Institute for Continued Learning
Willamette University

Health Reform and its Impact on Hospitals and Delivery Systems

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Chief Finance and Strategy Officer
Salem Health
Objectives:

This session will enable participants to:

• Understand market forces putting pressure on hospital margins

• Identify major components of State and Federal reform influencing healthcare finance and delivery

• Evaluate reform implications on relationships between hospitals and physicians in Salem, Oregon
Do we have a shared understanding of the problem?

<table>
<thead>
<tr>
<th>The American Healthcare System is Broken!</th>
<th>Unsustainable Cost</th>
<th>Overhead</th>
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<tbody>
<tr>
<td></td>
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<td>Conflicting Incentives</td>
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<td>Inefficiency</td>
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<td>Over Utilization</td>
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<td>Culture</td>
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<td>Unreliable Quality</td>
<td>Variation in Training</td>
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<td>Variation in Knowledge</td>
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<td>Variation in Process</td>
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<td>Variation in Patient Compliance</td>
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<td></td>
<td>Variable Access</td>
<td>Economic</td>
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<td>Personal Choice</td>
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<td>Provider Lifestyle</td>
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</table>
It is even more complicated

The American Healthcare System is Broken!

Unsustainable Cost
Unreliable Quality
Variable Access

Physicians
Hospitals
Pharmacy
Homecare
Long-term Care

Federal Budget – Taxes
State Budget – Taxes
Employers – Taxpayer compensation

the heart of healing
The New Logic of Wholesale Purchasers of Healthcare

Source: Health Care Advisory Board interviews and analysis.

Expanding Value Proposition

Cost
Convenience
Care Management
Collaboration

Commercial Payers

Activist Employers

Population Health Managers

Source: Health Care Advisory Board interviews and analysis.
Four Forces Changing Hospital Economics

Decelerating Price Growth
- Federal, state budget pressures constraining public payer price growth
- Payments subject to quality, cost-based risks
- Commercial cost shifting stretched to the limit

Continuing Cost Pressure
- No sign of slower cost growth ahead
- Drivers of new cost growth largely non-accrative

Shifting Payer Mix
- Baby Boomers entering Medicare rolls
- Coverage expansion boosting Medicaid eligibility
- Most demand growth over the next decade comes from publicly insured patients

Deteriorating Case Mix
- Medical demand from aging population threatens to crowd out profitable procedures
- Incidence of chronic disease, multiple comorbidities rising

Cost Driver: Aging, Sicker Population

Deteriorating Mix

Projected Increase in Chronic Disease Cases
2003-2023

<table>
<thead>
<tr>
<th>Condition</th>
<th>Increase</th>
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<tbody>
<tr>
<td>Stroke</td>
<td>29.0%</td>
</tr>
<tr>
<td>Pulmonary Conditions</td>
<td>31.0%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>39.0%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>41.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>53.0%</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>54.0%</td>
</tr>
<tr>
<td>Cancer</td>
<td>62.0%</td>
</tr>
</tbody>
</table>

19%: Projected population growth, 2003-2023

Shifting Payer Mix

Inpatient Volume by Payer Class

2011

- Commercial: 35%
- Medicare: 37%
- Medicaid: 22%
- Self Pay: 5%

2021

- Commercial: 27%
- Medicare: 52%
- Medicaid: 20%
- Self Pay: 0.3%

Employers Already Scaling Back Coverage

Individuals Covered by Employer Sponsored Insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>69.7%</td>
</tr>
<tr>
<td>2011</td>
<td>59.5%</td>
</tr>
</tbody>
</table>

11.5M fewer individuals

Contribution to Insurance Premiums

<table>
<thead>
<tr>
<th>Year</th>
<th>Employer</th>
<th>Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$5,866</td>
<td>$2,137</td>
</tr>
<tr>
<td>2012</td>
<td>$11,429</td>
<td>$4,316</td>
</tr>
</tbody>
</table>

95% growth

102% growth

23% Employers planning to offer consumer directed health plan as the only plan option, 2014

Nine Imperatives to Sustain the Margin

1. Maximize revenue capture
2. Excel under performance risk
3. Bend Labor cost curves
4. Standardize clinical care pathways
5. Redesign inpatient care models
6. Build effective capacity
7. Reassess supply of less profitable services
8. Deflect demand of less profitable services
9. Secure surgical market share

Affordable Care Act: Impact on Provider Payments

$110 Billion
Cuts to Medicare FFS Rates

$36 Billion
Cuts to Disproportionate Share Hospital (DSH) payments

$84 Million
Impact to Salem Health

Components of Current Health Reform

- **Reduce cost**
  - Force integrated delivery/Provider collaboration
    - Accountable Care Organizations - Federal
    - Coordinated Care Organizations - State
  - Pay less
  - Shift risk

- **Expand coverage**
  - Medicaid
  - Health Insurance Exchange

- **Increase quality**
  - Application of evidence based medicine
  - Readmissions
  - Hospital acquired conditions
  - Patient satisfaction
Re-examining the ACA “Grand Bargain”

ACA Hospital Payment Cuts

2013-2023

- Hospital Payment Rate Cuts: $260B
- DSH Payment Cuts: $56B
- Total Hospital Cuts: $316B

Projected Coverage Expansion

Net Reduction in Uninsured Individuals


1) Non-elderly population.
Health Insurance Exchange

- Federal Mandate in each State by January 2014
- Applies to
  - Individuals that do not have access to affordable coverage at work
  - Employers with fewer than 50 employees, 100 in 2016
- CoverOregon.Com is our State sponsored exchange
  - Compares plan offerings
  - Determines tax credit eligibility
  - Assesses individual eligibility for other insurance programs
- Exchange participant plans vary in premium for a few reasons
  - Plan design (Bronze, Silver, Gold)
  - Geographic location
  - Family status
  - Age rating
  - Tobacco usage
Medicaid Expansion No Sure Bet

State Participation in Medicaid Expansion - May 2013

Source: Health Care Advisory Board interviews and analysis.
Some Employers Dodging Their Mandate

Strategies to Avoid ACA Penalties

- Cut jobs to remain under 50 FTEs
- Hire all new employees at part-time status
- Convert full-time employees to part-time status
- Split into smaller companies with fewer than 50 FTEs

31% Franchisees that plan to cut jobs to stay under 50-employee threshold

32% Retail and hospitality companies that plan to “change workforce strategy” to avoid penalties


1) Full-time equivalents.
2) n=72 franchisees, all industries.
3) n=1,203 employers.
## Performance Based Payment

<table>
<thead>
<tr>
<th>Payment Driver</th>
<th>Description</th>
<th>Payment Reduction Timeline</th>
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</thead>
<tbody>
<tr>
<td><strong>Value-Based Purchasing Program</strong></td>
<td>• Mandatory pay-for-performance program</td>
<td>• Withholds begin at 1% in 2013, grow to 2% by 2017</td>
</tr>
<tr>
<td></td>
<td>• Percentage of hospital inpatient payments withheld, earned back based on quality performance</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Readmissions Reduction Program</strong></td>
<td>• Hospital with greater than expected readmission rate subject to financial penalty</td>
<td>• Penalties capped at 1% of total DRG payments in 2013, 2% in 2014 and not to exceed 3% in 2015 and beyond.</td>
</tr>
<tr>
<td></td>
<td>• Performance based on 30-day readmission metrics for three conditions in 2013, expanding in 2015 to include four others</td>
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<tr>
<td><strong>Hospital-Acquired Condition (HAC) Penalty</strong></td>
<td>• Hospitals in top quartile of national, risk-adjusted HAC rates subject to financial penalty</td>
<td>• 1% penalty deducted from DRG payments starting in 2015</td>
</tr>
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Flawed Assumptions

• People with coverage will seek appropriate care in the appropriate setting.

• Provider access will be adequate at the current level of reimbursement for the new insured population

• Major shifts in delivery system practices will occur without major shifts in incentives and without investment in the transformation process

• We can cover more people with less money

• Patients will accept and adapt to the new system
Oregon’s Response to Healthcare Reform: The Coordinated Care Organization (CCO)

• Definition of a CCO ...
  - ...Accountable for care management and provision of integrated and coordinated health care for each member...
    • Manage within fixed global budgets
    • Efficiency and quality improvements
    • Reduce medical cost inflation
    • Development of regional and community accountability
    • Maintaining quality and affordability for all Oregonians

• Express language concerning the medical home model

• Oregon Health Authority will gather, evaluate and publish performance against defined quality outcomes
Willamette Valley Community Health

- The CCO serving Marion and Polk Counties
- Hospitals
  - Salem Hospital
  - Santiam Hospital
  - Silverton Hospital
  - West Valley Hospitals
- Physician Organizations
  - WVP Health Authority
  - Salem Clinic
  - Yakima Valley Farm Workers
  - Northwest Human Services
- Other Constituents
  - Mid-Valley Behavioral Care Network
  - Capitol Dental
  - Marion County Commissioner
  - Polk County Commissioner
  - Atrio Health Plans
- Community Representatives
Where are these forces and reforms leading us? What conclusions should we draw?

1. The old business model for healthcare is dying

2. The new business model will emphasize outcomes and efficiency (quality and cost)

3. Patient service revenue and underlying costs will be under tremendous pressure

4. Payers may require integrated care organizations to participate (Medicare, Medicaid, PEBB)

5. Instability in the marketplace may drive new alliances

6. New core competencies will be a condition of success
How do we solve this problem?

- Design a model that:
  - Aligns all provider incentives. Everyone wins when the right care is delivered in the right setting at the right time
  - Stop building unnecessary capacity
- Share the pain. Funding cuts need to be born equally among the stakeholders, including patients
- Patient and family engagement
  - Consequences for personal choices
  - Not all healthcare intervention is helpful
  - End of life decisions
Hospitals in Search of Scale

Hospital Mergers and Acquisitions

<table>
<thead>
<tr>
<th>Year</th>
<th>Mergers and Acquisitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>52</td>
</tr>
<tr>
<td>2010</td>
<td>72</td>
</tr>
<tr>
<td>2011</td>
<td>90</td>
</tr>
<tr>
<td>2012</td>
<td>94</td>
</tr>
</tbody>
</table>

Hospitals Employing or Affiliating with Physicians

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Employment</th>
<th>Other Formal Affiliations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>76%</td>
<td>11%</td>
</tr>
<tr>
<td>Orthopedists</td>
<td>39%</td>
<td>24%</td>
</tr>
<tr>
<td>Neurologists</td>
<td>13%</td>
<td>37%</td>
</tr>
<tr>
<td>General Surgeons</td>
<td>11%</td>
<td>39%</td>
</tr>
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Traditional Motivations for Consolidation

- Increase negotiating power
- Control referral pathways

The New Rationale of Partnership Rapidly Evolving

Objectives of Partnership

- **Financial**
  - Centralize supply purchasing
  - Consolidate local position

- **Operational**
  - Merge back office functions
  - Increase operational efficiency

- **Clinical**
  - Integrate services across care continuum
  - Develop care management competencies

- **Reach**
  - Stake regional footprint
  - Establish national network

**Source:** Health Care Advisory Board interviews and analysis.
Hospital-Physician Relationships

Source: Health Care Advisory Board, Playbook for Accountable Care, 2010
Any Questions??

THANK YOU!!