Hospitals and Healthcare Reform: What Does The Affordable Care Act Mean for Facilities Big and Small?

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U.S. spending comparison

**Exhibit 1**

The United States spends far more on health care than expected even when adjusting for relative wealth

Per capita health care spending, 2006

$ at PPP*

2006 $R^2=0.88$

Per capita GDP

United States

Spending above ESAW**

Source: Organisation for Economic Co-operation and Development (OECD)

* Purchasing power parity.
** Estimated Spending According to Wealth.
Sources of spending differences

Exhibit 3

The United States spends nearly $650 billion more than expected, with outpatient care accounting for over two-thirds of this amount

$ billion, 2006

Total health care spending

- Outpatient care*
- Inpatient care
- Drugs and nondurables
- Health administration and insurance care
- Long-term and home care
- Durables
- Investment in health

* Outpatient care includes physician and dentist offices, same-day visits to hospitals including Emergency Departments (ED), ambulatory surgery (ASC) and diagnostic imaging centers (DIC), and other same-day care facilities.

Source: OECD; McKinsey Global Institute analysis

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Factors in growth in health spending

- Price per unit of service
- Number of units of service
- Addition of new more expensive service for lower cost service
- Increased prevalence of disease
- Increased number of people using services
- Desired target should be per member/per month growth in spending
Trajectory to Value Based Purchasing: Achieving Real Care Coordination and Outcome Measurement

HIT Infrastructure: EHRs and Connectivity

Primary Care Capacity: Patient Centered Medical Home

Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination

Value/Outcome Measurement: Reporting of Quality, Utilization and Patient Satisfaction Measures

Value-Based Purchasing: Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)

Achieve Supportive Base for ACOs and Bundled Payments with Outcome Measurement and Health Plan Involvement

Source: Hudson Valley Initiative

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Health Care Costs Concentrated in Sick Few

Distribution of Health Expenditures for the U.S. Population, by Magnitude of Expenditure, 1997

Potential cost of one extra test

- If 1 extra test per day = 253 tests per year.
- $100 per test x $253 = $25,300 per year for ONE PHYSICIAN.
- There are 661,400 (Bureau of Labor Statistics, 2008) physicians in the US.
- 661,400 ordering 1 extra $100 test per day costs - $16,733,420,000 per year
The U.S. Health Care Delivery System Is Flawed

- The Leapfrog Group, made up of many major corporations pushing for effective health care purchasing, finds that the quality of the U.S. health system is at best equal to how well the airline industry handles baggage – versus the safety record for flying planes.

- Study by researchers at Rand Corporation found that providers follow best practices on average 54% of the time, lowest for alcohol related conditions, highest for mammography screening.
Application of Six Sigma to Airline and Health Industries

- Domestic Airline Flight Fatality Rate (0.43 PMM)
- 44,000 - 98,000 Preventable Hospital Deaths (IOM)

DPMO

- 93% good
- 99.4% good
- 99.98% good

SIGMA

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The U.S. Health Care Delivery System Is Flawed, continued

Poor health care quality caused 30% of U.S. total health care spending (between $344 and $689 billion) in 1998 (the Juran Institute study for the Midwest Business Group on Health)

Poor quality comes from overuse, under use, and misuse of health care services

Per the Dartmouth Atlas, could reduce spending by 30% on care for Medicare people with severe chronic conditions with better outcomes if resources and utilization of efficient providers were realized by all providers serving these patients
Other sources of waste

- Administrative waste
- **Quality waste**: Poor quality can produce waste (re-do procedure, complication, costs of medication reconciliation)
- **Inefficiency waste**: Doing something unnecessary—redundant patient family history acquisition, delays, failure to use all available resources
Not all hospitals are alike

- Are different types of hospitals
  - Community hospitals
  - Critical Access hospitals
  - Specialty Hospitals
  - Teaching Hospitals
  - Academic medical centers
Not all hospitals are alike

- Who provides different mix of care
  - General surgery and medical management
  - Some with no emergency room, others at different levels of capability
  - Some whose focus is tertiary or quaternary levels of care, where sicker patients get referred
  - Some with special units, such as burn units
  - All with different patient volumes and mixes
Not all hospitals are alike

- With great variation within and between states in costs and outcomes
  - For Medicare hospital conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital
    - 5 best states 4,136 admission for 100,000
    - All states median 6,262 per 100,000
    - 5 worst states 8,768 per 100,000
Comparison of hospital care intensity across states
(red line denotes midpoint)

The hospital care intensity index measures the propensity to rely on the acute care hospital in managing chronic illness.

http://cecsweb.dartmouth.edu/atlas08/datatools/hci_s1.php
State Comparison Hospitalization for Ambulatory Sensitive Conditions

Source: Harold Miller keynote presentation to Ohio Payment Reform Summit, December 4, 2010
State Comparison ER Visits

Emergency Room Visits Per 1,000 Population, 2007

Source: Harold Miller keynote presentation to Ohio Payment Reform Summit, December 4, 2010
Not all hospitals are alike

- With different relationship with physicians and other ambulatory care providers
- With different levels of health information technology investments and capacity
- Some who run their health plan, most that do not
- With differing levels of demand for use of hospital beds or other services
With different payor mixes

- Private plans
  - employer-based and individual
  - Varying levels of patient liability (cost share)
- Medicare
- Medicaid
- Self-pay
- Uncompensated care
Call for payment reform

- Reviews of health spending cite need for payment reform
- See existing fee-for-service payment system as critical source of problems
- See payment structure reinforcing lack of integration and coordination among providers serving same patient
Problems with traditional fee-for-service payment models

Use of fee-for-service payment:
1. increases the volume and intensity of services without enhancing the quality of care or its efficiency.
2. may contribute to the overuse of services with little or no health benefit.
3. does not foster coordination of care across providers or care delivery organizations.
4. measures currently used to assess the system and needs of payment reform models have many gaps.
Issues with Reimbursement and Waste

- Decrease in unit price $\rightarrow$ increase in frequency
- Cherry picking and skimming
- Physicians & hospitals paid for waste (adverse events)
- Population waste can still be beneficial for individual hospitals and providers
Payment Methodologies

- **Charges**: The provider’s usual and customary fee for a given service.

- **% of Charges**: A discount off of charges.
Payment Methodologies

- Fee Schedule: A payor established schedule of their payments to providers typically based on a CPT or ICD-9 code.
Payment Methodologies

- Per Diem: A daily rate paid by the payor to the provider for all services provided to the patient. Typically used for hospital payments.
Payment Methodologies

- Case Rate: A flat payment amount that covers all care provided to a patient for a given episode of care. Typically used for physician payments for surgical procedures or deliveries and for hospital payments. A DRG (Diagnosis Related Group) payment is a Case Rate.
Payment Methodologies

- Bundled Payment: The combining of physician and hospital payments for a given procedure or diagnosis into one overall payment. Typically offered to the hospital to administer the distribution of payments between physicians involved in the patient’s care and the hospital itself.
Payment Methodologies

- Capitation: The payment of an overall fee to the provider for the provisions of all (or a subset of) healthcare services to a given person for a given period of time.
The Challenge of Payment Reform by cutting FFS payment rates

- Make up for cuts by:
  - Seeing patients more frequently, perhaps than truly needed
  - Ordering more tests
  - Changing coding for services done to higher level
  - Unbundling of services where possible
  - By shifting people to inpatient setting
  - By seeing fewer sicker people that take longer to examine so can have more visits
The limit on the price control approach

“...The secret is not, however, to re-jigger 10,000 prices in 3,000 counties so that we get them ‘right’ once and for all (until medical knowledge or technology or input prices change again).... The secret is to pay for what we want – health – and then monitor our progress toward that end with EHRs [Electronic Health Records] while bundling ever-larger sets of services into one payment, which frees clinicians and providers to find the most efficient way to deliver health, given our particular circumstances.” Len M. Nichols, PhD Testimony to U.S. Committee of the Budget, June 26, 2007
New payment approaches
Shift from fee-for-service to fee-for-performance

- New payment approaches to pay for health care have been in experimentation in recent years.
- They include incentives to improve quality and reduce the use of unnecessary and costly services.
- Are designed to achieve two interrelated goals: quality improvement and cost containment.
- Patient Protection and Affordable Care Act (PPACA) of 2010 has given a new impetus to these payment approaches.
# Goals of payment reform models

## Cost containment goals
- Reverse the FFS incentive to provide more services
- Provide incentives for efficiency
- Manage financial risk
- Align payment incentives to support quality goal

## Quality goals
- Increase or maintain appropriate and necessary care
- Decrease inappropriate care
- Make care more responsive to patients
- Promote safer care
Harold Miller’s 10 Barriers to payment reform

- Continued use of fee-for-service, even with shared shavings designs
- Expecting providers to be accountable for costs they cannot control
- Physician compensation based on volume, not value
- Lack of data for setting payment amounts
- Lack of patient engagement

10 Barriers to payment reform

- Inadequate Measures of the Quality of Care
- Lack of Alignment Among Payers
- Negative Impacts on Hospitals
- Policies Favoring Large Provider Organizations
- Lack of neutral convening and coordination mechanisms
- See handout which is page 4 in report for table on solutions to barriers

Other challenges

- Need for leadership
- Organizational culture
- How to do work in present payment structure while transitioning to new system
- Free rider and prisoner dilemma concerns
- Investments needed to underwrite transition costs
- Variation in state of ambulatory care capacity for all populations; transitions to care
Michael Porter on value-based competition

- Value = quality of health outcomes per dollar expended
- Current competition is dysfunctional
- Takes place at wrong levels & on wrong things
- Care is structured around medical specialties, discrete services vs. care cycle, patient-centered approach
- Participant compete to shift costs, accumulate bargaining power, and limit services

Porter on value-based competition

- Which does not create value for patients, but erodes quality, foster inefficiency, creates excess capacity and drive up admin costs
- More focus on driving down costs, more they go up
- Therefore, need to compete on value on results, not price, striving for excellence relative to peers
- Value-based competition requires not micromanging care delivery

Porter on value-based competition

- Therefore, need to compete on value on results, not price, striving for excellence relative to peers
- Value-based competition requires coverage for everyone, though not through single payer
- Value-based competition requires not micromanaging care delivery
- Consumer driven health care oversimplifies the problem expecting them to navigate a system that their providers can’t

Health Reform: Ramp Up

- Insurance Market Reforms
- M & M Payment Reforms
- Comparative Effectiveness

2010
- State Health Insurance Exchanges
- Drug/Pharmacy Reforms
- Payment reform-primary care, geographic variation, GME, hospital reductions
- CMS Centers for Innovation

2012
- Accountable Care Organizations
- Continued payment reform

2013
- Tax increases
- Insurance reforms
- Payment reform
- Health Benefit Exchanges

2014
- Individual insurance mandates
- Public insurance expansions
- Insurance Reforms

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Pressure on hospitals

- Health insurers pushing for below commercial rates for hospitals who want to be on their exchange products, some hoping for rates that match Medicare
- Demands for more transparency
- Focus on disconnect between charges, costs, and what people pay
- Shift to primary care access, push to reduce use of inpatient and outpatient hospital services
- Bitter Pill article in Time Magazine effects
- How/when to invest in upgrades and improvements
Pressure on hospitals

- Payment reforms that reduce payments for
  - Adverse events
  - Too high an amount of hospital readmissions
- Push to move from fee-for-service to outcomes-based payment
- Goal to reduce specialty visits and procedures
- Payment cuts to Medicare under ACA and sequestration
- Possible state Medicaid payments cuts
- ACA disproportionate share reductions
Making the Transition

Payment Methodologies

Population/Global Payment

Shared Savings

Individual/Fee For Service

Care Delivery

Volume

Encounter

Episodes

Lifetime

Making the Transition

Today

Foster Innovation and Disruptive Models

Achieved by Q1 2012

Market Relevance

Global Adoption

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Payment Impact on Hospitals

How to achieve new breakeven level?
- Accountable Care Organization
- Clinical Integration
- Clinical Care Process Redesign
- Operations Improvement

Total Contribution Margin

Payer Type
- Commercial
- Medicare
- Medicaid
- Indigent/No Pay
- Undocumented Aliens

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The Model

Low

Likelihood of Inpatient Stay or Cost

High

Population Base

Primary Care

Medical Specialists

Surgical Specialists

Tertiary

Quaternary
The Challenge

- Hospitals must find a way to increase the population base they serve, while simultaneously becoming more efficient, and maintaining, or improving quality
- Requires a plan for offense
- To thrive while reimbursement shrinks, hospitals will simultaneously need to grow while we become more efficient
- How?
  - Provide the right care
  - In the right place
  - At the right cost
Five Key Strategies To Meet Payment Reform

- Create a fully integrated healthcare delivery continuum
- Develop the ability to manage the health of large populations
- Expand the population base through primary care growth, wellness programs and strategic alliances
- Provide quality outcomes at a decreased cost through a new model of care
- Realign organizational structure to support strategies 1-4
Non-traditional alliances

“You should have activity in all these areas” – Dr. Paul Keckley

- Hospital – Hospital
- Acute - Physician
- Acute – Post Acute
- Acute – Alternative Health
- Wellness/healthy living – targeted to employers
- Retail health and acute sector
Consequences for hospitals

- Will vary by type of hospital
- Push to increase size of health system
- Push to employ physicians
- Need to expand primary care capacity through employment or partnerships
- Possible inability to continue certain services or locations
- Could lead to shifts in employment, possible overall reductions in employment
Consequences for hospitals

- Integration would lead to greater power to negotiate payment rates with payors
- Medicaid expansion desired to increase paying customers as Medicaid pays better than uncompensated care, especially with cuts coming to DSH and other payment reductions
- More hospitals likely to seek to become health plans
- Many hospitals will try to become ACOs
Special challenges for academic medical centers

- Academic medical centers have three part mission:
  - Care
  - Education
  - Research

- Current payment system subsidizes education and research
- Payment reform may undermine ability to subsidize these activities through payments
- What alternatives are there to finance these activities?
Conclusion

- Health transformation is necessary in the U.S.
- Too much waste, not enough value
- Payment reform is a key approach being pursued
- Will lead to shift from fee-for-service to emerging form of pay for value, likely leading to global budgets
- Hospitals are in the cross-fire of this transformation as most hospital visits get seen as failures
- Payment reform will change incentives, creating new opportunities and requiring elimination of certain current practices with potential local economic and community effects that may be adverse at times
Questions?

Thank you!

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