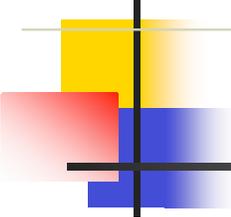


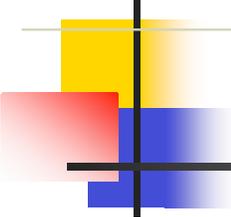
Federal Health Care Reform: Implications for Hospital and Physician partnerships

Walter Kopp
Medical Management Services



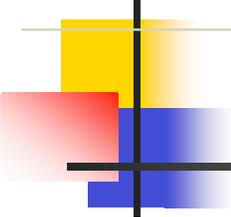
Outline

- Overview of federal health reform legislation
- Implications for Care delivery
- Implications for Community Clinics
- Implications for Hospital based clinics
- Accountable Care Organizations
- Discussion



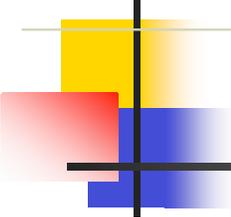
Provisions to Expand Coverage

- Medicaid expansion
- Insurance market reforms – expanding coverage and changing the rules by which health insurers offer coverage
 - Extends coverage for the young
 - Provides coverage protection for the sick
 - Prohibits lifetime limits and restricts use of annual limits
- Insurance Exchange
- Wide range of provisions intended to control healthcare costs and improve the healthcare delivery system
- New individual responsibilities coverage responsibilities
- New employer responsibilities



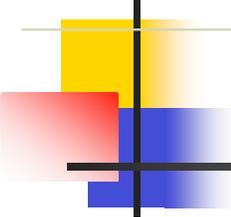
Delivery reform

- Delivery reform holds promise of containing costs and improving quality
- Public reporting to promote transparency
- Comparative effectiveness research
- Local decisions developed by Accountable Care Organizations (ACOs) with support from Evidence Based Guidelines



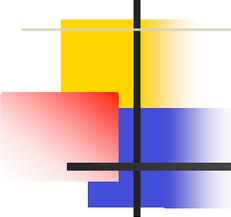
Payment reform

- Independent payment advisory board will make recommendations for payment changes in Medicare policies in the private sector
- CMS Innovation Center
- Alignment between public and private Payers
- Accountable care organizations will use bundled payments and shared decision-making to improve outcome and costs locally
- Provides five-year 10% bonus for primary care and general surgeons in healthcare professional shortage areas
- Medicaid primary-care rates will be 100% of adjusted Medicare rates for 2013 and 2014
- Differential payment for positions based on quality of care compared to cost
- Reduces payment for readmissions in selected conditions starting in 2012
- Expansion of value-based purchasing program (pay for quality and outcomes and not just services)



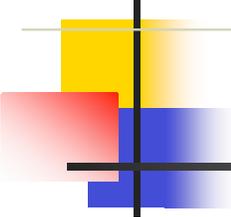
Health information technology

- Bills on HITECH incentives
 - The existing law provides incentives for the adoption of Meaningful Use (CalHIPSO) and implementation of health information exchanges (CEC)
- Promotes tele-health
- Each state quickly moving to implement HITECH
 - CalHIPSO
 - CEC



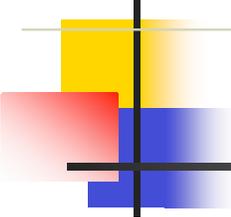
Demonstration Projects

- Patient Centered Medical Home
- Innovation center
- Value based purchasing for hospitals, SNFs HHAs, Ambulatory Surgery Centers
- Hospital readmissions reduction program
- Pediatric ACOs
- Pilot program for Bundled Payments
- Quality Reporting for LTC, Rehab and Hospice
- Payment Adjustment for Hospital Acquired Conditions



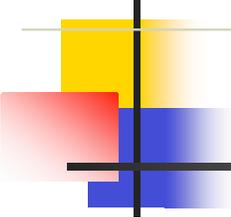
Implications for Care Delivery - Community clinics

- Community health center expansion: \$11 billion in new funding over five years starting in FY 2011
- Expanded National Health Service Corps
- Medicaid expansion to 133% of poverty with no restrictions
- Exchanges and community clinics: private insurers in exchanges cannot be paid less than Medicaid rate and requires plans to contract with exchanges
- Medicare: FQHCs will be paid for preventative services
- Development and support of residency programs in FQHCs



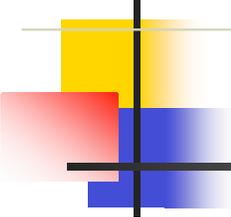
Implications for Hospitals

- Understanding implications of different payment methods, ACO, bundled payments,
- Finding constructive ways to work with your medical staff or local IPA
- Consider investments in integrated groups
- Evaluate your systems ability to manage care and control costs
- Evaluate your market opportunities and how they will change as more get insurance
- Consider branding strategies that position your organization to market directly to patients as an organized system of care. (electronic ID card, benefits of membership in your organized system of care)



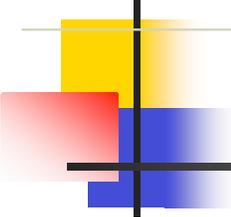
Financing

- Reduce spending in Medicare program (volume and incentives)
- Increase Medicare payroll tax on high earners
- New taxes and fees on drug manufacturing, devices, and health insurance sector
- Eliminate various tax benefits and exclusions
- Impose penalties on employers and individuals
- Reduce Medicare Disproportionate Share Hospital (DSH) payments
- Impose tax on high-cost employer health plans



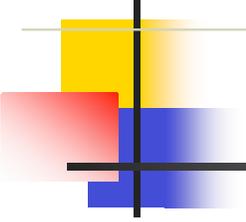
Short-term Impact

- New, temporary high-risk pool funded from federal government
- New consumer protections for people with private coverage
- Tax credits for small, low-wage businesses
- Reduced costs for consumers in Medicare “doughnut hole”
- Reduced payments, potential cuts to Medicare Advantage coverage



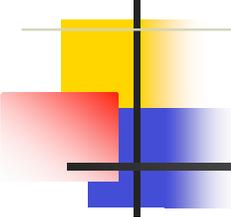
Long-term Impact

- Many newly enrolled in Medicaid
- Medicaid primary care provider payments rise to Medicare levels (initially 100% federally funded) 2012 and 2013
- many gain private coverage through new market rules, subsidies, and mandates
- many remain uninsured



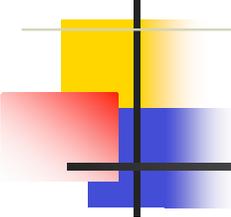
Long-term Impact

- Systemwide cost trends
- State budget impact
- Availability of doctors and other health care providers
- Impact on safety net providers and county programs



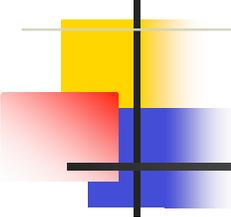
Accountable Care Organizations

- Medical groups with 5000 Medicare lives may apply in 2014
- Hospital participation not required
- Savings from reduced costs will be shared with ACO
- Creates incentives for physicians to manage care and benefit from the savings
- Best if hospitals and physicians learn to work together to control costs and produce better outcomes
- What implications will this create for how hospitals and physicians work together to care for a community



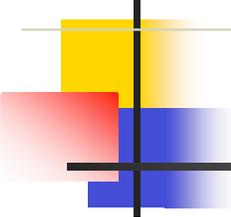
Establishing ACOs

- Eligible Organizations
- Assigning Medicare beneficiaries to the ACO
- Setting spending benchmarks
- Performance Measurement and accountability
- Distributing Savings
- Hospitals can assist medical groups to get prepared with an EHR and an organized system that can attract patients and manage care cost effectively with better outcomes



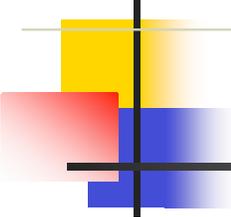
Building a Successful ACO

- Know your costs and utilization issues
- Build physician leadership and understand Utilization Management and Chronic Disease management systems that can reduce costs and increase health outcomes
- Integrated Electronic Medical Record with community wide integration and coordination
- Understand your community health profile and how you delivered care in the past
- Patient-Centered Medical Home structure
- Financial models and performance metrics
- Become a real health center



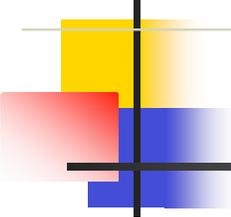
Finding Best Practices

- Taking the Cleveland Clinic to McAllen
- Acuity adjusted cost per discharge
- Cost (management) vs. Utilization (MD) issues
- Use of checklists
 - Checklist Manifesto, Atul Gawande
- Cultural Barriers
- Data Barriers
- Clinical Judgment
- Evidence based guidelines
- Applying best practices
- Google diagnostic
- Quality Monitoring
- IHI.org Implementation Map (Don Berwick- CMS)



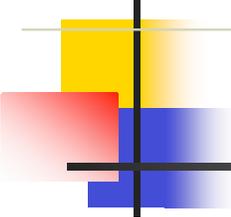
Implementation issues

- Will your physicians engage?
- Will they accept check lists and protocols?
- Will they react to the incentives?
- What is right for your community?
- Understanding what for profit ACOs are planning with Wall Street?
- Will CMS develop an NTSB approach?
- The advantage of plane crashes



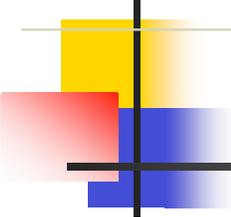
Legal Challenges that impact ACOs

- Federal fraud and abuse laws
- Antitrust restrictions
- Tax-exempt issues
- Liability
- State laws



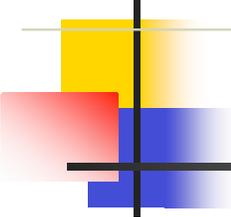
Medicare Shared Savings Program

- ACO defined as: “groups of providers of services and suppliers meeting criteria specified by the Secretary may work to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’)”
- Many more specifics to come
- Unknown acceptance by Health Plans



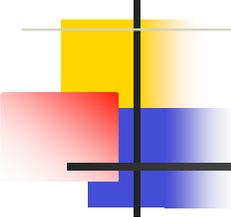
Who is eligible to be an ACO?

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals (through contractual affiliation)
- Partnerships or joint venture arrangements between hospitals and ACO professionals (contractual or organizational)
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary deems appropriate.



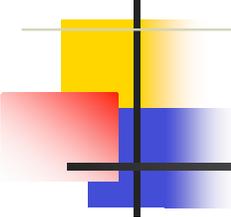
ACO Requirements

- An ACO must: Be accountable for quality, cost, overall care of the Medicare FFS beneficiaries assigned to it. How will Secretary assign beneficiaries?
- Enter into an agreement with the Secretary to participate in the program for not less than a 3-year period
- Have a formal legal structure that would allow the organization to receive/distribute payments for shared savings to participating providers/suppliers



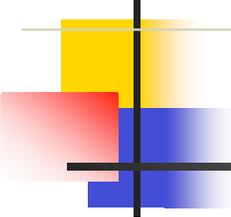
Payment To ACOs

- Payments will continue to be made to providers of services and suppliers participating in ACOs under Medicare's FFS Program for Parts A & B
- ACO is entitled to receive payment for shared savings if it meets certain requirements:
Quality performance standards established by the Secretary
- Reporting requirements
- Benchmark target



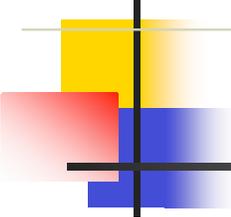
Payment To ACOs

- In each year of an agreement period ACO shall be eligible to receive payment for shared savings only if: The estimated average per capita Medicare expenditures under the ACO for Medicare FFS Beneficiaries (adjusted for beneficiary characteristics) is at least the benchmark percent



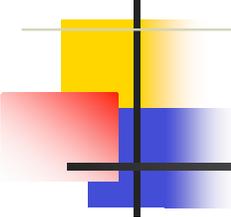
Payment To ACOs

- If ACO meets quality and savings requirements ACO may be paid a percent of the difference between the estimated average per capita Medicare expenditures for the beneficiaries under the ACO and the benchmark. Timing of payment?
- What's the percentage?
- Medicare retains the difference
- Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO. What is the cap?
- Secretary may sanction (including terminate) an ACO for avoiding at risk patients in order to reduce likelihood of increasing costs. Could financial sanctions be greater than the shared savings?



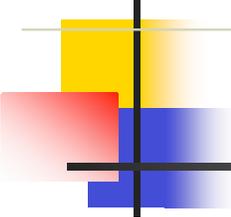
Partial Capitation Is An Option

- Secretary has option to use partial capitation model to make payments to ACOs
- ACO at risk for some but not all of the items and services under part A & B
- Secretary may limit partial capitation model to ACOs that are highly integrated and capable of bearing risk (as determined by Secretary)
 - Secretary may use other payment models it determines will improve quality and efficiency of items and services Reduction in FFS Payment for Non-ACOs?
 - Mandatory ACOs?
- Unknown role for health plans? (ACOs exclude Medicare Advantage members)
- Should providers consider forming insurance companies?



Provider Implications

	Costs	Quality	Coordination	Risk
FFS	+++	?	--	0
P4P	++	+	--	0
Bundled Pmt	--	+	+	0
PCMH	-	+	++	0
Profit Share	--	?	+	0
Risk Share	--	?	++	+++

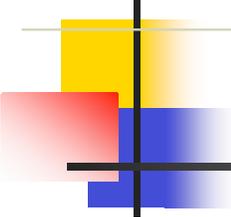


Payment implications

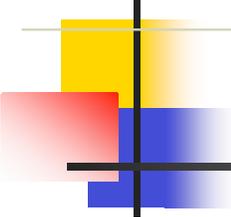
Payer	Clinics	Hospitals
Medicaid	same	negative
New Medi-cal	positive	negative
Medicare	same	same/negative
Commercial	positive	same/negative
New commercial*	positive	positive
Still uninsured	same/negative	same/negative
Undocumented	same/negative	same/negative

*formerly uninsured

Implications for medical practices

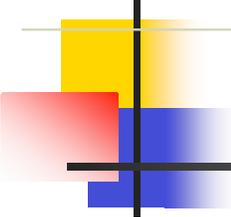


- Medical groups can form ACOs directly with Medicare and other payers
- Medical groups with capitated experience are well-positioned
- Aggressive medical groups are trying to expand their market
- Capital investment needed to meet ACO requirements
- Working with hospitals and health plans can help control costs and be a source of capital



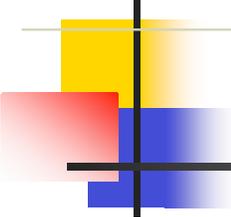
Implications for health plans

- Health plans can form ACOs with physicians
- Health plans can change reimbursement methodology to align goals with physicians
- Health plans can be a source of data and capital to help facilitate the development



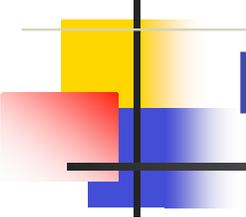
Implications for Community clinics

- Will Clinics continue to grow and serve low income populations?
- What will happen to funding for clinics and DSH?
- Where will clinics refer patients in the future?
- Will private physicians and integrated groups compete for newly insured patients?
- How will community clinics continue to serve undocumented and still uninsured patients?



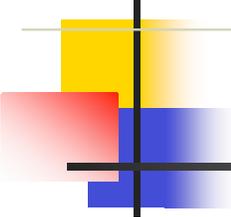
Implications for Hospital based clinics

- Hospitals can organize their affiliated groups and clinics to form ACOs with them
- If hospitals do nothing physicians can organize around them and profit from reducing services
- Better integration and coordination of care works to the benefit of the hospital and over all costs
- Better to be part of it than just sit back and have it done to you.



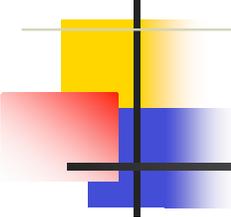
Examples of Successful Integrated Models

- Kaiser
- Mayo Clinic
- Cleveland Clinic
- Geisinger Clinic
- Virginia Mason
- Sutter Health
- Intermountain Healthcare
- Healthcare Partners



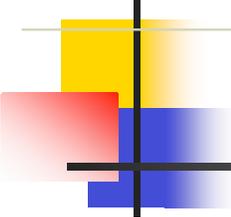
Aligning incentives

- Do we understand how each party is affected?
- Can we identify common strategies that help both parties?
- What resources are needed to be effective?
- How will each party benefit from these changes?



Discussion

- Communities can benefit from the years experience in other communities' implementation of quality metrics and clinical integration (Learn from Kaiser, PAMF, Mayo, Gisenger, et al)
- Develop an integrated medical community that can work to improve outcomes at lower cost.
- Providers and Payors can benefit from federal health reform, if implemented as envisioned
- Implementation will unfold over a lengthy timeline, and are not certain until final regulations are issued
- Payment incentives and Utilization Management will change the way we deliver care.



Thanks for listening

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Thanks to Peter Lee from PBGH and Marian Mulkey CHCF and CAPG