



U.S. Health Reform Status and Update WIS 2010 Conference

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U.S. Health Reform

Key Topics

- Factors contributing to U.S. Healthcare Crisis
- Why did Health Reform Bill pass?
- Key Provisions of the Bill
- Volume Driven to Value-Added Healthcare
- Pay-for-Performance
- Price Transparency
- Accountable Care Organizations (ACO's) and Patient Centered Home Medical Model (PCHM)
- ICT and Meaningful Use

U.S. Health Reform

Why is Healthcare Reform necessary?

- Poor coordination of care
- Stakeholders not aligned
- Lack of care for 47 million Americans
- Current rising cost are unsustainable

U.S. Health Reform

Key provisions of the bill include:

- Coverage and Choice
- Affordability
- Shared Responsibility
- Controlling Costs
- Prevention and Wellness
- Workforce investment

U.S. Health Reform

Why did the Bill pass now?

- Has been tried by every previous administration since (D), F.D. Roosevelt (Democrat – 1940's) including past presidents – Nixon (R), Ford (R), Carter (D), Reagan (R), Bush (R), Clinton (D) and Bush (R),
- Obama (D) campaigned on “Change We can Believe In”
- He was able to build enough consensus between Democrats and Republicans
- 85% of the Bill contains the version John McCain proposed prior to the US elections
- It just took 2,500 pages to get this “compromise”

U.S. Health Reform

Staggering Statistics

- The average premium for family health coverage through an employer was \$13,375 in 2009, of which covered workers paid an average of \$3,515
- Since 1999, family premiums for employer-sponsored insurance have increased 131 percent, while wages have gone up 38 percent and inflation has gone up 28 percent
- For the first time on record, the annual increase in the Consumer Price Index exceeds the increase in national health spending per capita, 3.8% vs. 3.5% in 2008

U.S. Health Reform

Staggering Statistics

- Health spending in the United States averaged \$7,681 per person in 2008, totaling \$2.3 trillion, or 16.2% of our nation's economy, up from 7.2% of GDP in 1970 and 12.3% of GDP in 1990
- The top 1% of the U.S. population was responsible for 23% of health care spending in 2007
- 47 million non-elderly Americans were uninsured in 2007, and eight in ten were in families with at least one worker = “the working poor”

U.S. Health Reform

Government Programs

- Medicare covers 44 million Americans -- 16% of whom are under age 65 and disabled -- at a projected cost of \$420 billion in 2009
- Medicare accounts for 14% of the total federal budget, more than the 7% accounted for by Medicaid, but a smaller share than Social Security (22%) or defense (20%)

Employer Programs

- Employers are the principal source of health insurance in the United States, providing health benefits for about 159 million people, or about 52% of all Americans; however, the percentage of employers who offer such benefits has been falling: 69 percent offered health coverage benefits in 2000, compared to 60% in 2009

Global Health Care Trends

If current trend continues, most OECD countries will spend up to one-fifth of GDP in health care

Currently:

- U.S. – 2009 – 5,800 Euros per capita
16.7% of GDP
Most Americans surveyed report been satisfied with their healthcare; ironically the only one surveyed are those with health insurance
- Finland – 2009 - 2,586 Euro per capita
8.2% of GDP
77% of Finnish population is satisfied – Eurobarometer public opinion surveys

Volume-Driven to Value-Added

Current U.S. healthcare payment systems encourage volume-driven HealthCare

Stakeholders – hospitals, physicians and other health care providers gain increased revenues by delivering more services

Current system penalizes health care providers for providing better quality of care

Urgent need to review current payment systems and determine how better payment systems can be designed

Value is defined as combination of both quality and cost

Incentives are to focus more on volume

In other industries, consumers reap the benefits of lower cost and higher quality, not in health care

Volume-Driven to Value-Added

Fundamental impediments to improving value in health care are that efforts to improve quality and reduce cost can be viewed as being at odds with each other:

Patients may believe that lower cost means lower quality and that efforts to reduce cost will require “rationing” or restrictions on their ability to receive needed care

Payers often believe that higher quality means higher cost, and providers often request higher payments to support initiatives to improve the quality of care delivery

Volume-Driven to Value-Added

In health care, there are easily identified examples where improvements in both quality and cost are possible

Example: Health care-acquired infections and other adverse events. Numerous studies have shown that unnecessarily high rates of preventable adverse events occur within hospitals and other health care settings

In most cases, payers pay more when these events occur, and patients suffer from them, often seriously

Reducing these adverse events would be a win-win for both quality and cost

In the Healthcare Reform Bill, the government will establish a penalty for these “never events”

Volume-Driven to Value-Added

Studies have shown that a large number of hospitalizations are preventable through improved care coordination

Patients who have what are known as “ambulatory sensitive conditions: asthma, chronic obstructive, pulmonary disease, congestive heart failure and diabetes

Payers also pay more when these admissions and readmissions occur

Reducing admissions and readmissions represents a potential win-win for both quality and cost

In the Medicare program today, there are 20% readmissions within 30 days. The Healthcare Reform bill has implemented penalizing hospitals by not paying if patient is readmitted within 30 days.

Pay-for-Performance

Pay-for-performance (P4P) programs have been created in an effort to address the problem

Pay-for-performance systems may unintentionally result in an overly narrow focus on the specific processes being rewarded, potentially causing providers to lose sight of the true goal—improving patient outcomes.

Widespread agreement that the health care system today does not provide good value, where “value” is defined as the combination of both quality and cost.

Price Transparency

Formally, deductibles ranged from \$500 to \$1,000 per individual family member; as employers shift the burden increasingly to consumers, the deductibles are more in the range of \$2,000 to \$5,000 per individual family member

As the number of patients with higher deductibles increases, there is increased motivation for price comparison and cost savings

There is a disconnect between the actual cost of services and the amount billed

Price Transparency will be most effective for price elastic services such as MRI's, CT's, X-rays and laboratory services

Initial price transparency is evident in non-covered services such as LASIK and cosmetic plastic surgery

Benefits of Price Transparency

End the current widespread practice of charging patients different prices

Help providers improve the benchmarking their performance against others

Encourage private insurers and public programs to reward quality and efficiency

Help patients make informed decisions about their care

Consumer Driven Health Care is key for Price Transparency

ACOs/PCHM Model

The ACO aims to reward clinical integration and care coordination among multiple providers.

ACO Definition: A local entity and a related set of providers that can be held accountable for the cost and quality of care delivered to a defined [set] . . . of beneficiaries.



Provided by Hospitals/Health Systems

- Inpatient, outpatient, and post-acute services.
- Physician network (*typically employed*).
- System management expertise.

Provided by Physicians

- Clinical expertise.
- Professional inpatient and outpatient services.
- Other potential assets (e.g., ASCs, managed care lives).
- Ability to affect quality and outcomes.
- Peer review.
- Group management expertise (*if partnered with independent practice*).

Source: Based on K. Devers and R. Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" Robert Wood Johnson Foundation, Princeton, October 2009.

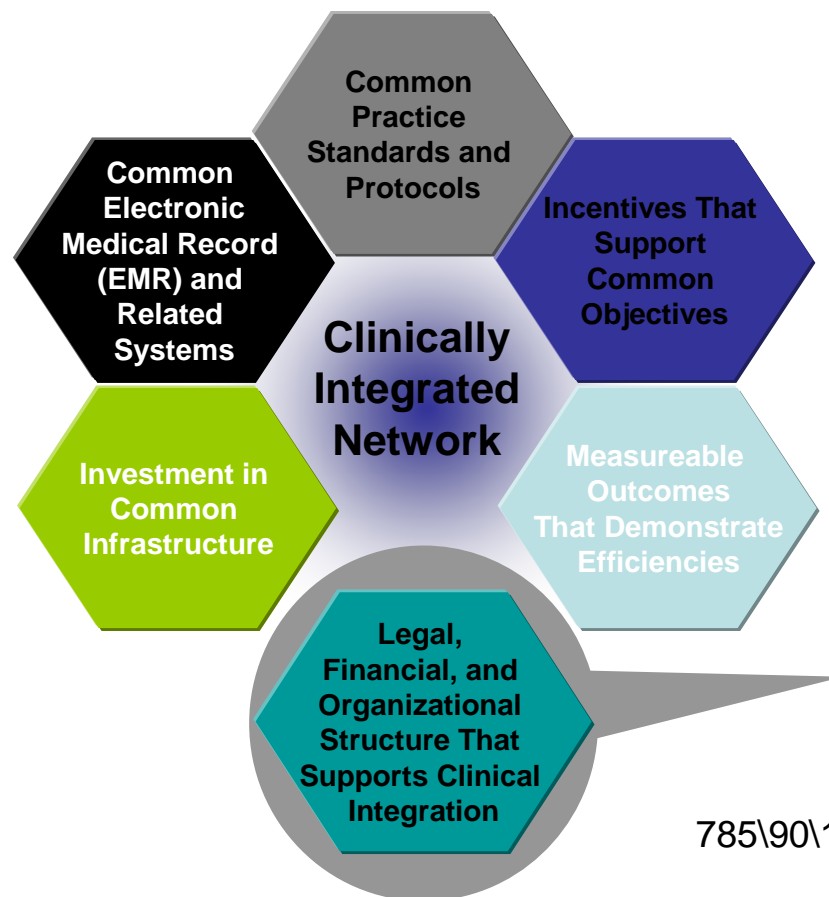
ACOs are designed to encourage providers to think of themselves as a group with a defined patient population, care delivery goals, and performance metrics.

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ACOs/PCHM Model

Essential Features

The legal, financial, and organizational relationship among participants in an ACO is ultimately designed to provide a framework within which it can legally establish the common infrastructure, financial arrangements, and contracts to support clinical integration.



Essential Characteristics of Alignment Model

- Network of sufficient size and distribution to support effective management of care across all settings and specialties.
- Legal framework and capabilities that will allow for the participants to collectively enter into contracts.
- Well-defined governance and decision-making structure.
- Alignment of financial incentives among participants toward common objectives.
- Single signature authority for contracts with commercial and government payors.
- Capable of accepting common financial risk for performance and of internally distributing revenues and allocating expenses.
- Sufficient size to support comprehensive performance measurement and reporting.

ACOs/PCHM Model

Essential Features (continued)

While various types of ACO models have been proposed, they share three essential features.

Feature 1 – Designated Accountable Care Entities

- ACOs are a collection of provider organizations.
- While some qualifying entities may exist, most will have to be formed.

Feature 2 – New Payment Approach

- Proposals suggest that payments should be based on the collective care an ACO provides to its designated population.
- Under some approaches, these payments would supplement existing FFS reimbursement.

Feature 3 – Performance Measurement

- Supplemental payments would be provided retroactively based on an ACO's ability to meet quality goals while reducing costs.
- While still in development, it is expected that quality metrics will be outcomes-based and not purely process-based.

Source: M. Gold, "Accountable Care Organizations: Will They Deliver?" Mathematica Policy Research, Inc., Princeton, January 2010.

ICT and Meaningful Use

- Investing in IT as well as specialized staff -coding and data-mining
- Aligning of incentives among providers across the continuum to improve cost and quality
- Collaborating with physicians through organizational structures such as Physician Hospital Organization (PHO's) and employment of physicians
- Managing turbulent utilization factors considering economic recovery
- Focusing on reducing readmissions
- Implementation of medical homes
- Provider consolidation

ICT and Meaningful Use

Integration – Ultimate success of payment reform depend heavily on collaboration among stakeholders across the care continuum between hospitals and physicians

Risk Management – Payment reform may shift portions or all of financial risks among industry stakeholders based on quality and risk

Pricing – Establishing accurate price relationship to cost has been difficult under the traditional fee-for-service payment

Maximize current P4P program incentives –Medicaid and Medicare Programs

ICT and Meaningful Use

EHRs have the potential to improve clinical decisions and patient outcomes

The Health Information Technology for Economic and Clinical Act (HITECH) authorizes incentive payments

Federal Government will commit \$44,000 to \$63,000 per clinician

Currently 20% of Physician Offices have EHR and only 10% of hospitals have truly integrated systems

Deadline for Meaningful Use is 2015; hospitals and physicians that don't comply will be penalized

ICT and Meaningful Use

To be considered meaningful users, providers will have to meet certain targets related to EHR use. Some examples of required core measures include:

Implement one clinical decision support rule

More than 30 percent of patients with at least one medication in their medication list have at least one medication ordered through CPOE

More than 50 percent of patients who request an electronic copy of their health information receive a copy within 3 business days

ICT and Meaningful Use

The menu of other measures includes these targets:

- Generate at least one listing of patients with a specific condition
- More than 10 percent of patients are given patient-specific education resources
- Medication reconciliation is performed for more than 50 percent of transitions of care

U.S. Health Reform Summary

Adoption of ICT Meaningful use will save the health care system approximately \$100 Billion a year

Reform the insurance market to end discrimination based on pre-existing conditions and health status

Eliminate yearly and lifetime limits on the amount of coverage plans provide

Create web-based insurance exchanges that would standardize health plan premiums and coverage information to make purchasing insurance easier

Give consumers the choice of non-profit, consumer owned and oriented plans (CO-OP)

Health Reform Key Topics

In Summary, we discussed:

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Questions

Thank You for your interest and attention

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