Emerging Under Health Care Reform - Operational Imperatives

- Improved efficiency:
 - Investments in technology and in business intelligence
 - Standardization of clinical protocols, evidence-based medicine, etc. - “One best way”
 - Facility design/redesign
- Increased hospital-physician integration:
 - Aligned economic incentives
 - Service line management
 - Enhanced physician leadership and training
 - Enhanced clinical interdependency (e.g., medical home)
- Enhance the patient experience:
 - Deliver the “promise” each and every time
- Improved data collection and transparency:
 - Quantify, demonstrate, and market quality and value

New Care Delivery Models Emerging Under Health Care Reform - Operational Imperatives

CMS Quality Reporting	PPS Hospital 1	PPS Hospital 2	CAH Hospital
Heart failure patients given discharge instructions	93%	81%	64%
Heart failure patients given an evaluation of left ventricular systolic (LVS) function	100%	96%	80%
Heart failure patients given ACE inhibitor or ARB for LVS dysfunction	95%	98%	69%
Heart failure patients given smoking cessation advice/counseling	100%	100%	75%

New Care Delivery Models Emerging Under Health Care Reform - Operational Imperatives

A Note for Rural Providers:

- For rural providers, there are additional considerations:
 - Size - Many will not meet size levels for participation (relates to reporting and cost risk).
 - Resources and complexity - Significant investments may be prohibitive.
 - Additional complexity - Size and lack of specialists likely to require coordination with other hospitals/systems.
 - Payment - Cost-based reimbursement versus bundled or population payments.
 - Market share - Rural providers may lack clout when negotiating “fit” within urban-based networks.
 - Advantages - Cost and quality of rural providers may be strengths as larger providers work with bundled payments or look to reduce readmissions.
 - Alignment - Many rural providers have alignment locally between PCP and hospital.
- Rural providers should target building blocks and look to potentially partner with other providers, networks, or systems to address gaps in size and resources.
- State and federal pilots/grants may provide critical resources.

NOTE: This does not suggest that the only strategy is joining a system!

A Common Reaction...

“We need to join a system.”



Potential Impact of Health Care Reform on CAHs

Common Reasons for System Alignment:

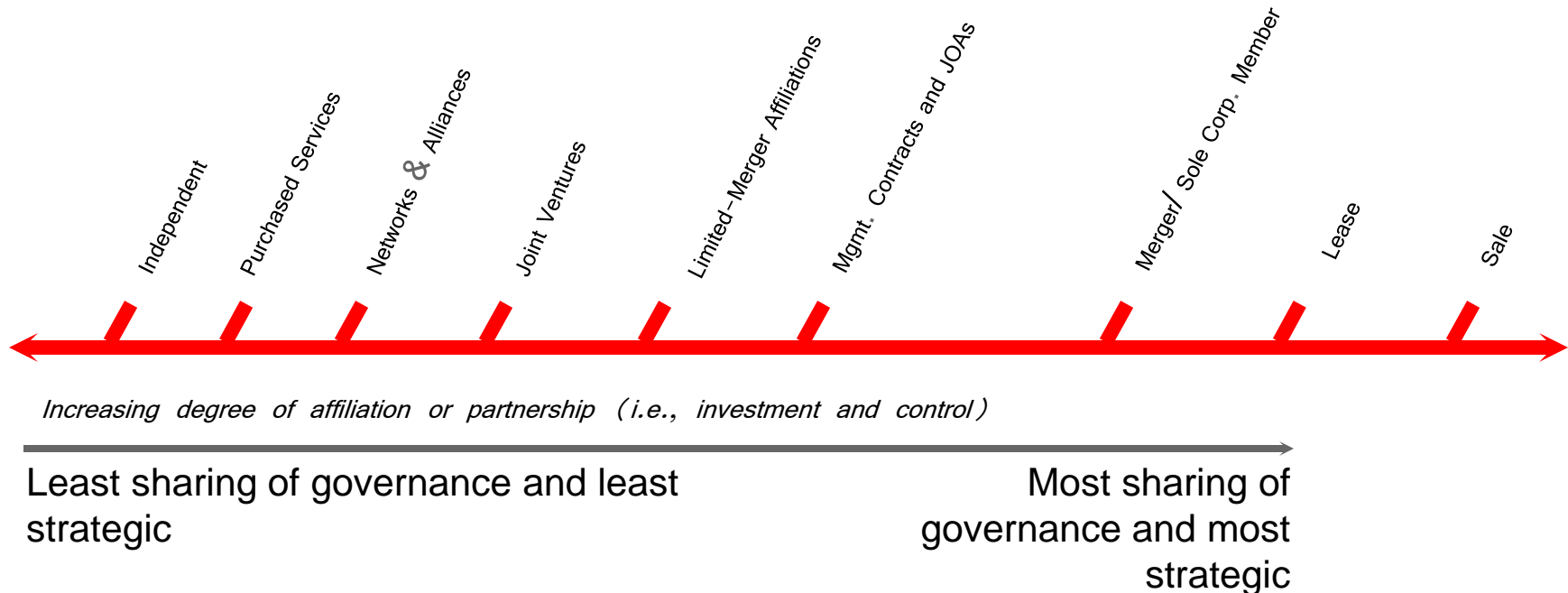
- Access to capital
- Clinical and/or management expertise
- Access to specialty care
- Strong competition from one or more competitors who share the market
- Desire to spread fixed costs
- *IT Support*

Potential Impact of Health Care Reform on CAHs

Common Reasons for System Alignment:

Many CAHs are evaluating alignment options—but is this necessary?

Range of Options That Do Not Require A Full Merger



Preparing for Reform - A Multifaceted View

A recent seminar presented a panel of experts including a family physician, an insurance executive (WellPoint), an actuary (Milliman), and a CEO of a small health system in Illinois. The following is what they recommended health systems do now to prepare for reform initiatives:

Actuary:

- Know your market well (not just your facility information).
- Execute clinical protocols well.
- Embrace payment changes (remember fee for service is only good if volume increases).
- Identify your partners or potential partners and begin to develop a “knowledge base.”
- Identify gaps in your continuum.

Preparing for Reform - A Multifaceted View

Actuary: (Continued)

- Execute clinical protocols well
- Embrace payment changes (remember fee for service is only good if volume increases) and be willing to take the lead as a provider to define what is desirable with payors; however, interim steps may be necessary.
- Businesses are looking for unique relationships with clinics to create different care models.
- Identify your partners or potential partners and begin to develop a “knowledge base.”
- Data and analytics will be used to provide incentives for outcomes in the future.

Preparing for Reform - A Multifaceted View

CEO of a Health System:

- Take command of the “pipeline” for volumes (arms race for PCP/retail clinics/etc.).
- Develop strategic alliances for pre- and post -acute care (very few providers are ready for full ownership of the entire continuum of care).
- Identify your partners or potential partners and begin to develop a “knowledge base.”
- Communication with payors and physicians needs to be more transparent. Show benefit and risk for changes in reimbursement and care models. Remember, behavior follows incentives.
- There is an opportunity to be successful with the commercial market; however, incentives need to be paid for sustained benefits as this is costly to pursue (i.e., cannot keep reducing reimbursement with changes).
- Change will be required of the end consumer who still pays the least for health care today (diet, smoking exercise ,etc.). Employers need to focus on this key element today to create change—employers are not good purchasers of health care today).
- Health system board member comment - Change requires clarity, participation, ownership, and a reward structure. Does not see this in health care today. “We have *product* innovation but not *process* innovation in health care.”

Preparing for Reform - A Multifaceted View

Payor (WellPoint):

- Insurers are looking for partners willing to pilot a variety of innovative reimbursement structures. This is built on trust (barrier now IT systems “collide”—need interfaces?).
- Insurers and providers need longer term relationships to really develop innovative programs (at least 5-year contract—one contract cited for 15 years).
- Talk to the clinicians; they know where there are gaps in the system.
- Insurers have clinical data to tell the story of how consumers used health care (i.e., did that prescription really get filled?) and have data to help clinicians develop dashboards to decrease redundant care.
- Insurers realize they need to take a bigger role in engaging/educating the consumer.
- Do not fear your payors.

Preparing for Reform - A Multifaceted View

Family Physician:

- Find the 20% of your physicians who are willing to take on a leadership role now.
- How to get ready for tomorrow but still remain profitable today is a big challenge. How can we build bridges from a fee-for-service model to bundled payment and remain viable in the transition period? ***Remember, we cannot use fee-for-service data to understand the future.***
- Get the community involved. Use phone, e-mail, and other tools to link service to the community—change will be a grass roots effort.
- All physicians will not be treated equally as in the past (equitably yes—equal no).

In Summary...

The reality of Health Care Reform will drive many initiatives. Focus resources are needed to delivery preventative, diagnostic, and treatment services to a given population via a lower cost model that enhance clinical outcomes.

**“The right care...
at the right time...
in the right setting...
at the right cost...
with the right outcome.”**



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