

Reform and Reimbursement: Implications for Hospital- Physician Strategies

Community Hospital 100 Webinar Series

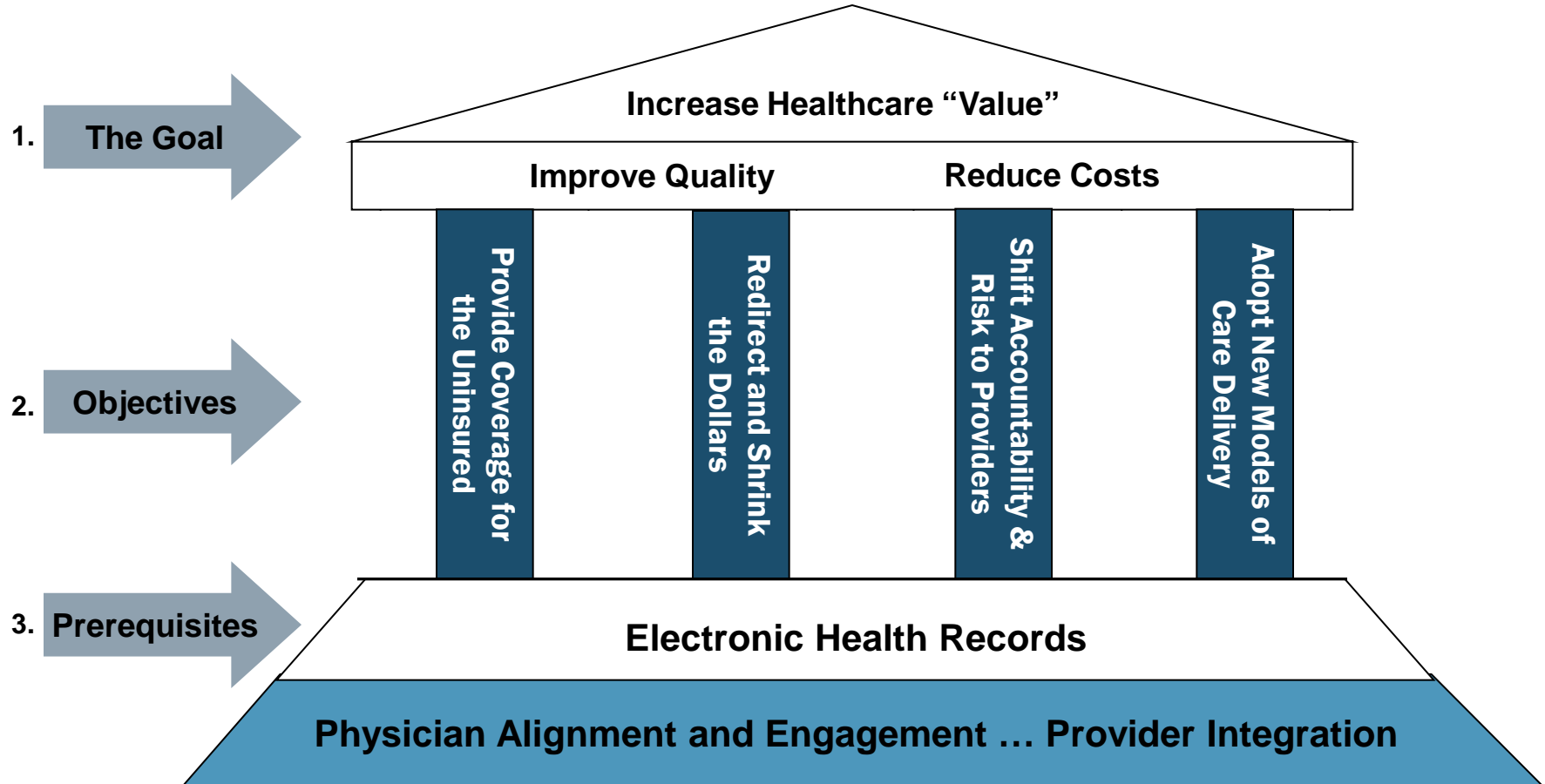
Wednesday, February 9, 2011



- **Update on Healthcare Reform Rollout**
- **Impact of Healthcare Reform on:**
 - **Hospital Reimbursement**
 - **Physician Reimbursement**
 - **Hospital-Physician Alignment**
- **Reform Imperatives and Action Items**

Update on Healthcare Reform Rollout

Healthcare Reform Provisions

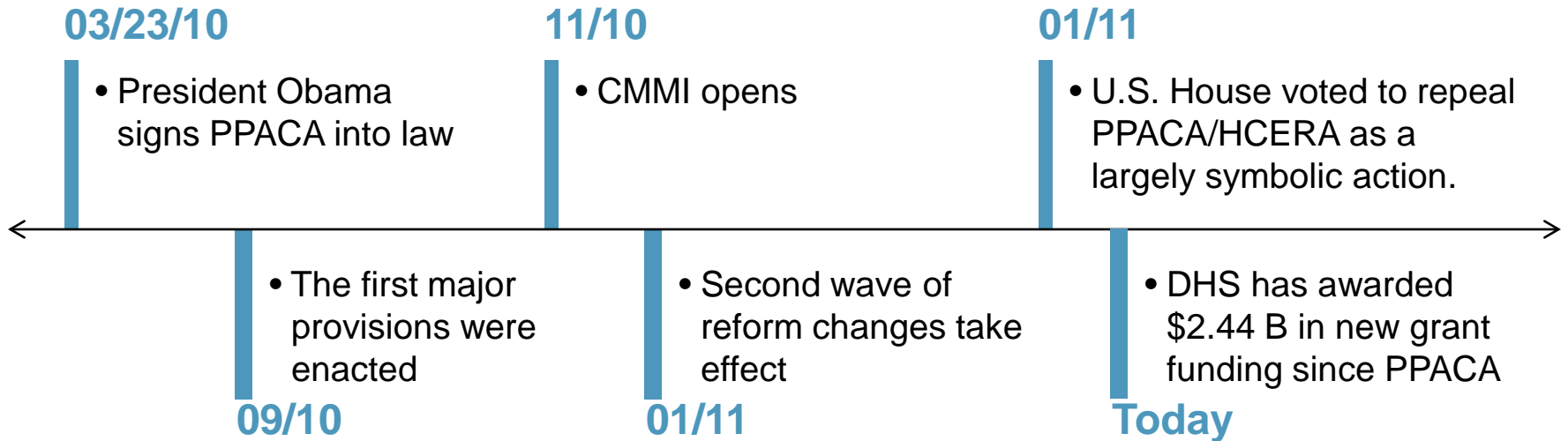


Source: HFMA Regulatory Sound Bites | September 2009

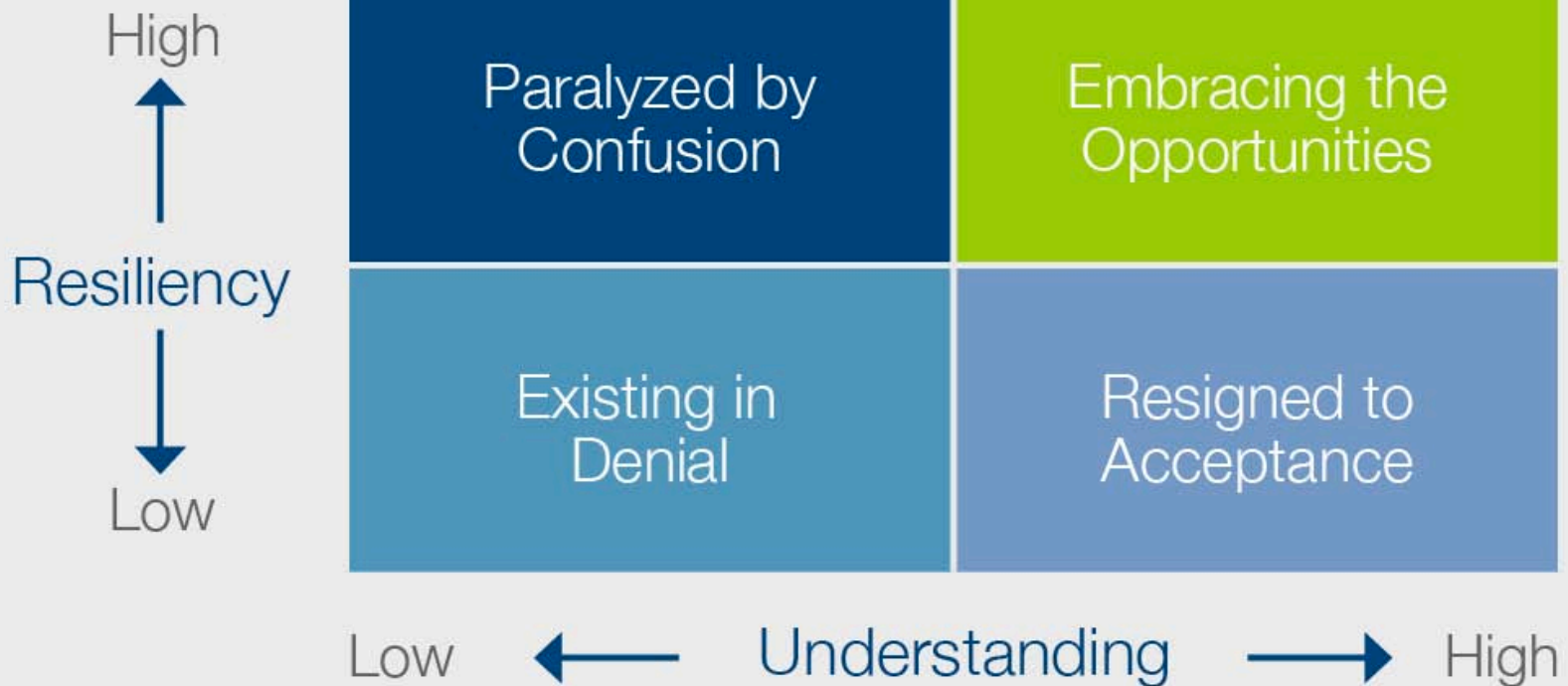
Transform the current system that is seen as inefficient and unsustainable

- Focus on managing patients more efficiently through the system
 - Incentivize behavior to accomplish this
 - Punish the providers that can't figure it out
- Emphasize value and mechanisms to capture and report value-based metrics
- Begin movement to employ best practices and standardization

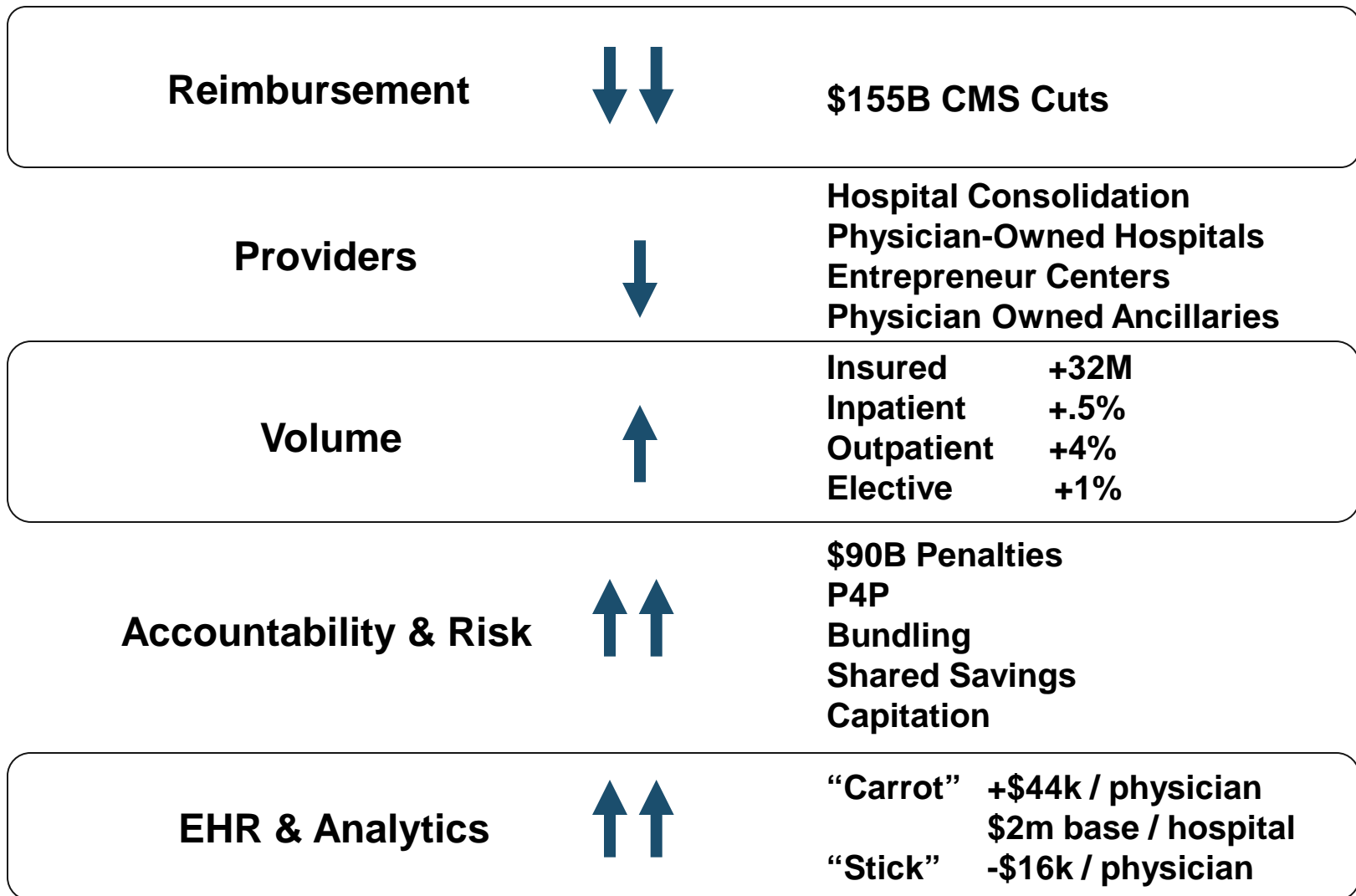
Healthcare Reform Update



Healthcare Reform Response



Reform Squeezes Providers



Reform Shifts Accountability



Source: HFMA | 2010
Source: The Advisory Board | 2010

Reform Accelerates Alignment



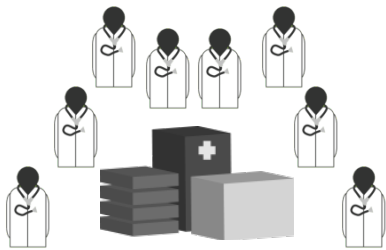
Pay-for-Performance Incentives
payments for higher quality

Value-based Purchasing
Reimbursement at risk, earned back by quality outcomes

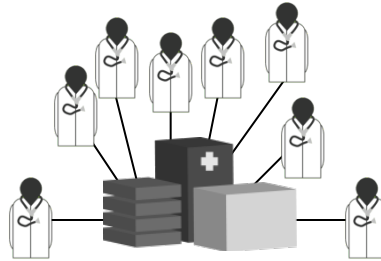
Bundled Payments
Single payment shared by hospital and physicians

Shared Savings
Percentage of savings shared with hospitals and physicians

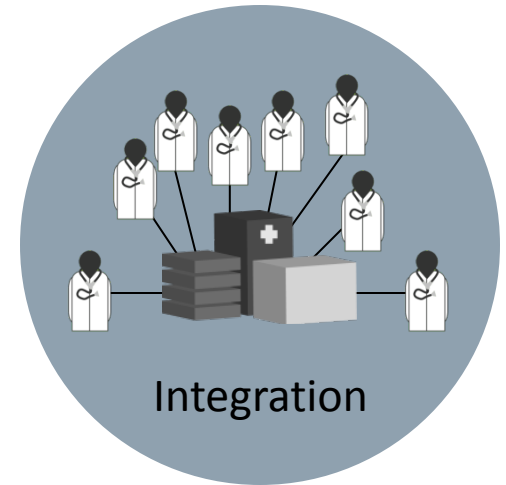
Global Payments
One payment that manages the patient across the delivery system



Independent



Alignment



Integration

Reform Defines New Realities

- Doing more with less
- Learning to trade on value
- Driving toward wellness & prevention
- Investing in workforce
- Using technology as an enabler

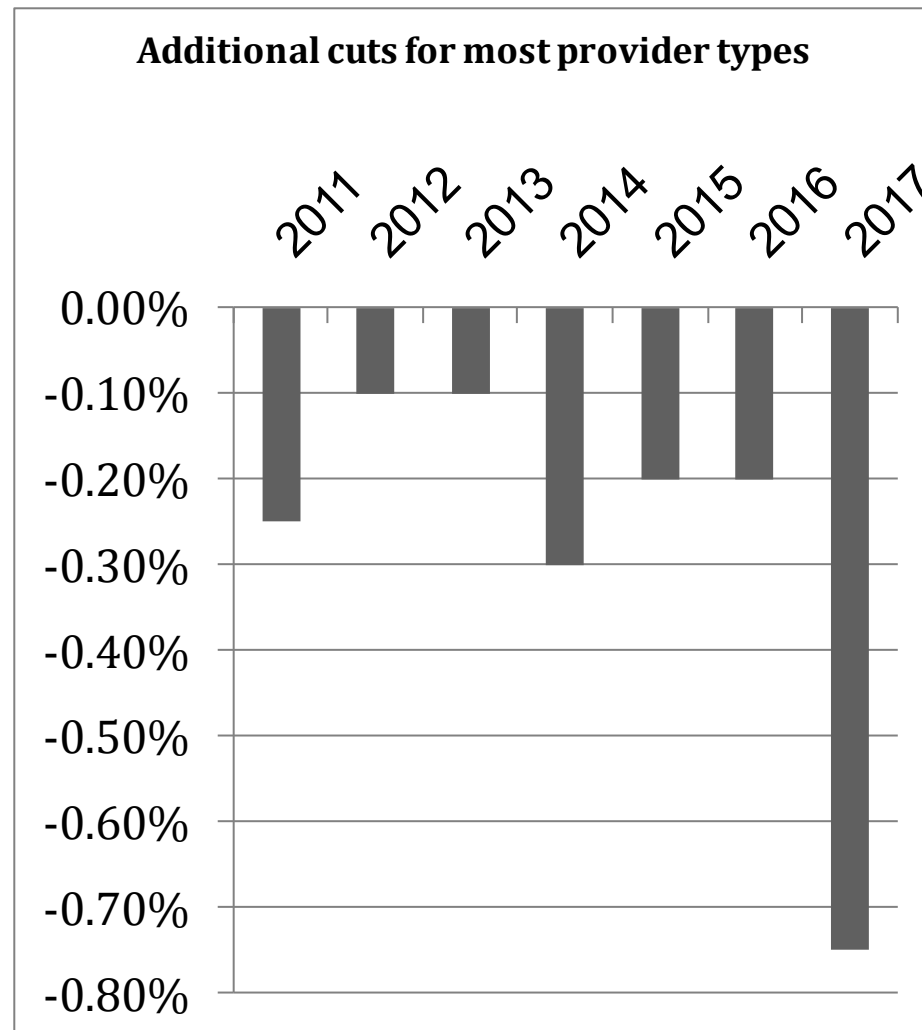
Impact of Healthcare Reform on Hospital Reimbursement

Reform: Reimbursement Impact on Hospitals

- Medicare Adjustments to Market Basket Updates
- Medicare DSH Payment Revisions
- Medicaid DSH Payment Reductions
- Medicare Hospital Value-Based Purchasing Program
- Medicare Hospital Readmissions Reduction Program
- Medicare Adjustments for Hospital Acquired Conditions (HAC)

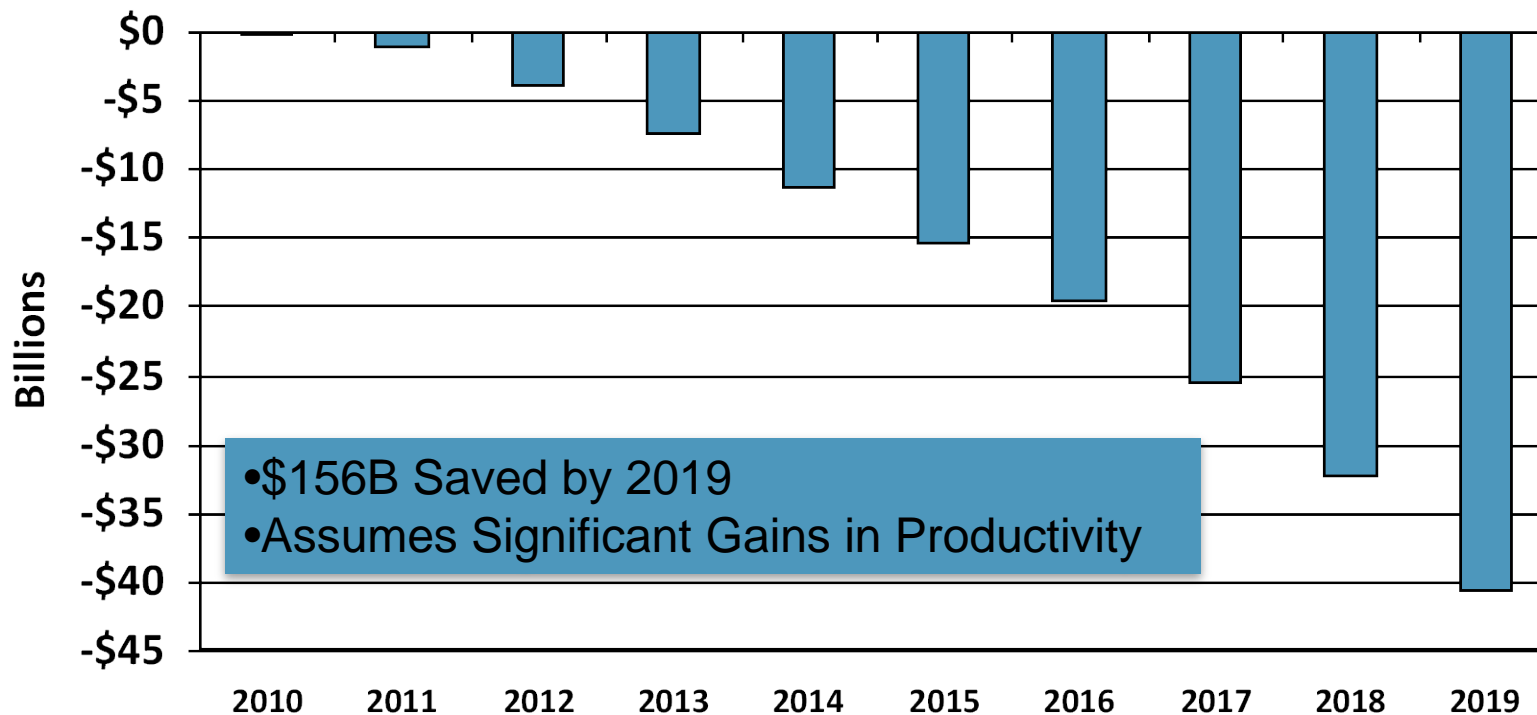
Adjustments to Market Basket Updates

- **Automatic reductions to annual market basket updates have already begun**
 - Retroactive .25% decrease effective January 1, 2010 for OPPS; April 1, 2010 for IPPS, Rehab
- **Most providers will be subject to productivity adjustments beginning in 2012**
 - Actual decrease will be based on 10-year rolling average, expected to be in .8% - 1.4% range



Adjustments to Market Basket Updates

CBO Projected Program Savings:



Adjustments to Market Basket Updates

- **Significant decrease outside of reform law effective in FY 2011**
 - FY 2011 IPPS Final Rule includes 2.9% decrease to market basket to account for “documentation and coding effect” resulting from transition to MS-DRGs that began in FY 2008
 - CMS had proposed similar 1.9% decrease for FY 10, but backed off when rule was finalized
 - CMS has indicated they believe a similar decrease will be necessary for FY 2012
 - CMS believes it needs to “recoup” \$9.1 billion for FYs 08 and 09

Medicare DSH Payment Revisions

- **Beginning in FY 2014 aggregate Medicare DSH payments will be reduced**
 - Hospitals paid 25% of what they would have been paid under current DSH regulations
 - Hospitals receive additional payment amount(s) based on amount of uncompensated care compared to aggregate
 - Total amount available under additional payment(s) will be reduced as the uninsured population decreases
- **CBO projected aggregate reductions:**
 - FY 14 – \$3.6 billion (25.4%)
 - FY 15 – \$4.0 billion (26.5%)
 - FY 16 – \$5.0 billion (31.1%)
 - FY 17 – \$4.4 billion (25.7%)
 - FY 18 – \$5.1 billion (27.9%)

Medicaid DSH Payment Reductions

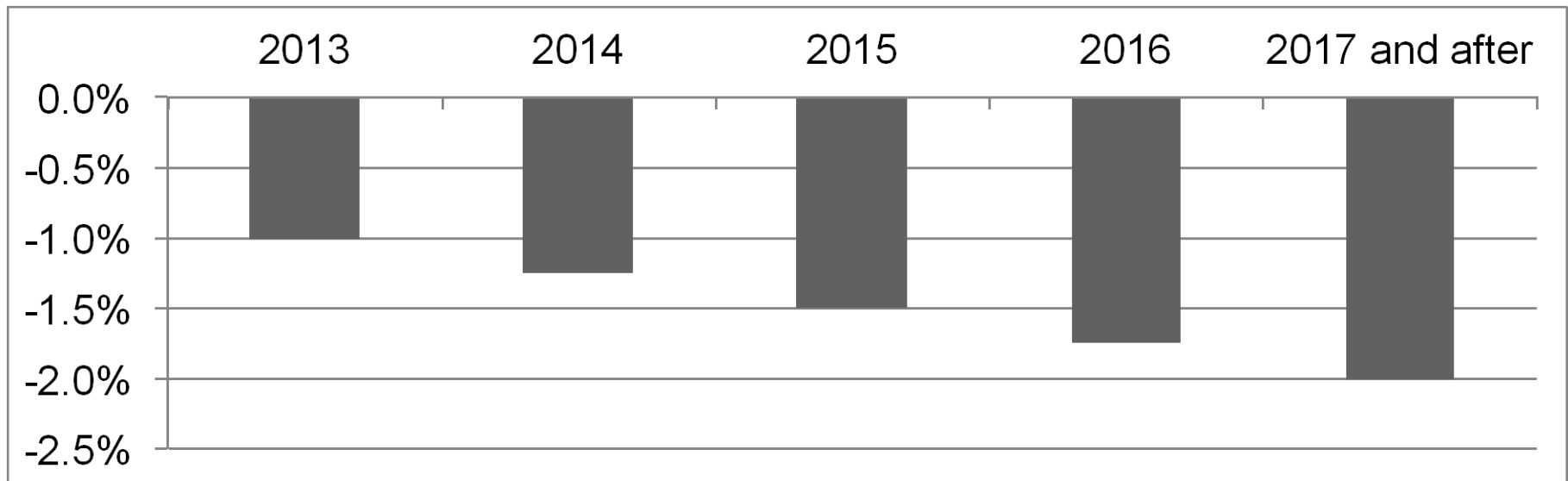
- **Beginning in FY 2014 aggregate Medicaid DSH payments will be reduced**
 - CMS will determine specific reductions by state
 - Largest reductions will be applied to states that have the lowest percentage of uninsured or states that do not target DSH payments to hospitals with high Medicaid utilization or uncompensated care
 - Smallest reductions will be applied to states with low DSH
- **CBO projected aggregate reductions:**
 - FY 14 – \$500 million (5.1%)
 - FY 15 – \$600 million (5.9%)
 - FY 16 – \$600 million (5.8%)
 - FY 17 – \$1.8 billion (17.1%)
 - FY 18 – \$5.0 billion (46.7%)
 - FY 19 – \$5.6 billion (50.9%)

Hospital Value-Based Purchasing Program

- **Beginning in FY 2013 Medicare hospital DRG payments will be subject to adjustment (positive or negative) based on performance (pay for performance)**
 - Measures selected for FY 2013 will include:
 - Acute myocardial infarction (AMI)
 - Heart failure
 - Pneumonia
 - Surgeries, as measured by the Surgical Care Improvement Project
 - Healthcare-associated infections
 - Additional measures meeting certain requirements may be added for FY 2014 – forward
 - CMS published proposed rule in January 13, 2011 Federal Register. Accepting comments through March 8, 2011.

Hospital Value-Based Purchasing Program

- **Hospitals that meet or exceed standards will receive incentive payment add-on**
 - Add-on percentages to be developed by CMS, will be calculated to equal total aggregate payment reductions for the value-based program
- **Hospitals that do not meet standards will receive payment deductions**



Hospital Readmissions Reduction Program

- **Beginning in FY 2013 DRG payments may be reduced for hospitals experiencing excessive readmissions**
 - Initially three conditions will be applicable, with four or more additional conditions added in FY 2015
 - Excess readmissions will be determined based on a risk-adjusted readmission measurement methodology
 - Payment adjustment will be based on ratio of aggregate payments for “excess readmissions” to aggregate payments for all discharges
 - Adjustments will be capped as follows:
 - FY 13 – 1%
 - FY 14 – 2%
 - FY 15 and after – 3%

Adjustments for Hospital Acquired Conditions

- **Beginning in FY 2015 hospitals in the highest 25% of hospital acquired conditions will receive a reduction to DRG payments**
 - Eligible hospitals will receive 99% of the payment that would otherwise apply
 - CMS is to report to Congress by January 1, 2012 on the potential for expanding HAC policy to other facilities including inpatient rehab and SNF

Additional Reimbursement Changes

- **PPACA also established the Independent Payment Advisory Board (IPAB)**
 - Objectives include:
 - Reduction in overall spending
 - Maintained or improved access
 - Better care coordination
 - Improved quality
 - In years when Medicare costs exceed a specified growth rate, IPAB may make recommendations that automatically take effect unless Congress approves an alternative that achieves similar cost savings
 - IPAB proposals affecting providers will not be implemented before 2020; proposals affecting suppliers may begin in 2015

Responding to Reimbursement Reform

- **Cost Management**

Are your operations as efficient as possible? Can you reach cost levels of 95-98% of Medicare rates? Can you survive if Medicare becomes your best payor?

- **Medicare and Medicaid Reimbursement**

Are there opportunities to increase reimbursement through special designations, ACO participation, or pilot / demonstration programs?

- **The Next Wave of Medicare Emphasis on Quality**

Value-based purchasing, readmissions, and HACs will change payment rates, and serve as a differentiating factor among hospitals.

- **Ongoing Information & Analysis**

Many critical components of Healthcare Reform are still works in process. Every hospital must stay on top of new rules as they are proposed and finalized.

Impact of Healthcare Reform on Physician Reimbursement

Reform: Reimbursement Impact on Physicians

- Imaging caps /self referral notice
- Small business tax credits
- Grant program for Primary Care Residency Programs
- Development of the Physician Compare Website
- RAC expansion
- Primary care incentives
- Medicare shared savings program
- Value based purchasing program
- Pilot program on payment bundling

Reform: Reimbursement Impact on Physicians

Professional Fees



Ancillary Revenue



Payor Leverage



Profitability & Personal Income



Operating Expense



Administrative Burden



Assessment / Audit Risk



Alignment with Hospitals



Impact of Healthcare Reform on Hospital-Physician Alignment

Reform: Impact on Hospital-Physician Alignment

- Physicians and hospitals that embrace technology, new care models, and joint payment models will emerge as leaders
- More physicians will consider hospital alignment, employment or collaboration
- Hospitals will need physicians to help improve the quality of care now more than ever

Reform: Impact on Hospital-Physician Alignment

- Accelerated alignment activity
- *Thoughtful process and approach*
- Decisions driven by strategic plan
- *Focus on highly integrated models*
- Adequate due diligence on both sides
- Aligned incentives and clear expectations
- Collaborative, team-oriented implementation
- Ongoing, cooperative evaluation

Effective Alignment Characteristics

- Values
- Alignment of mission and values
- Cultural compatibility
- Brand value
- Market share
- IT compatibility and functionality
- Capacity and scalability
- Management
- Financial viability
- Communication
- Integrity and transparency
- Flexible business models

Thoughtful Process and Approach

PHASE I Assessment and Options

Win-Win
Criteria

Assessmen
t

Organizational
Options

REVIEW

PHASE II Vision and Structure

EDB
Envision, Design, Build

Organizational
Recommendations

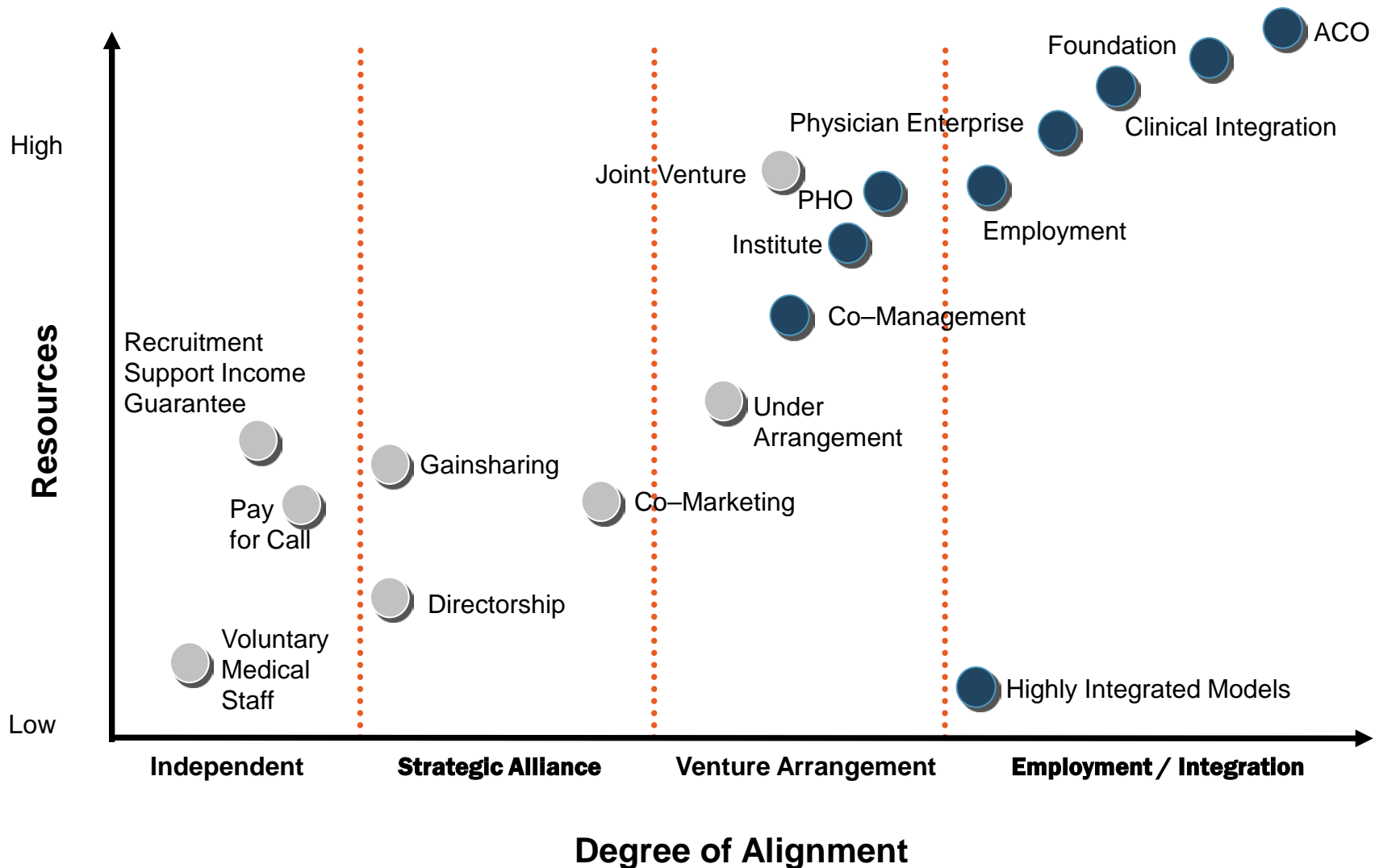
REVIEW

PHASE III Planning and Execution

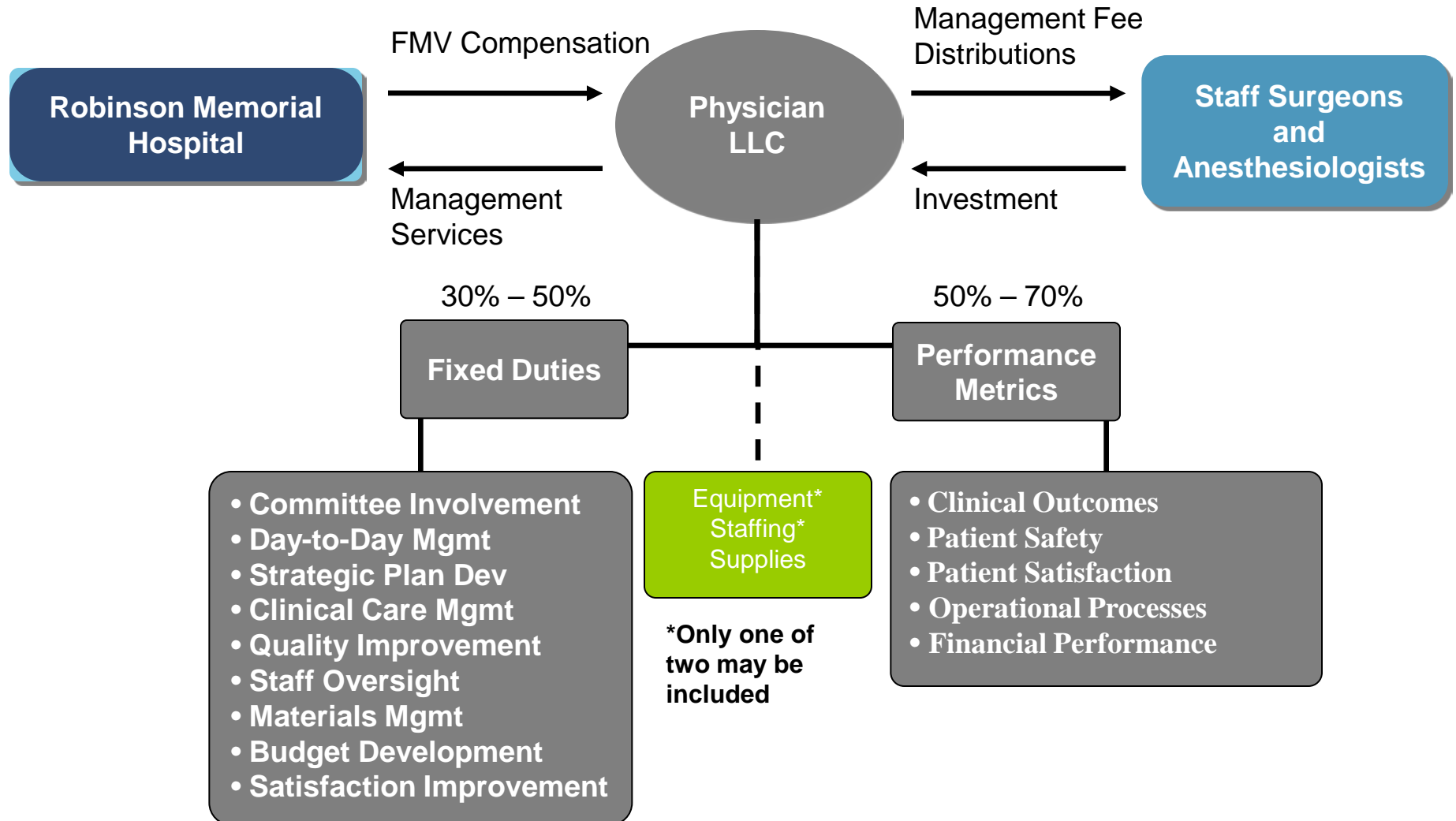
Development

Rollout

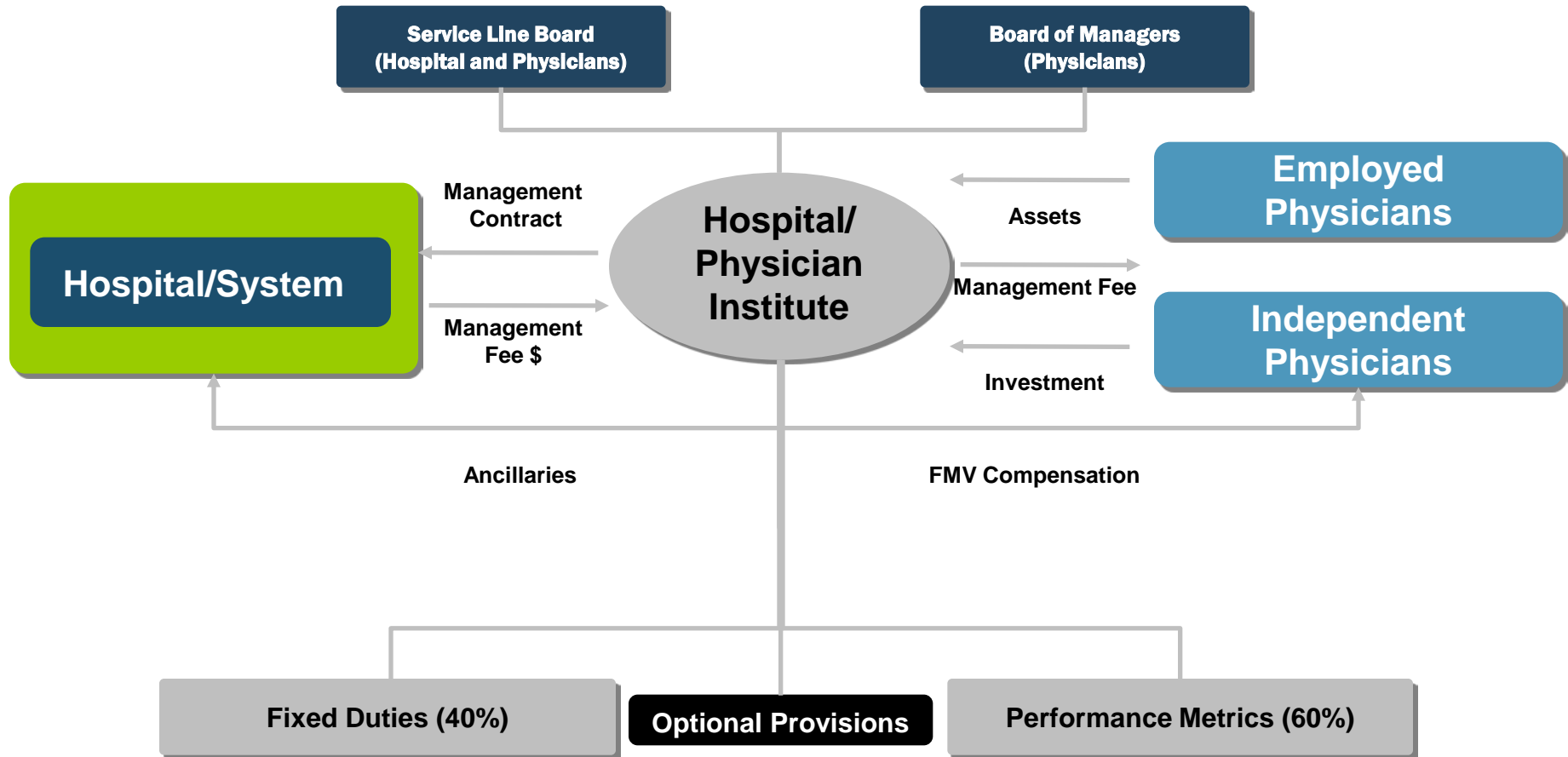
Physician Alignment Models



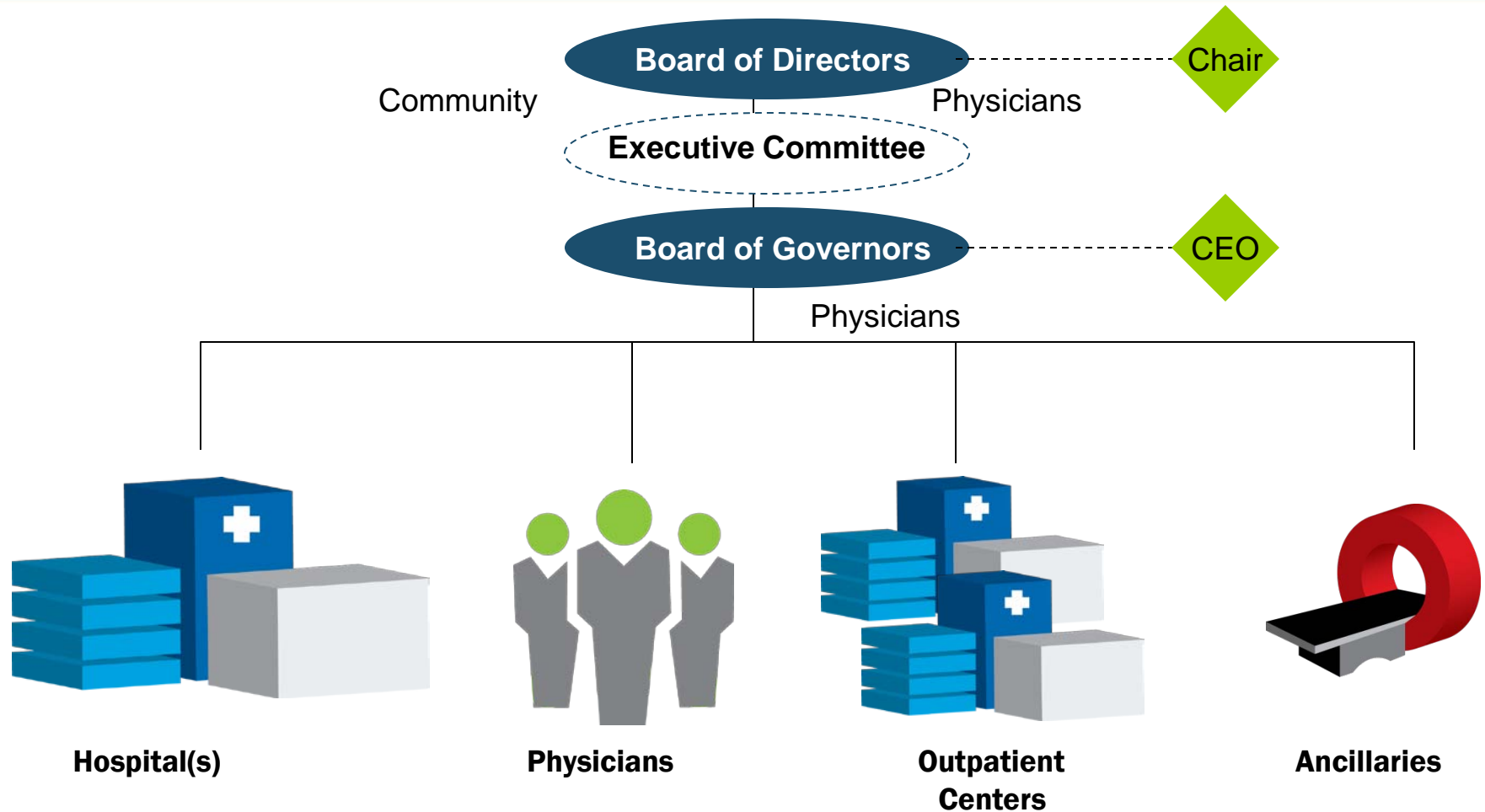
Co-Management Model



Institute Model



Foundation Model



Foundation owns and operates all Facilities and Ancillaries
Foundation employs all physicians
Foundation bills all technical and professional fees

ACO Model

Specialists:

Increased level of integration with PCPs, increased efficiency, focus on reducing re-admissions

Primary Care Provider:

Increased focus on patient and health, greater access to information; better reimbursement, increased use of quality metrics

Patient: Less costly, more convenient care ; coordinated services, productive long-term relationship with PCP



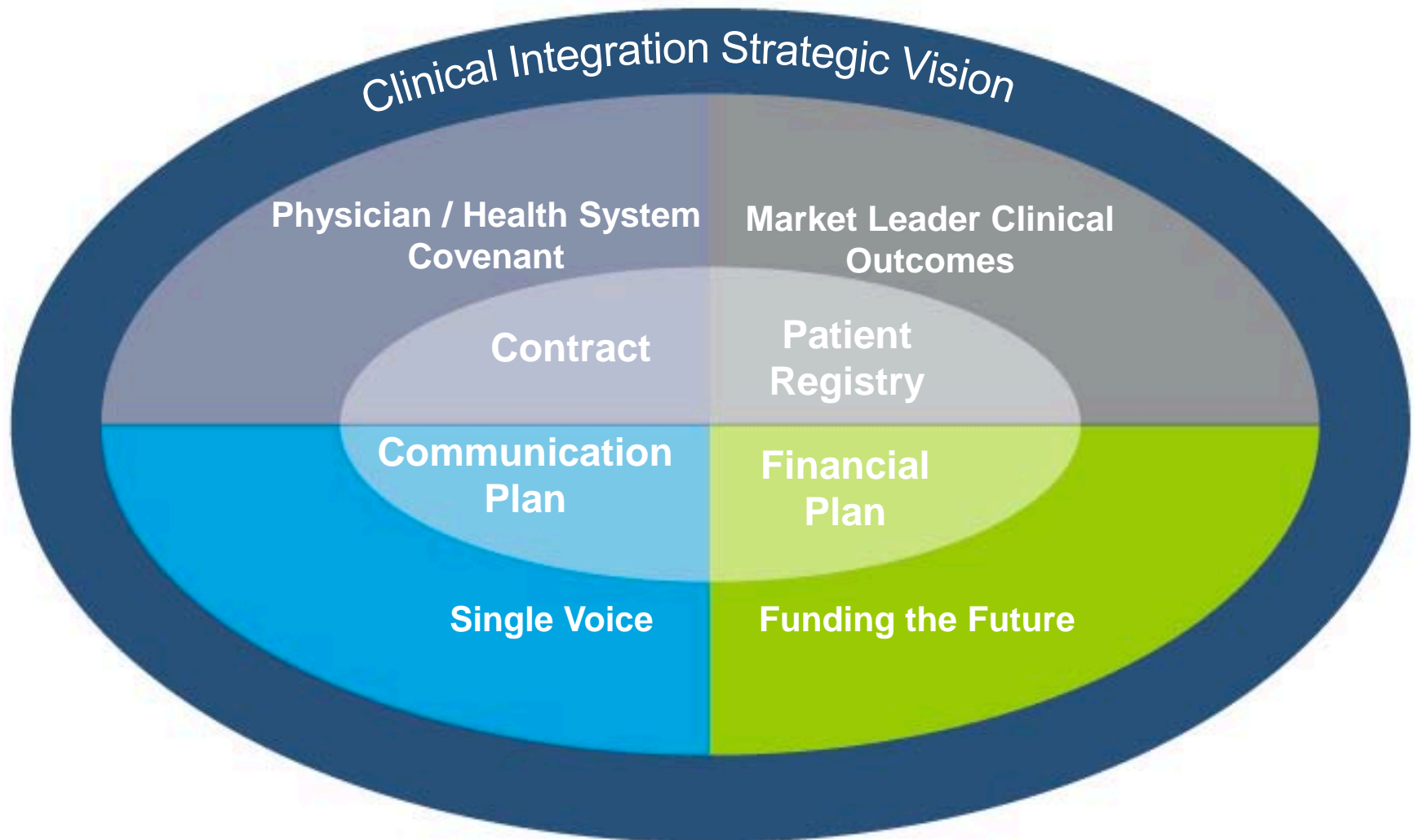
Hospital: Lower admissions and re-admissions for chronic disease patients; more appropriate use of ED

Payer: Improved member satisfaction, lower costs, opportunity for new business models

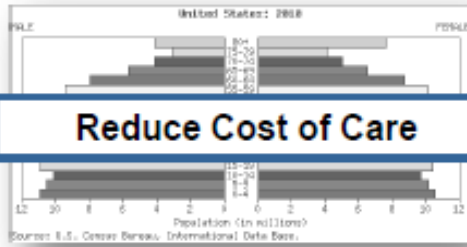
Government: Lower healthcare costs, healthier population

Employer: Lower costs, more productive workforce, improved employee satisfaction

Clinical Integration Model



Imperatives / Immediate Action Items



- 13.9% = Average hospital cost structure reduction needed to sustain current margins at Medicare payment rates



- Clinically
- Economically
- Structurally



- Community to inpatient, inpatient to home/SNF
- 24.7% of Medicare heart failure patients are re-admitted within 30 days

Responding to Reform: Action Items

- Understand reform provisions and what they mean to your facility
- Project the financial impact on your facility
- Identify and begin responding to threats, opportunities, and new requirements
- Assess operational efficiencies and financial readiness
- Evaluate physician alignment strategic plan
- Begin cost saving initiatives

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Founded in 1998, **Lincoln Healthcare Events** is an independent organizer of executive leadership communities in healthcare. We strive to positively impact the quality and effectiveness of the U.S. healthcare system by delivering the single most valuable conference and community of healthcare executives in each of the sectors we serve. Our conferences offer senior-level executives highly focused venues for understanding strategic trends, sharing best practices and building strategic relationships.

The logo for Community Hospital 100 features a blue square icon with a white grid pattern to the left of the text "COMMUNITYHOSPITAL100" in a bold, blue, sans-serif font. Below this, a dark blue horizontal bar contains the text "EXECUTIVE MANAGEMENT CONFERENCE" in white, uppercase, sans-serif font.

October 23-25, 2011

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