What Trustees Need to Know About Healthcare Reform

Annual Rural Health Care Leadership Conference
February 2013

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President and CEO
Grinnell Regional Medical Center

We’re here for you when you need us.
Presentation Overview

- Setting the Stage – What’s Driving Reform
- PPACA – Impact for Hospitals
- Rural Challenges and Concerns
- Positioning for Success

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
• Hospital CEO for 25 years
• Raised in a Rural Hospital Family
• American Hospital Association Board of Trustees 2000-05
• Nat’l Advisory Committee for Rural HHS 2008-11
• Current Boards:
  • Health Forum (AHA)
  • Grinnell College
  • University of Iowa College of Public Health
• Faculty:
  • American College of Healthcare Executives
  • University of Iowa
• Testified multiple times for US Congress

We’re here for you when you need us.
“Go West Young Man, Go West”

Home to Grinnell College

First Prepaid Health Plan 1921

We’re here for you when you need us.
Obama Health Reform Efforts

- **CHIP Reauthorization**
  - 11 million new kids and pregnant moms
  - Feb. 4, 2009

- **American Recovery and Reinvestment Act**
  - Feb. 17, 2009

- **FMAP HIT Comparative Effectiveness Wellness**

- **Affordable Care Act**
  - 32 million more covered
  - Insurance reforms
  - Individual mandate
  - Insurance exchange
  - Administrative simplification
  - Provider cuts
  - Quality initiatives
  - New delivery models
  - Wellness initiatives
  - New taxes
  - Program integrity
  - March 23, 2010

**LOST DOG**

- 3 legs blind in left eye
- missing right ear
- tail broken
- recently castrated....

Answers to name of "Lucky"
Let me get this straight. We're going to be "gifted" with a health care plan we are forced to purchase and fined (taxed) if we don't, written by a committee whose chairman says he doesn't understand it, passed by a Congress that hasn't read it but exempts themselves from it, to be signed by a president who also smokes, with funding administered by a treasury chief who didn't pay his taxes, to be overseen by a surgeon general who is obese, and financed by a country that's broke.

What could possibly go wrong?

Maxine on Healthcare Reform
Health Care Reform – Despite ACA
Dramatic Change, Great Opportunity

- Reform (ACA) abstract; skeptics, political,—However the market is driving reform
- Health cost curve not sustainable; National economy remains unstable
- Payments declining; Production costs increasing; Payer mix deteriorating (increasing government); Patient mix changing (increasing chronic diseases)
- Exponential increase in medical knowledge / technology
- Wide variation in clinical practices
Health Care Reform – Despite ACA

Dramatic Change, Great Opportunity

- Improving IT systems—availability of clinical data
- Change accelerating—business model changing, population health, skill & scale required, risk sharing, markets at different stages
- Increase in retail health care—employer health plans uncertain; Insurance Exchanges are the 2014 “Jump Ball”; consumer is king
- Relentless Demographics—Boomers / aging, obesity
- Significant health professional shortages—particularly in rural areas

“Even if you are on the right track, you’ll get run over if you just sit there.”

- Will Rogers
Health Care Reform...
It is different from the 1990s!

- Costs TRIPLED - 20 years ($2,800 to $9,000+/capita)
- Demographics & lifestyles led to skyrocketing incidence of chronic disease & spending
- The number of uninsured has grown to 50 million +
- Insurance company abuses have grown
- The economic collapse at least partially caused by the housing “bubble” taught us some crises can’t be sustained

Health Care Reform...
It is different this time!

- State and federal budget woes impacting $$ available for Medicare and Medicaid
- Fee for service is declining – hospital revenue base is eroding
- Clinical data has shown everyone the variation in care delivered and in outcomes
- THIS TIME the discussion isn’t just about managing payment – it’s about changing how care is delivered
We need to fix this!

U.S. HEALTHCARE IS ONLY EXPENSIVE WHEN YOU USE IT!

Medicare Spending Varies Widely

- More than 3-fold variation between regions
- When accounting for differences in illness, variation still is 2-fold
- Due to differences in volumes of services to patients

Iowa = $5,310 to <$7,000;
Louisiana = $9,000 to $16,350

Dartmouth Atlas Project, February 27, 2009

Quality Varies Widely Too

Average Annual % of Diabetics Receiving Hemoglobin A1c Testing at Least Once Per Year

- Central Iowa = 84% to 92%
- Central Louisiana = 66 to 77%

Dartmouth Atlas Project, September 9, 2010
Over-Utilization

Guess the following number:
- How many doctors are involved in the care of a single Medicare patient, on average, in the last 6 months of life, at New York University Medical Center? (i.e. How many doctors are billing for care of one patient in 6 months?)

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“What is Common Sense?
That sense which is not commonly applied! ”

- Mark Twain
What is Reform About *This Time*?

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>INSURANCE REFORMS</th>
<th>DELIVERY SYSTEM REFORMS</th>
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<tbody>
<tr>
<td>Hope to cover 32 million more people, or 94%; 23 million will remain uninsured</td>
<td>End the abuses</td>
<td>Improving value – both carrots and sticks</td>
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<tr>
<td><strong>Medicaid Expansion</strong></td>
<td>New structures for purchasing – insurance exchanges</td>
<td>Reducing waste – 40% ?</td>
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<td>Payment Reforms – Value-Based, Shared Savings, bundled payments</td>
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<td>Innovation Center</td>
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What is Reform About *This Time*?

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<tr>
<th>OTHER</th>
<th>SAVING MONEY</th>
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<tbody>
<tr>
<td>Wellness &amp; Prevention</td>
<td>Increased Taxes</td>
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<tr>
<td>Quality &amp; Safety</td>
<td>Fraud and Abuse / RAC recoveries</td>
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<td>Workforce education, training</td>
<td>Reduced Payments – <em>at least $155 BILLION less paid to hospitals over 10 years</em></td>
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<td>Regulatory Oversight</td>
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<td>Community Needs Assessments</td>
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<td>Incentives to reduce utilization of services</td>
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Future Health Care Economic Model

- **Pay for Performance**
  - Cost
  - Quality
  - Access
  - Service

- **Bundled Payments**
  - Individuals' Care Across Settings

- **Global Payments**
  - Discrete Populations
  - Disease based

- **“Own” the Lives**
  - Shared Savings
  - Capitation

**Today: Paid for Volume**
- Maximize Clinical Operations
- Highly Effective Delivery System

**Soon: Paid for Events**
- Assume Performance Risk
- Integrated Healthcare Delivery

**Tomorrow: Paid for Lives**
- Manage Population Health
- Insurance Risk Capable

**Health Care Reform – Shifting Risk to Providers**

**Biggest Challenge: When And How Do We Transform To Accountable Care?**

- Traditional Fee-for-Service FFS
- Shared Savings
- Episodic Bundling
- Global Payments
- Traditional Capitation

New Value-Based Payment Models: When Do We “Jump”?
Value Based Purchasing Quality Measures: 2013

• For FY 2013, CMS finalized 13 total measures
  – 12 process measures in process measures domain
  – HCAHPS patient experiences with care in patient experiences domain

• For FY 2013, performance measured July 1, 2011 – March 31, 2012

• How to include CAHs??

Scoring Hospitals’ VBP Performance

• Hospitals will receive the higher of their attainment or improvement score on each measure
• Score on each domain equals points earned out of total possible points

• FY 2013 payment based on:
  
  HCAHPS 30%  Process 70%

FY 2014 payment based on:

  HCAHPS 30%  Outcomes 30%  Process 20%  Efficiency 20%
Hospital-Acquired Conditions

Beginning in FY 2015, adds a 1 percent penalty to hospitals in the top quartile of rates of Hospital-Acquired Conditions, resulting in reductions of $1.5 billion over 10 years.

Fitting It All Together

ACOs  Center for Innovation

Readmissions  Bundled Payments  VBP
Health Insurance Exchanges

“Why They Matter”

- Potential to shift the nature of the health care transaction
- Rapid transition from Defined Benefit Pensions to Defined Contribution Benefit Pensions should be seen as a precedent and likely bellwether
- At the low end, roughly 10% of the population. At the upper end, 50% + of the population eventually involved

Health Insurance Exchanges

“Why They Matter”

- Likely to survive political winds of change due to bi-partisan nature, state control and market orientation
- Most people entering at the bronze and silver levels – huge financial implications for providers
- Will employers opt out and take the penalty??
Surveys Show Wide Range Forecasts of Shift Away from Employer-Sponsored Coverage

• Mercer (Marsh & McLennan company) study
  – Overall, only 8 percent “definitely or probably” will stop offering employer-sponsored health insurance after 2014

• McKinsey study
  – Overall, 30 percent “definitely or probably” will stop offering employer-sponsored health insurance after 2014
  – Employers with “high awareness” of health reform provisions reported even higher numbers – between 50 and 60 percent likely to drop coverage
  – Lower income workers will be more likely to switch to exchanges, while higher income employees may remain in employer-sponsored plans

Ready or Not... Paying For Value is Here

- Medicare
  • Payment cuts for poor patient satisfaction (now)
  • Payment cuts for poor quality (soon)
  • Bundled payments and “ACO” payment models (now)
- Commercial Insurers
  • Pilot programs implemented
  • Increasing pre-certification requirements and denials
  • Interest in permanent changes to payment systems
- Large employers
  • Direct contracting for preferred providers for selected services (Lowe’s contract with Cleveland Clinic for open heart surgery)
  • Interest in relationships with providers for improving employees’ health and reducing insurance costs
Summary of the “New Normal”
Under an Accountable Health Network Model:

- **Changed Care**: focus on population health, care management, improved outcomes
- **Changed Payment**: pay for value not volume, more economic risk for providers
- **Changed Experience**: more engaged patients, increased consumerism

Adapted From: Health Care Advisory Board “Accountable Care Playbook” 2011

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So is the New Law…

Good? or Bad?

YES
High Triple Aim Goals

- **Improved Health of the Population**: The best local & national health outcomes, the healthiest communities, and patients who are the most engaged and accepting of personal accountability
- **Enhanced Patient Quality/Experience**: The best performance on customers’ willingness to recommend our clinics, hospitals and partnered health plans to family & friends
- **Reduced per Capita Cost of Care**: Cost trends that are at or below general inflation; the best performing overall health care costs in the region
Hospitals will need to be:

More Integrated
More Accountable
More At-Risk

Health Reform Implementation...

This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.

Winston Churchill, November 10, 1942
at the Lord Mayor’s Luncheon at Mansion House in London, in response to the Allied victory at the Second Battle of El Alamein.
### Implications for Rural Community Health Systems

- Need to be a part of systems involved in the new payment systems (shared savings, risk) or lose volumes to those who are

- Rural providers may be MORE important than ever in the health system: lowest cost setting of care, ability to engage patients and providers, ability to impact health status

- Drive toward patient-centered medical homes represents an opportunity for rural providers – its what we already do!

### Challenges:

- Physician shortages—will become even more difficult

- IT requirements and costs—high and getting higher

- Sharing risks with new entities we don’t control

- Ability to DEMONSTRATE high quality and low costs, in order to be included in the system of care

- Complex Organizational and legal structures
Concerns for Rural Providers

• CBO: Eliminate alternative hospital designations:
  – Critical Access Hospital
  – Sole Community Provider
  – Medicare Dependent Hospital
  (Endorsed by Ways & Means Democratic Staff)

  – Total cut to rural facilities over 10 years:
    • $62.2 Billion

Adapted from Alan Morgan, CEO National Rural Health Association
Concerns for Rural Providers

• President Obama:
  – End add-on payments for docs and hospitals in frontier states
  – Reduce CAH reimbursement to 100% of cost
  – End CAH reimbursement for hospitals located 10 miles or less from another hospital.
  – Cut to rural facilities over 10 years:
    • $6 Billion

Concerns for Rural Providers

• House Republican Leadership:
  – Cut $2 billion from frontier state add-on payments
  – Cut $14 billion from rural hospital reimbursement structures
  – Cut to rural facilities over 10 years:
    • $16 Billion
Concerns for Rural Providers

• Sequestration cuts:
  – Super Committee failed to produce savings and therefore an automatic cut of two percent is instituted for all providers.
  
  – Cut to rural facilities over 10 years:
    • $5.9 Billion

Concerns for Rural Providers

• Critical Access Hospitals:
  – Medicare and Medicaid
  – Created in 1997 to prevent rural hospital closures (360 hospitals closed in 1980-90s)
  – 101% cost reimbursed
  – 41% CAH operate at a financial loss today

• Cost Based Payment is not consistent with where reform is going…
  – Does not necessarily incent low cost or high quality
“When you come to a fork in the road, take it!”

Yogi Berra

Positioning for Success

Trustees Must Have a Focus on:

• Quality
• Safety
• Costs
• Experience
• Special Focus on Integration
GRMC has a Running Start

- Iowa 9th most efficient state Medicare Spending
- GRMC tied for 6th most efficient hospital
- GRMC one of only 5 hospitals in Iowa to earn an “A” rating for patient safety from Leapfrog
- Value Based Purchasing already in bonus (Core Measures/Patient Satisfaction)
- Patient Satisfaction in top quartile
- Leapfrog “Top Rural Hospital” rating
So What’s This All Mean?

Find a way to organize ourselves into an approach that delivers on the Triple Aim

1. Improved Health of the Population
2. Enhanced Patient Quality/Experience
3. Reduced per Capita Cost of Care
Clinically Integrated Organization

• Clinical Integration Legal (FTC) Definition: “…an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.” It is not capitation and it is not the messenger model of the past.

Clinically Integrated Organization

• Our Definition: “Aligning physicians, hospitals, and other providers to improve quality, safety and efficiency, and to contract effectively in order to compensate providers for value created. CI is not an end, in and of itself. Its purpose is to position us for success in the management of population health and to sustain the viability of our mission.”
Possible Grinnell – Clinically Integrated Organization – Relationships

- Developed initially as GRMC Subsidiary—has the ability to change into Joint Venture
- Clinically Integrated Organization – (CIO, LLC)
  Single or Multi-Member Subsidiary of GRMC
  Could include physician & other hospital owners; Physician-led

Provider Clinical Integration Agreements

- Other Healthcare Providers
- Post Acute Care Facilities
- Independent Practices
- GRMC Employed Physicians / Mid levels

Mercy Health Network CIO Structure

- Trinity Health Novi, MI
- Catholic Health Initiatives Englewood, CO
- MRTC/Telehealth
- Population Health Shared Services
- PhyCare
- Mercy-Sioux City CIO
- Mercy – Dubuque CIO
- Other Future CIOs: Grinnell?
- Mercy – North Iowa CIO
- Mercy – Clinton CIO
- Mercy Health Services – Central Iowa CIO

Significantly Increased Responsibility/Accountability for State-Regional Markets
University of Iowa Healthcare Alliance Structure

Network Board and Management

Member Sub-Agreements

Required Components of Network Membership

Primary Care Development/Care Coordination
Research & education
Insurance Initiatives/Relationships
ACSSO (Accountable Care/Shared Services)
Medicare ACO
Integrate Ancillary/Treatment Services
Clinical Services
Ambulatory Services
Home Care
New Technologies/Innovation Businesses
Specialist Relationships
Tele-health

Initial Alliance Members/Affiliates

1 University of Iowa Hospitals & Clinics
11 MHN Hospitals
1 Mercy Cedar Rapids
4 Genesis Health System Hospitals
30 Rural Affiliated Hospitals
Why Does It Matter?
Acknowledgments

• John Combes, MD
  – American Hospital Association

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  – American Hospital Association

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  – Mercy Medical Center – Des Moines

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  – University of Iowa College of Public Health

• Alan Morgan
  – National Rural Health Association

• Association Hospital and Health Systems – January 2011