

# **Indiana Hospital Association Health Reform Update**

Indiana Council of Community Health Centers

February 9, 2012



**Indiana Hospital Association**

# Indiana Hospital Association

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- Public policy and advocacy
- Regulatory support
- Data and reports
- Education
- Communication
- Indiana Patient Safety Center

# Health Reform: What is next?

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# Why Pursue Reform?

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***It is helpful to remember that our current system is on an unsustainable path:***

- 51 M uninsured and growing
- Over the last 10 years, insurance premiums rose 131%
- Healthcare as % of GDP approaching 20%

*“Health care is a scarce resource, and all scarce resources are rationed in one way or another. In the United States, most health care is privately financed, and so most rationing is by price: you get what you, or your employer, can afford to insure you for.”*

-Peter Singer, professor of bioethics at Princeton University

*“In the public sector, primarily [Medicare](#), [Medicaid](#) and hospital emergency rooms, health care is rationed by long waits, high patient copayment requirements, low payments to doctors that discourage some from serving public patients and limits on payments to hospitals.”*

-Peter Singer, professor of bioethics at Princeton University

# Health Reform is Law

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The Patient Protection and Affordable Care Act (PPACA) was signed into law March 23, 2010



# The PPACA: What's In The Bill

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- Expanding coverage
- **Delivery system reform**
- Taxes/financing changes
- Workforce development
- Wellness/prevention
- Quality and safety



# Reforming the Delivery System

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Creates new ways to tie  
payments to quality improvement

- ★ *Accountable Care Organizations*
- ★ *Bundling Pilots*
- ★ *CMS Center for Innovation*
- ★ *Value-Based Purchasing*
- ★ *Geographic Variation*
- ★ *Medical Homes*
- ★ *Gain-sharing*
- ★ *Medical Liability Demonstrations*

***“Value Over Volume” or “Quality vs. Quantity”***

# **Can Delivery Reform Deliver Cost Control?**

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“There must be a tighter incorporation of doctors into the business of hospital management. Physicians are the primary users of the hospital, yet they often remain completely isolated from the economic realities of hospital functioning.”

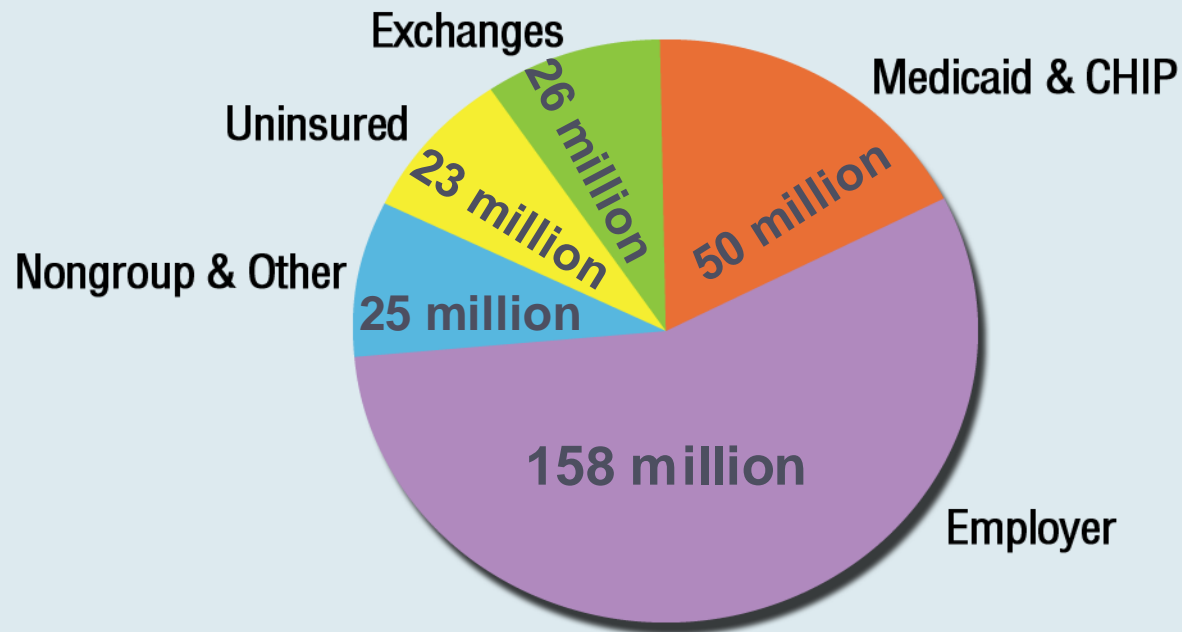


Kenneth Williamson, Associate Director of the AHA

(New York Times, April 28, 1968)

# Expanding Coverage to 32 Million

## What Would Happen Under Reform



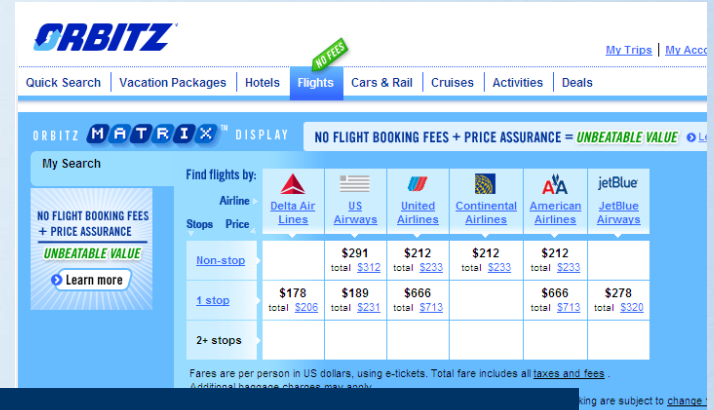
Source: Congressional Budget Office

# Insurance Exchanges

“Small companies and individuals who don’t have insurance through work will be able to purchase insurance through newly created marketplaces, known as insurance exchanges, created and regulated by states.

... Think of it as an Orbitz or Travelocity for health care plans.”

- *USA Today*



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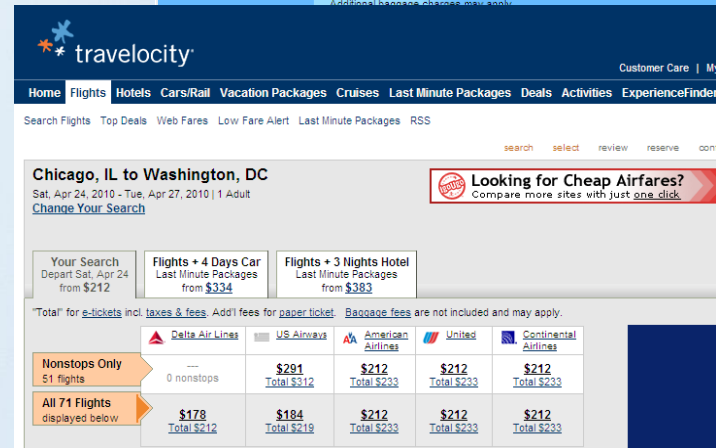
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Nonstops Only \$1 flights	0 nonstops	\$291 Total \$312	\$212 Total \$233	\$212 Total \$233	\$212 Total \$233
All 71 Flights displayed below	\$178 Total \$212	\$184 Total \$219	\$212 Total \$233	\$212 Total \$233	\$212 Total \$233



# Individual Mandate

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- If the individual mandate fails, what happens?
  - Less incentive for uninsured to get covered
  - Hospitals would be stuck with uncompensated care, \$155 B in cuts from PPACA
- Some alternatives exist, including a state-imposed mandate
  - Used in MA
  - Constitutional



# Insurance Reforms Implemented

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Effective September 23, 2010:

- No cancellation of coverage when someone becomes sick
- No lifetime benefit limits or unreasonable annual limits
- No pre-existing condition exclusions for children under age 19 (*others impacted in 2014*)
- Free preventive care (including immunizations for children)
- Adult children up to age 26 can stay on their parents' health plan

# **A change in payment approach**

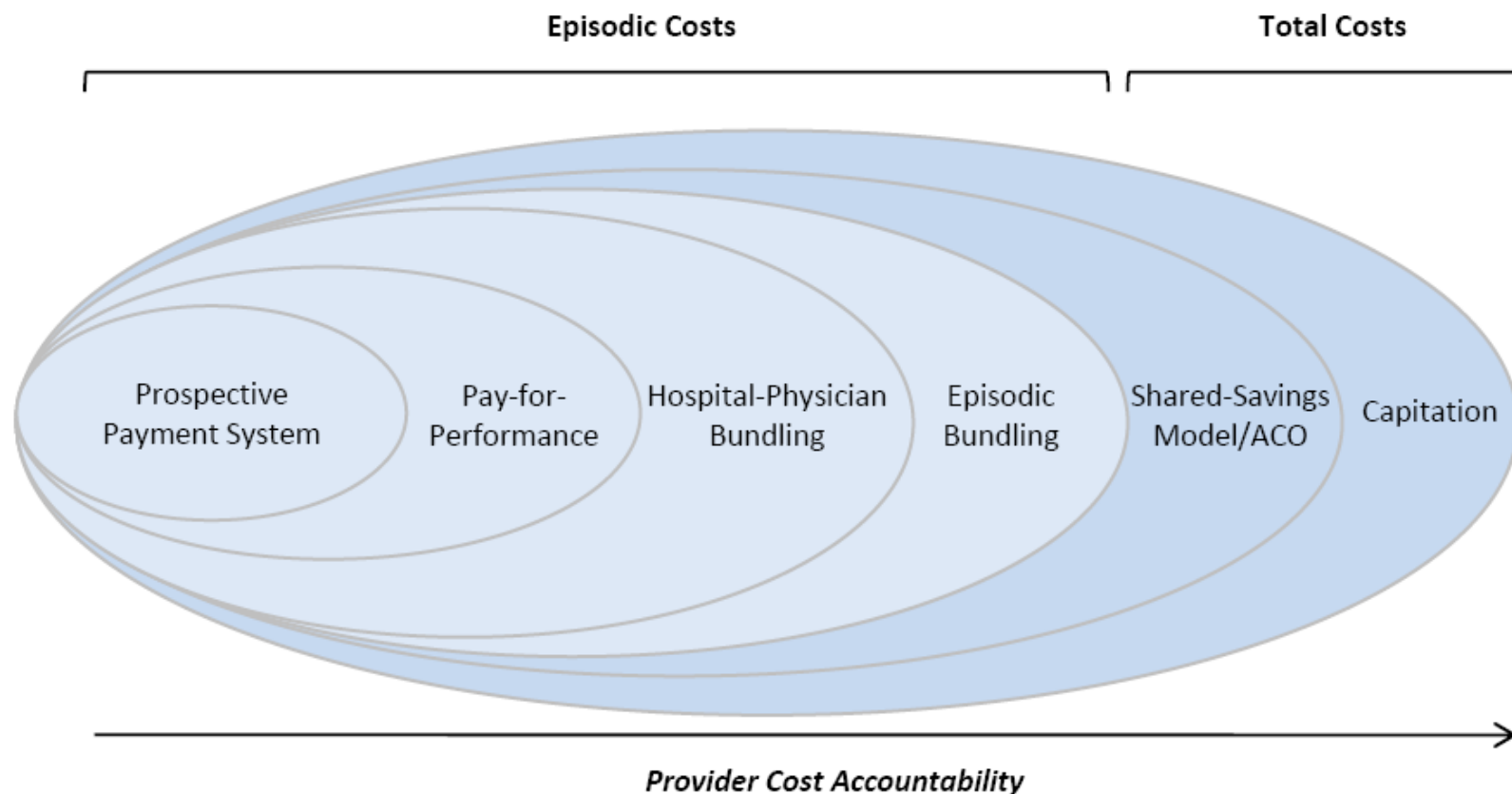
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**A move from “volume” to  
“value”....**

**One foot on the dock, one  
foot on the boat....**



# Changing the Payment Model



# **Accountable Care Organizations**

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- An ACO is a network of doctors and hospitals that shares responsibility for providing care to patients. In the new law, an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.
- There are very few ACO's per se, but there are many other experiments in creating accountable organizations. Many are with commercial payers (Norton and Humana)

# Accountable Care Organizations

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- ACOs can begin in 2012
- Also referred to as “Shared Savings Program”
  - Care for at least 5,000 Medicare beneficiaries
  - Must have sufficient primary care providers
  - Must coordinate care across various groups
  - Report on cost and quality measures
  - Could include hospital or be physician-only



# Pioneer ACO's

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- 32 Pioneer ACO's picked in December , 2011
- CMS predicts \$1.1b in savings over 5 years
- 160 organizations had sent letters of intent
- The Franciscan Alliance is the only IN entity selected

# Pioneer ACO's

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- First two years are a “shared savings” model
- Higher level of savings and risk than “traditional” ACO plan
- If successful in first two years they qualify in third year for “population-based” payment
- Will have to develop contracts with other payers for team-based care that lowers spending and boosts quality

# Behavioral Health

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- “People with mental illnesses will significantly benefit from the health care law”
- “Many individuals with mental illnesses will now have access to health insurance that covers mental health and substance abuse services on a par with the coverage of medical and surgical care. Those who cannot afford insurance will qualify for subsidies that will help them pay for it. Insurers will have to meet certain requirements, including covering people regardless of any pre-existing condition”

-Bazelon Center *For Mental Health Law*

# Behavioral Health

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- Mental health clearly linked to better outcomes
- Real key for hospitals will be partnering with BH providers to reduce readmissions

# Health Needs Assessment

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- Tax-Exempt Hospitals are required to file in each year a description of how they are addressing community health needs identified in a *community needs assessment* and any identified needs not being addressed and the reasons *why* they are not being addressed, along with audited financial statements.
- This description and the audited financial statements will be reported as part of the organization's Form 990. PPACA further mandates that the IRS review the community benefit activities of each hospital at least once every three (3) years.

# Opportunities

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What opportunities does health reform provide?

- Experimentation– Looking at new ways of care and partnering with other providers
- Being Paid to Deliver Quality Care– Getting incentives right is good for patients and providers
- Improved Health Status for Hoosiers– Wellness efforts combined with expanded coverage/better access to primary care can improve outcomes and lower long-term costs to economy
  - Hospitals will need to engage community in enrollment efforts closer to 2014

# Implementation

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What will be expected of health care organizations?

1. More integrated care

→ ***Innovation***

2. More at-risk payments

→ ***Cost, Efficiency***

3. More accountability

→ ***Quality, Transparency***



# **How will this impact hospitals?**

- Less revenue in the short term
- Need to improve “reliability” of care
- Need to invest in IT
- Need to reduce re-admissions
  - Align with long-term care providers
  - Managing chronic care-outside the walls of the hospital

# **How will this impact hospitals?**

- Need to improve HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores
- Need to become expert at enrollment
- Need to review services that are no longer affordable

# **New Financial Challenges:**

## **Demands on capital**

- Need to be in compliance with new Health Information Technology standards
- Improving old facilities:
  - All private rooms
  - Repairs and replacement
  - New technology

# New Financial Challenges:

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## Physician challenges

- On-call compensation
- Support for continuing to open panels to Medicaid
- Recruitment and retirements
- Electronic medical records investment
- Competition in outpatient services
- Competing specialty hospitals

# Hospital Responses:

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## Focus on quality and service:

- Improving patient safety
- Reducing avoidable errors
- Reducing avoidable readmissions
- Patient satisfaction
- Physician efficiency and satisfaction
- Employee satisfaction

# Hospital Responses:

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## Focus on transparency:

- Embrace public reporting on quality
- Be prepared for price transparency
- Share information openly with your community

# Hospital Responses:

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## Physician-hospital alignment:

- Employment
- Joint ownership models
  - Joint ventures-outpatient
  - Physician equity in hospital
  - Physician management of clinical departments

# Various Responses To Change

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**Experimenting:** IN system one of 32 initial Pioneer ACOs approved by CMS

- Responsible for 22,000 Medicare beneficiaries as of Jan. 1, 2012

**Partnering:** New affiliations to realize efficiencies in a challenging environment



# Hospital Responses:

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## Consolidation:

- Mergers
- Clinical alignment
- Joint ventures

# Hospital Responses:

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## Cost cutting:

- Lean/Six Sigma
- Eliminating services
- Becoming more efficient
- Reducing community benefit

# Hospital Responses:

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## Growing profitable services:

- Reducing “out-migration”
- Recruiting new specialties
- Acquiring new technologies

# To Remain Viable:

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Relentless focus and execution on:

- Costs
- Quality/Reliability
- Prices
- Transparency
- Service

# To Remain Viable:

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- Be agile: Quick to adapt to new ways of delivering care
- Be open to new thoughts and new relationships
- Be believed- by your Doctors, your patients, and your community
- Be financially astute

# **My Advice to Hospitals**

Do what is best for the patient  
and everything else will  
take care of itself.

# **Thank you!**

