

NACo is pleased to present

***The Changing Climate of Health Care:
County Challenges and Opportunities***

Wednesday, June 13, 2012



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Speakers

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The Changing Climate of Healthcare: County Challenges and Opportunities

June 13, 2012

John Peel, Principal
Jeff Sommer, Principal

STROUDWATER ASSOCIATES

- The Role of Counties in the Delivery of Healthcare
- The State of the Industry
- Key Drivers of Change
- Implications for Counties
- Strategic Responses

- As of 2010, there were 1,068 state and county-owned hospitals in the US representing 21% of all US hospitals
- While county hospitals may serve as “safety net” hospitals in some urban areas, in many states they provide a significant portion of total acute care
- Government-owned hospitals comprise more than 40% of all hospitals in: Wyoming (66%), Iowa (50%), Idaho (49%), Kansas (48%), Washington (45%), Nebraska (44%), Mississippi (43%)
- The 10 states with the most state or county owned hospitals are listed below
 - Texas (113)
 - California (69)
 - Kansas (62)
 - Iowa (59)
 - Georgia (52)
 - Louisiana (50)
 - Oklahoma (44)
 - Mississippi (41)
 - Nebraska (39)
 - Washington (39)

- Of the 15,622 nursing facilities in the US in 2010, 6% were county or state owned
- The percentage of nursing facilities that were government owned varied considerably:
 - High: Wyoming (45%), Alaska (40%), Nebraska (23%) and Hawaii (20%)
 - Low: Rhode Island (0%), Maine (1%), Massachusetts (1%), Connecticut (1%)

- ***More residents (32%) indicated they would prefer to be employed by a hospital than any other option.*** Only one percent of residents indicated they would prefer a solo setting as their first practice.
 - A majority of newly trained physicians are seeking employment via hospitals, systems or large physician groups
- ***Almost one half of residents (48%) said they are unprepared to handle the business side of medicine.***
- Residents identified “geographic location,” “personal time” and “lifestyle” as their most important considerations when evaluating a medical practice opportunity.
 - Lifestyle considerations frequently mean that it takes more than one physician to replace a single “old timer”
- ***The great majority of residents (94%) would prefer to practice in communities of 50,000 people or more.*** Only 6 percent would prefer to practice in communities of 50,000 or less.
- The majority of residents (72%) expect to make \$176,000 or more in their first practice.

- FQHCs
- RHCs
- Home health / VNAs
- Department of Health / Public Health
- Mid level providers:
 - Nurse practitioners
 - Physician assistants
- Telemedicine

- The provision of healthcare is vital to a thriving local community
 - Economic engine
 - The largest or second largest employer in most communities
 - A magnet for retirees and economic development
 - Access to needed healthcare services is one factor in improving health status
 - Historically, a hospital has been the cornerstone of sustaining a local medical community via attracting patients and more recently providing physician employment and practice subsidies
 - In many single hospital communities, if the hospital were to close, the local medical community would significantly downsize

- Transition from volume based to value based
 - FFS → Value Based Payment / ACO
 - *“The end of getting paid more to do more”*
- Quality as payment and market differentiator
- Limitations on ability to access to capital, yet
 - Information technology needs are accelerating
 - Must be able to recruit providers via a national marketplace for talent
- *Hospitals as cost centers not revenue centers*
 - The premium dollar and primary care as key drivers of strategic strength

Has Healthcare Reform Brought the End to "Hospital Systems?"

Beckers Hospital Review, June 05, 2012

- Many healthcare providers don't want to be known as "hospital systems" anymore. The phrase "hospital system" connotes a sense of limitation and constraint in today's healthcare environment, in which ***successful systems are expected to include surgery centers, physician groups, home health agencies, rehabilitation facilities and sometimes even health plans.***

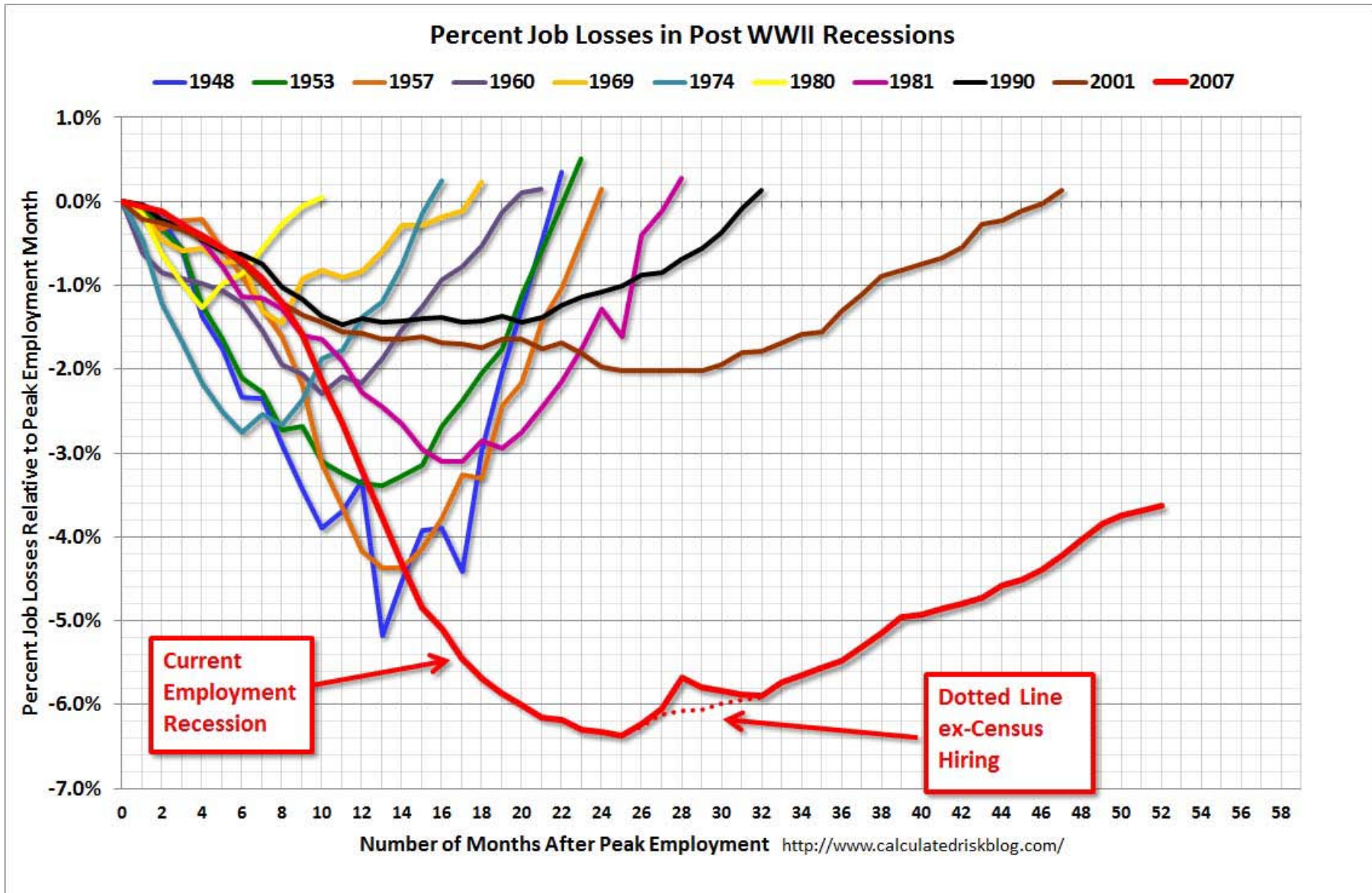
Is the Community Hospital a Dying Model, or is it the Future of Healthcare?

Beckers Hospital Review, May 30, 2012

- As the healthcare industry adopts the philosophy of accountable care, large hospitals and academic medical centers may seem to have the upper hand compared with community hospitals, because larger hospitals typically have greater access to revenue and offer more services along the continuum of care. ***However, community hospitals may be able to develop new care models more effectively because they are smaller and closely aligned with the community.*** While often seen as a disadvantage, community hospitals' small size may be an advantage in the drive to reduce costs and improve quality.

1. Recession with very slow recovery
2. Health care reform uncertainty
3. Continued pressure on local, state, and federal budgets
4. Escalating pressures from payment reform





1. Slowing or declining utilization, particularly for inpatient care and elective procedures
 - US admits per 1,000: 114
 - Lowest rate: VT @ 79
 - Highest rate: WV @ 150

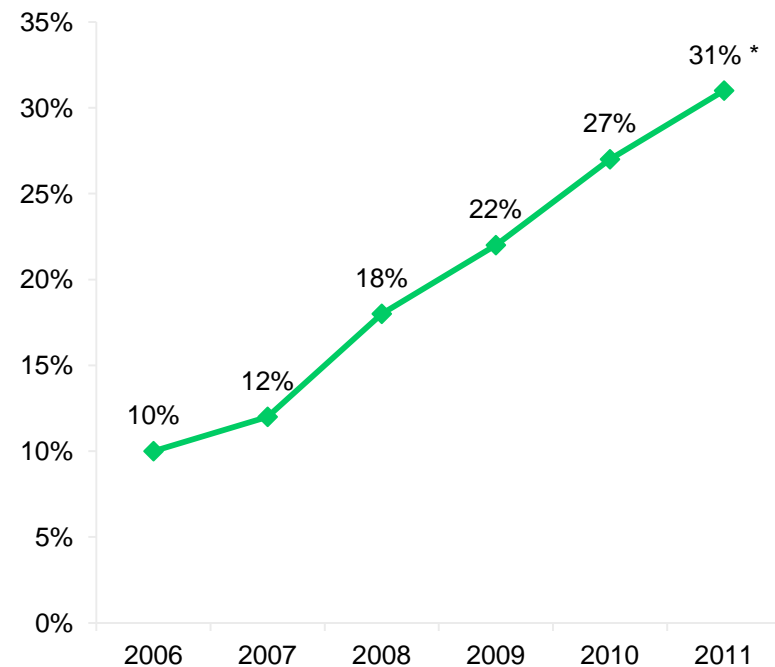
A significant decrease in hospital utilization is likely via payment reform



2. Consumerism and retail shopping mindset of patients

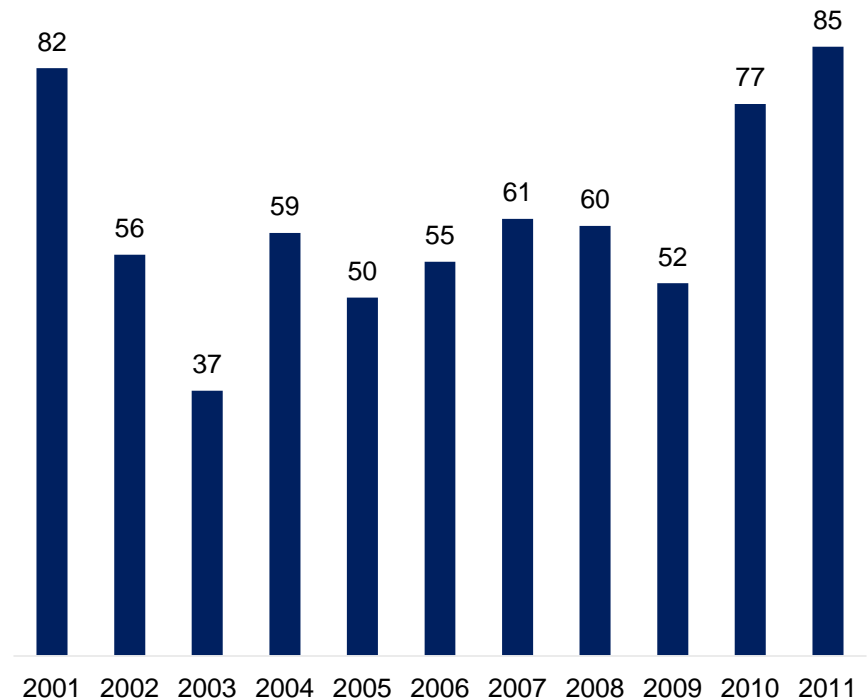
- High deductible health plans
- Emerging transparency re: quality and pricing

Percentage of Workers With Deductible of \$1,000 or More

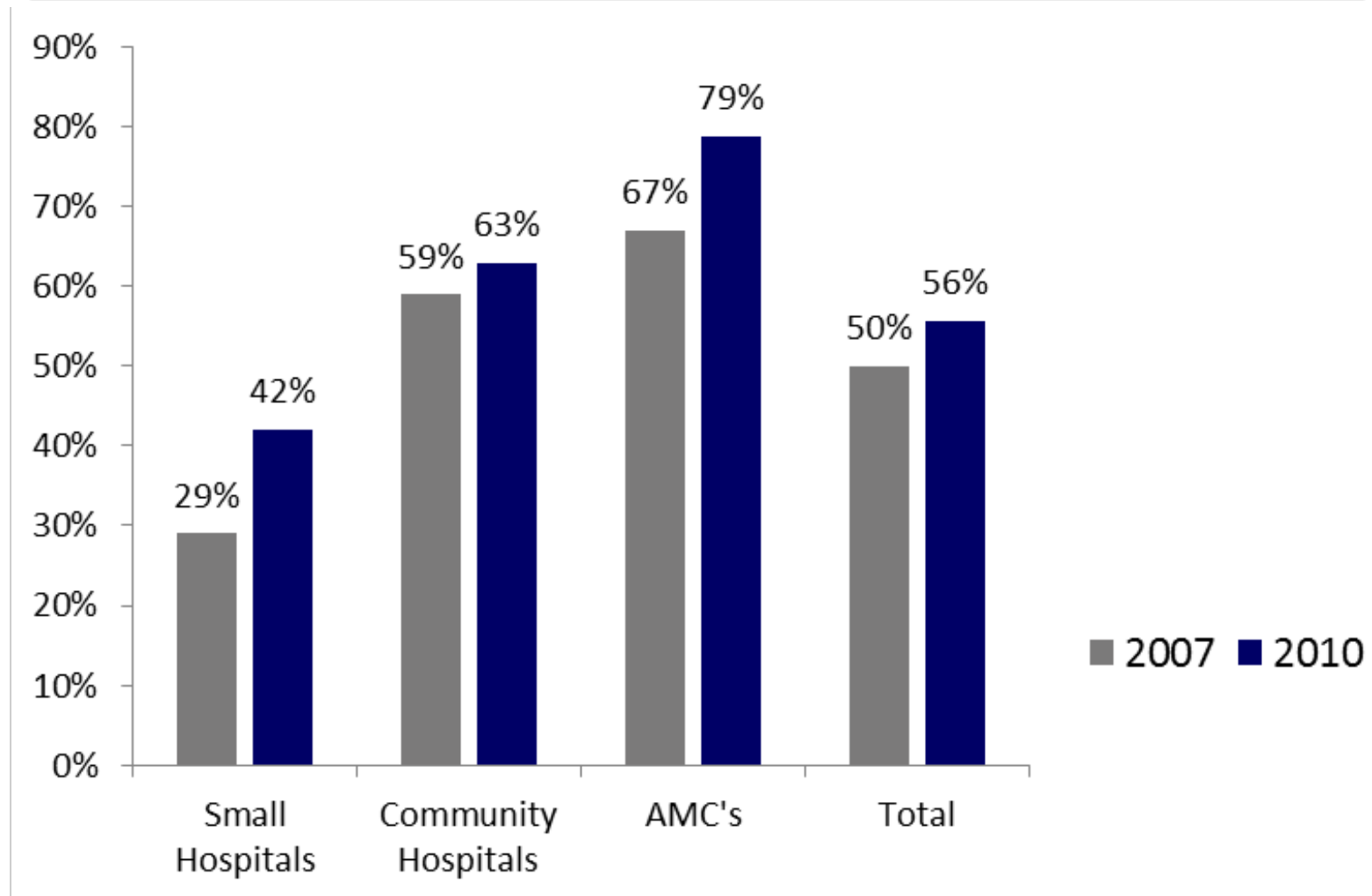


3. Consolidation via a wide variety of affiliation arrangements
- Some newly developing and informal
 - The number of transactions is up 10% over 2010 and 61% than the five year average.

Hospital Mergers and Acquisitions by Year



Percentage of Hospitals in Systems



4. Healthcare remains a political hot potato
 - Full scope of reform is not understood
 - Imperatives for higher quality and lower cost
 - Movement toward global budget payments
 - Meanwhile regulation is increasing



*“While higher-rated hospitals are likely to be better equipped to handle the broader changes resulting from health care reform, **we expect to see broad pressure on the ratios at all rating levels over the medium to long term, especially for providers unable or unwilling to make the changes necessary to preserve their financial and operating profiles.**”*

- S&P, August 2011

*“Moody's negative outlook for 2012 is based on the expectation of ongoing national economic softness, financial and operating pressures resulting from regulatory changes, and continued balance sheet challenges. **The sluggish economy is the driver of weaker financial results manifested in softer volumes, weaker payer mix, and stressed operating results.**”*

*“Ongoing uncertainty about changing regulatory requirements, **healthcare reform and severe federal budgetary stress is putting pressure on hospital management teams as they prepare for the coming era of lower reimbursements and different payment schemes under new business models.**”*

- Moody's, January 2012

- Stroudwater advises clients to prepare for a more challenging:
 - Financial environment
 - Capped and/or lower reimbursements, more mandated investments
 - Falling hospital utilization
 - Operating environment
 - Greater regulation and transparency
 - Significant focus on efficiency
 - Consumerism
 - Strategic environment
 - More competition for fewer dollars
 - Consolidation

- Past success is not an indicator of future success in the new environment
 - What do the examples of Blockbuster, Xerox and others tell us?
- Operating risks for hospitals and providers of all kinds are increasing
- The resources – capital, human and technological – necessary for success are increasing
- Counties should assess whether their owned healthcare facilities are positioned to succeed and fulfill missions?
 - If the answer is no or heightened concern about growing operating risks, one option is to explore partnering options
- Public / private partnerships are an increasingly common approach to sustaining or renewing critical healthcare infrastructure



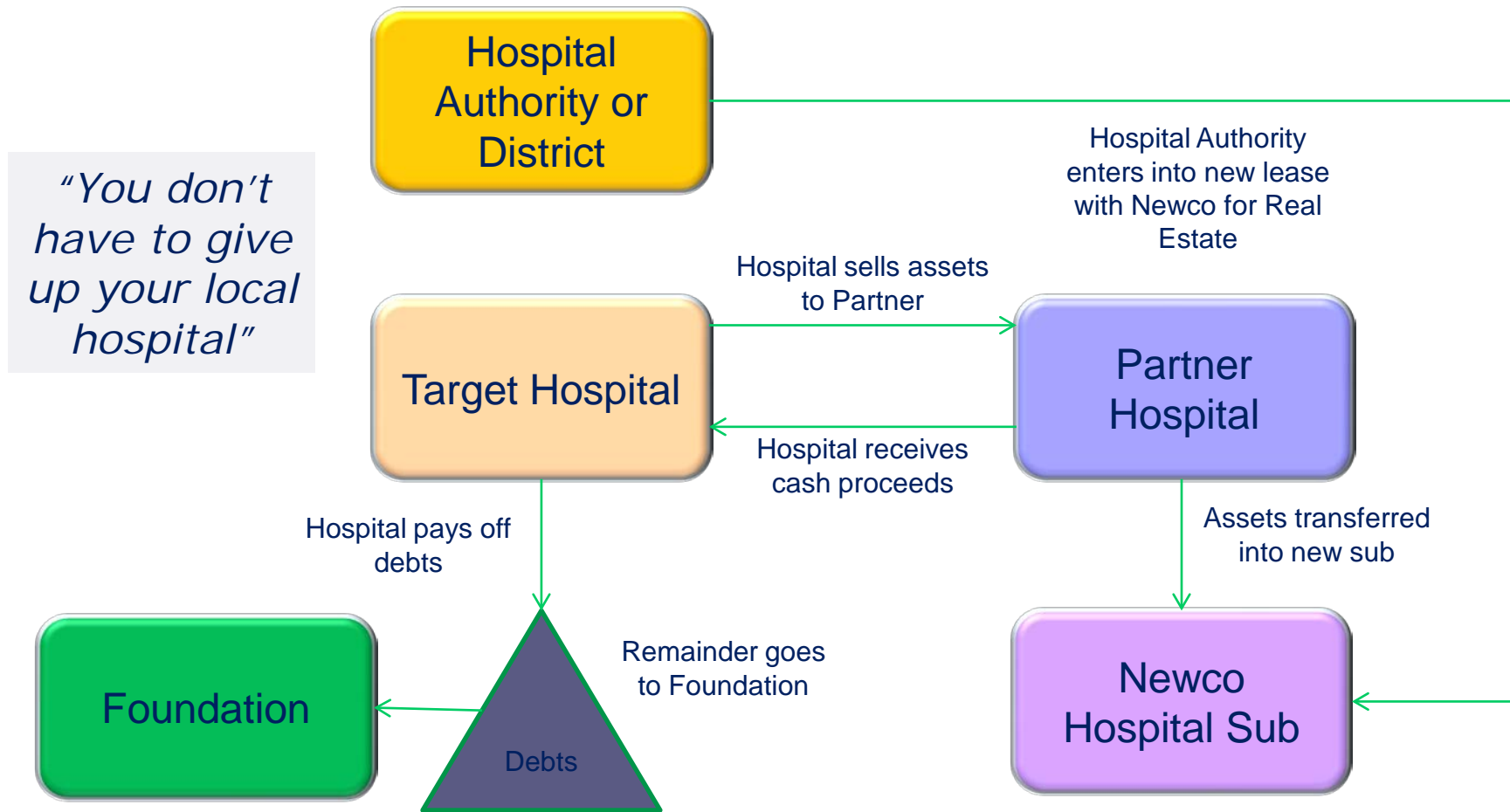
CHANGE

WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

- County healthcare assets are facing a turbulent operating environment
- What skills and additional resources will be required?
 - Access to capital for information technology, provider recruitment and retention, clinical technologies
 - Management systems to coordinate care across the continuum
 - Progress on quality and efficiency (cost)
 - Expertise and systems for managing population health vs. cases or episodes of care
- Do you have a plan to address these needs?

Remember: your healthcare delivery system is both a critical health and economic resource

- What is the best strategy to achieve your County's Healthcare mission and vision?
- How important is local control/governance?
- Is it feasible to remain independent or should your county seek a partner?
 - Independent strategy carries "execution risk."
 - Affiliation strategy carries "partner risk."
- What are some options to consider?



If the hospital real estate is owned by a District or Authority, the Authority can enter into a new lease, sell the assets to the Newco or joint venture with Newco. The value of the hospital assets sold will be reduced by the value of the lease payments or ownership stake retained.

- Bannock County, Idaho
 - Access to capital as driver
 - Partner acquired 80% of county owned facility
 - Commitment to build replacement facility
 - Funded local foundation
 - Governance 50/50
- Bamberg & Barnwell Counties, SC
 - Merger of county-owned facilities in two counties
 - Bankruptcy
 - 100% acquisition by partner
 - Buyer pledged to building a consolidated replacement facility

- Any hospital considering a partnership should ask themselves these questions prior to seeking a partner
 - Why are you considering partnership?
 - What do you need or want out of a partnership?
 - What elements are you willing to cede to a partner or demand to retain?
 - What are the constraints to a partnership?
 - The Big Questions:
 - With Whom?
 - How do we enforce our commitments to the Community?

- Clearly defined Partnership Criteria are the first and most important step in a good decision process. These objectives should:
 - Be developed collaboratively with hospital stakeholders, medical staff, community leaders, and even, if appropriate, the community at large
 - Be the focus of the entire decision process
 - Serve as the screening and selection criteria for candidates
 - Guide evaluations of and negotiations with partners
- These Partnership Criteria also serve as the framework for communicating the rationale for and terms of an affiliation to all the key stakeholders

Examples of Community Objectives:

- Improve access to local care
- Improve measureable levels of clinical care and patient satisfaction
- Access to capital
- Enhance recruitment of physicians
- Upgrade hospital medical facility and equipment
- Commitment to employees
- Governance and local control
- Commitment to the community

- Communications is Key to a successful public / private partnership process
- Timing of what to communicate and when is crucial
- Communications should be framed around the Partnership Criteria established early in the process
- Effective communications requires the active involvement of the County Leadership, Provider Board, Provider Leadership, Medical Staff and the Partner
- Have a plan and be prepared

If you have questions or feedback, please feel free to contact either presenter of today's webinar.

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The Changing Climate of Health Care: County Challenges and Opportunities

June 13, 2012

Blair Childs, SVP Public Affairs, Premier healthcare alliance

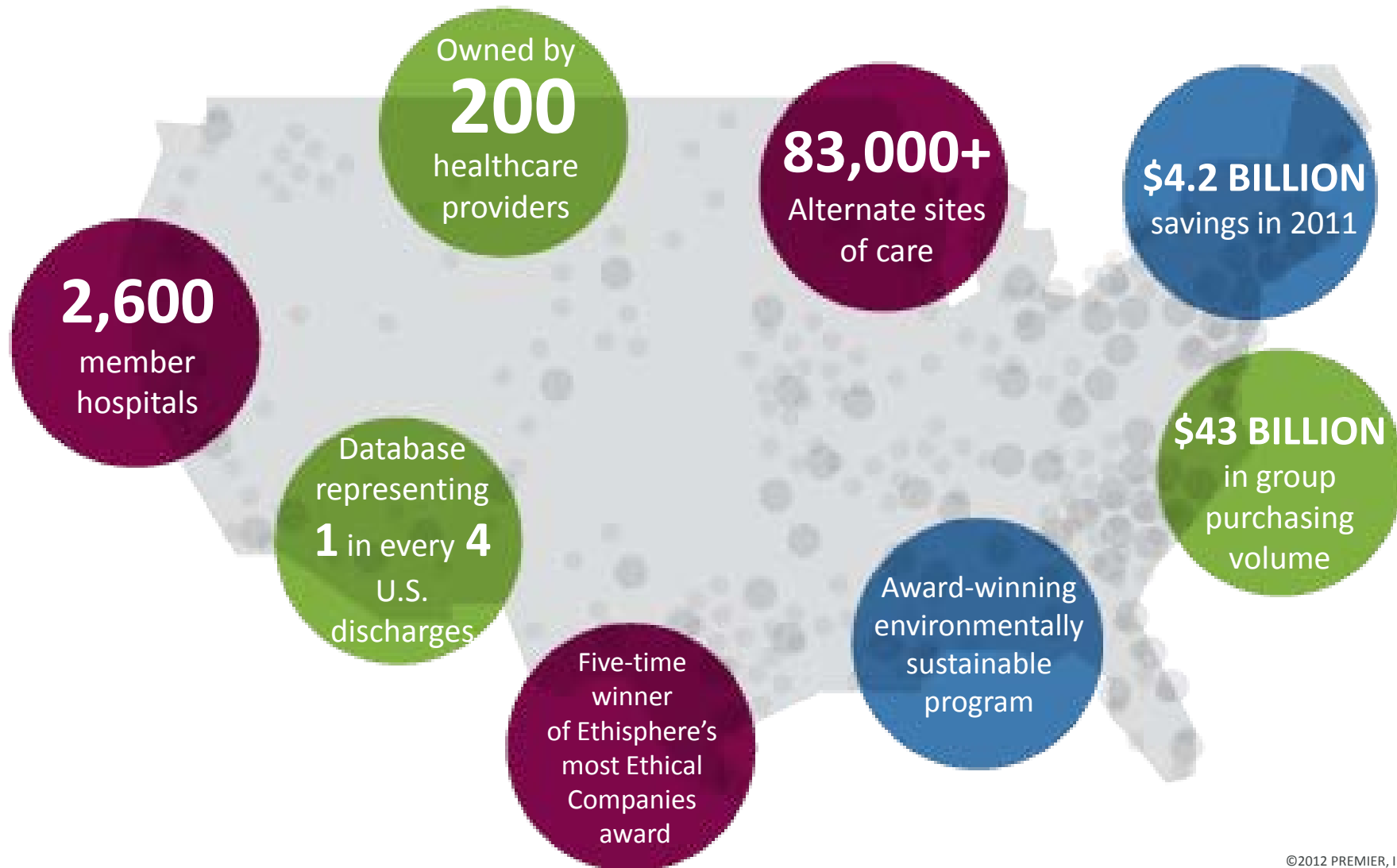
Mary Stokas, VP Chief of Staff, Premier healthcare alliance



Fixing healthcare from the inside

- ▶ Premier healthcare alliance
 - Transforming healthcare together
- ▶ Why is healthcare spending unsustainable?
- ▶ Federal and private sector solutions
- ▶ Premier's test and scale methodology & results
- ▶ What is needed now and the role of counties

Our mission: To improve the health of communities





Premier healthcare alliance:

Uniting a fragmented healthcare system



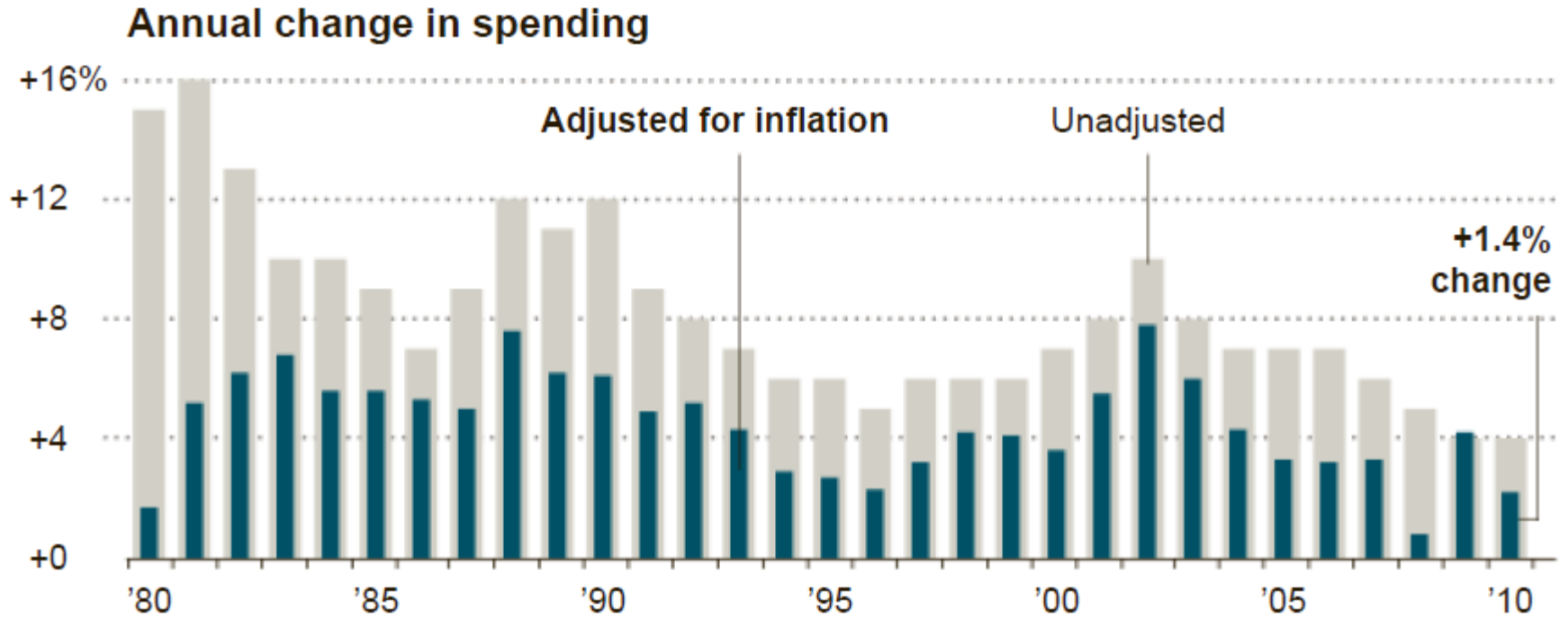
Make healthcare supply chain as efficient, effective as possible

**Deliver continuous improvement in cost and quality;
and enable success in new healthcare delivery/payment models**

Integrate data to create meaningful business intelligence



▶ Healthcare spending and inflation: outperforming



New York Times, April 29, 2012, Based on Bureau of Economic Analysis research

▶ Why is healthcare spending growing?

▶ Payment misalignment

- Rewards volume
- Focused on silos
- Competing incentives
- Legal impediments to collaboration

▶ Fragmentation

- 15 years for diffusion of a standard practice
- Significant practice variation

▶ Lack of consumer engagement

▶ The overarching strategic umbrella of healthcare reform



Cuts to Existing FFS System

- Market basket
- DSH cuts
- Nonpayment for anything preventable or unnecessary

Disrupt Existing System

- Bundled Payments
- Innovation Center
- Demonstrations
- ACOs

Changes are upon us now!

TRACK 1

TRACK 2

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
PAYMENT CUTS & COST SHIFT PROVISIONS											
	CMS Hospital Behavioral Offset relating to IPPS										
	Hospital Market Basket Reductions										
	PhRMA Tax (Ranging from \$2.5 B to \$4.1 B annually)										
	Hospital Productivity Adjustments										
	Medical Device Tax (2.9 B annually)										
	Medicare DSH Payment Reduction										
	Independent Payment Advisory Board (IPPS hospitals exempt until 2020)										
	Medicaid DSH Payment Reduction										
P4P & PENALTIES FOR POOR PERFORMANCE PROVISIONS											
RULE MAKING			Hospital Value-Based Purchasing							
RULE MAKING			Hospital Readmission Payment Reductions							
						Hospital-Acquired Conditions Penalties				
GEOGRAPHIC PAYMENT ADJUSTMENT PROVISIONS											
	Hospital Wage Index										
	Geographic Variation Bonus										
TRANSPARENCY PROVISIONS											
	Waste, Fraud, and Abuse Provisions for Medicare and Medicaid (RACs & MICs)										
	Disclosure of Standard Hospital Charges										
	Comparative Effectiveness Research										
	Disclosure of Industry Payments to Physicians and Teaching Hospitals										
COVERAGE EXPANSION PROVISIONS											
	Insurance Reforms (Pre-existing conditions for children, no annual or lifetime limits, children on parents insurance until 26)										
	Medicaid Expansion										
	Insurance Reforms (Pre-existing conditions for adults, premium limits)										
	Individual Mandate and Employer "Pay or Play"										
	State Exchanges										
DELIVERY SYSTEM PROVISIONS											
RULE MAKING	Accountable Care Organizations										
	Center for Medicare and Medicaid Innovation										
	Bundled Payments Pilot										

1987

Push/pull to accountable care (in X years?)

Track 1 -

Cuts to Medicare FFS System

Push

Readmissions penalty

- Penalty = 5x readmissions payment

HACs penalty

Partnership for Patients

- Will set a higher bar

Value based purchasing

- Efficiency measure: total spending 3 days prior/30 days post
- Care coordination measures

Private Payors and Medicaid

Bundled payment: 2016?

Track 2 - Pull

Disrupt Existing System

MSSP

Pioneer

- Flexible design; retro & prospective attribution

State/Federal duals demo

- State partnership; eased enrolling

Medical home demo; new CMMI

Primary Care Initiative

Reducing readmissions from nursing homes demo

Bundled payment demos

Our journey to care integration

Value-based purchasing:
HACs, quality, efficiency, cuts

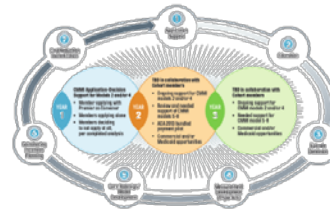
Bundled payment

Capitation

Partnership for Patients

Shared savings

MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS AND RISK



High-performing hospitals

- Most efficient supply chain
- Best outcomes in quality, safety
- Waste elimination
- Satisfied patients

High-value episodes

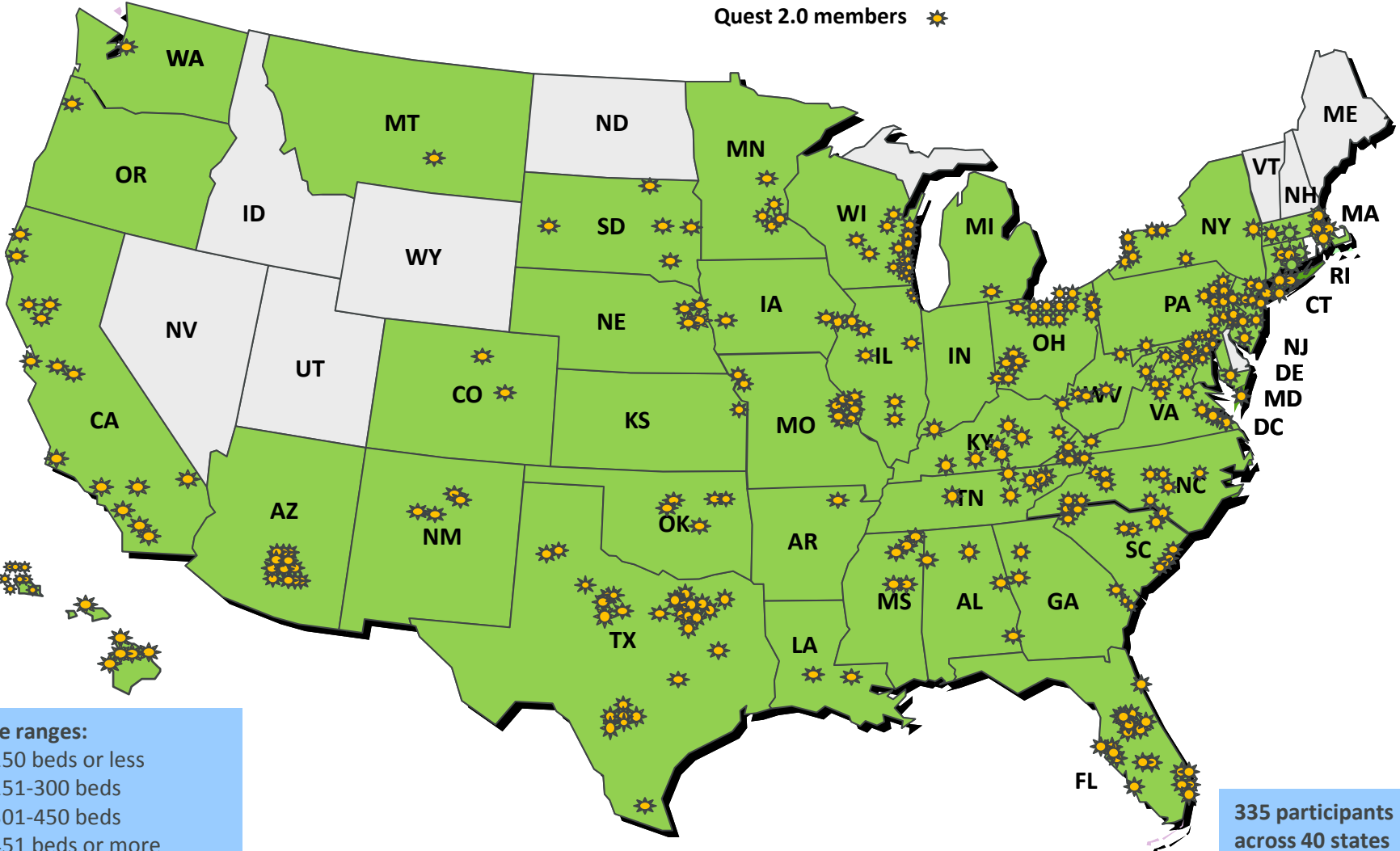
- DRG and episode targeting
- Care models and gainsharing
- Data analytics
- Cost management

Population management

- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration

QUEST participants

Quest 2.0 members 



335 participants
across 40 states

Bed size ranges:
22% - 150 beds or less
29% - 151-300 beds
25% - 301-450 beds
24% - 451 beds or more

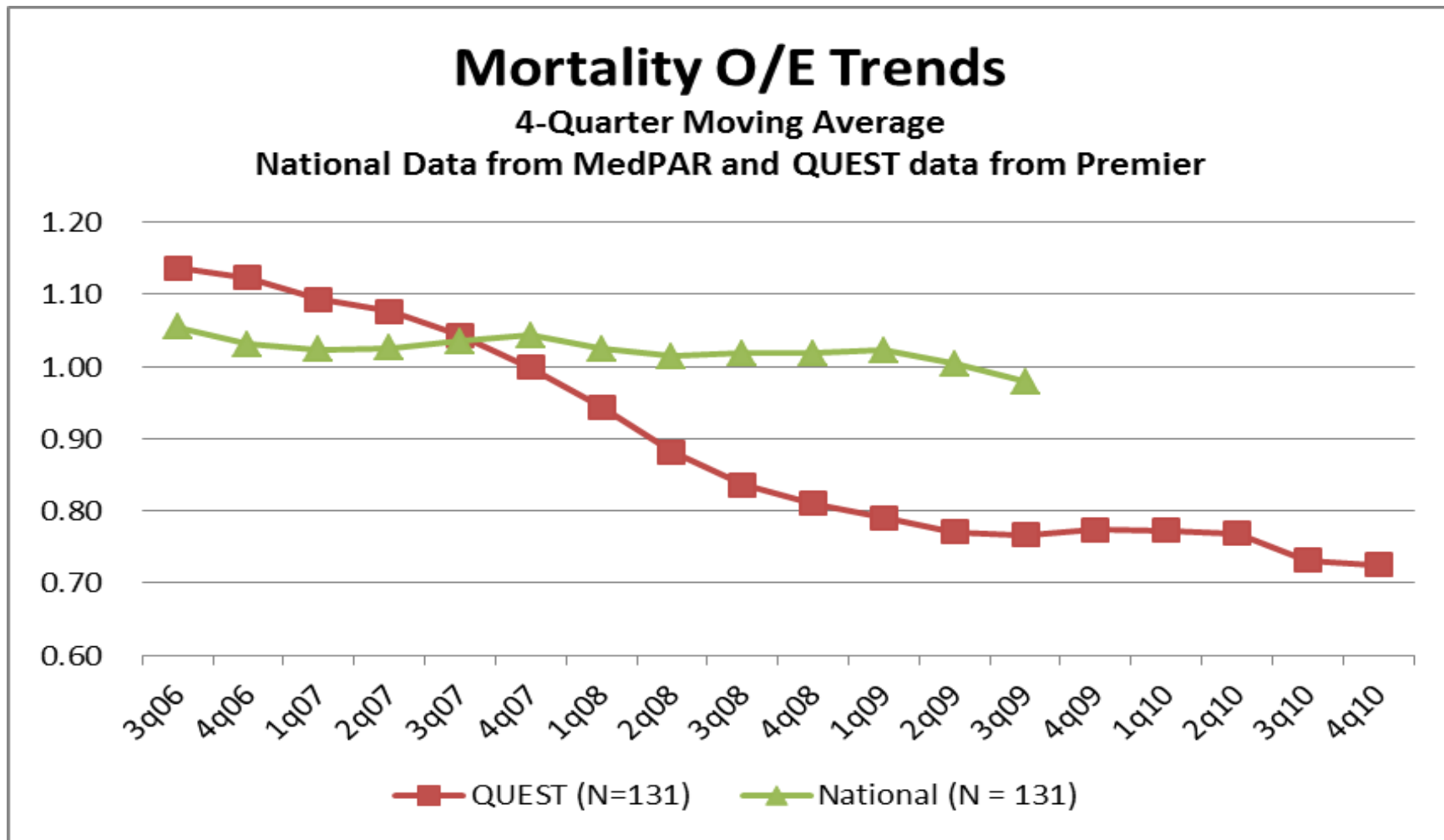
Real, sustained improvement over time

	Year 1	18 Months	Year 2	30 Months	Year 3
Lives saved	8,118	13,285	17,264	20,314	24,820
Dollars saved	\$685M	\$1.3B	\$2.1B	\$3.2B	\$4.5B
Patients receiving all EBC	18,359	31,090	44,629	60,247	75,638

If all hospitals across the country achieved these gains, an estimated **87,250 lives** and **\$34 billion** could be saved each year.

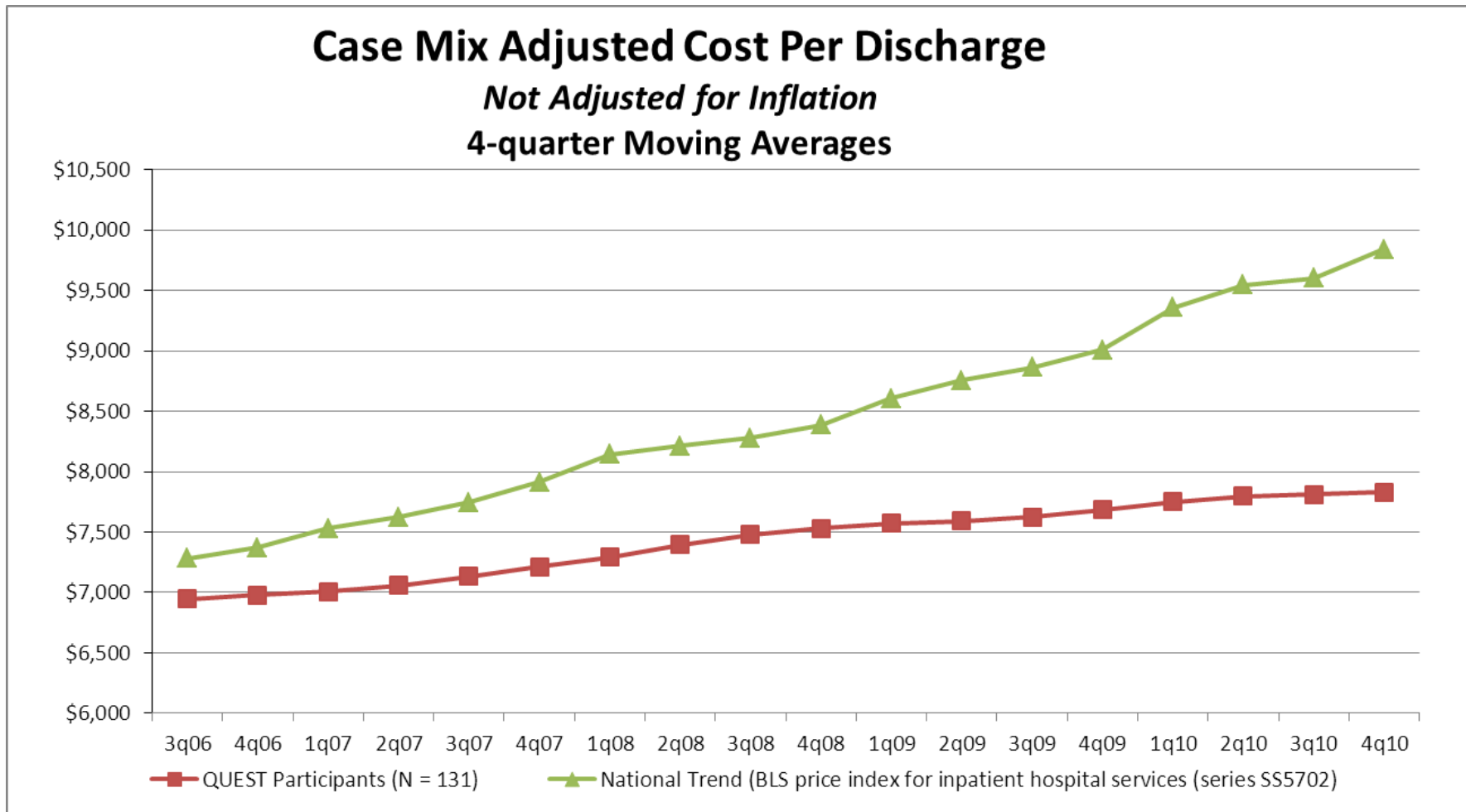


QUEST participants compared to national: Mortality trends



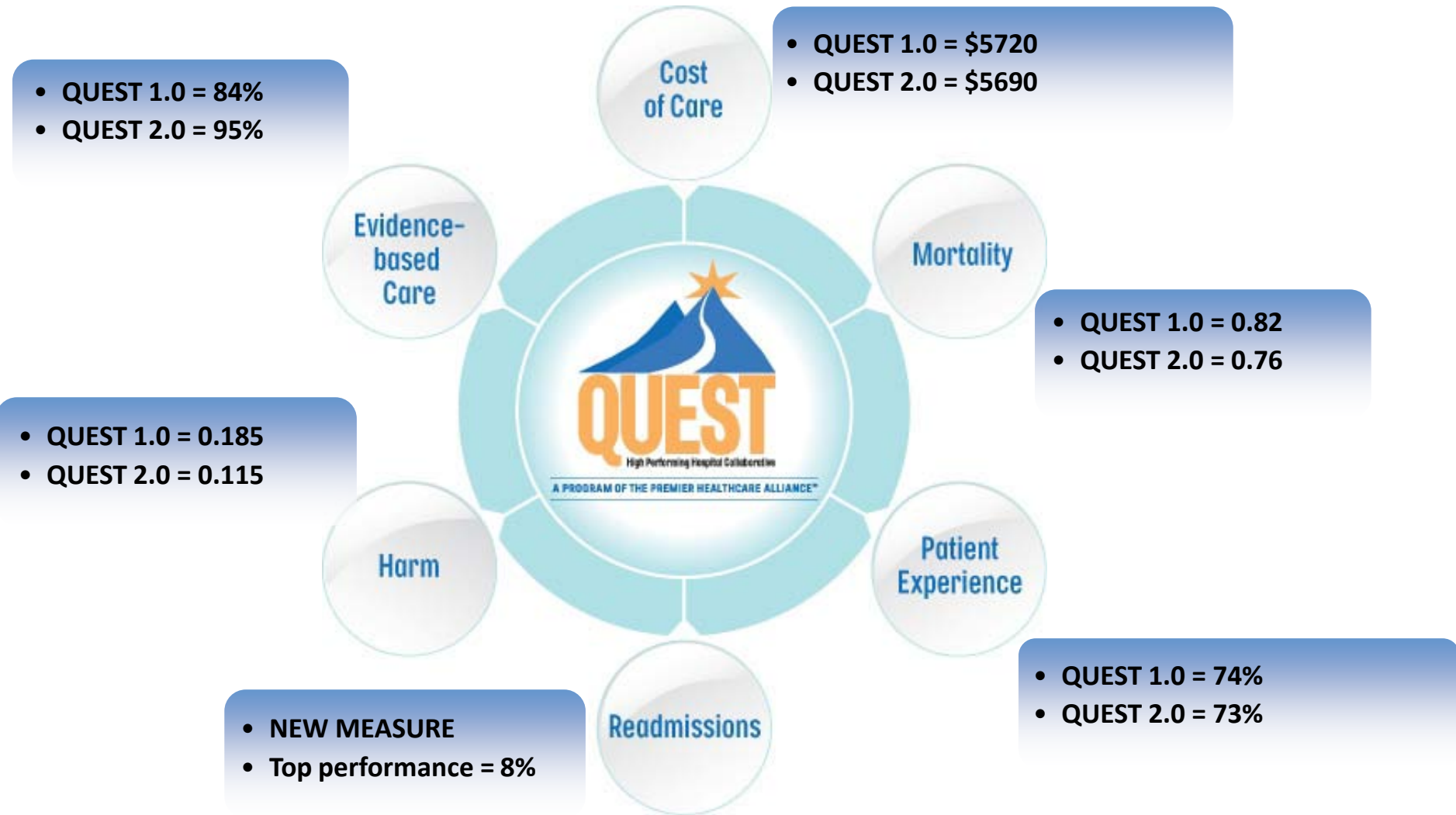
Quarterly results reflect moving averages centered on the corresponding quarter.

Cost trend comparison



Quarterly results reflect moving averages centered on the corresponding quarter.
National inflation base value is the average of a matched cohort.

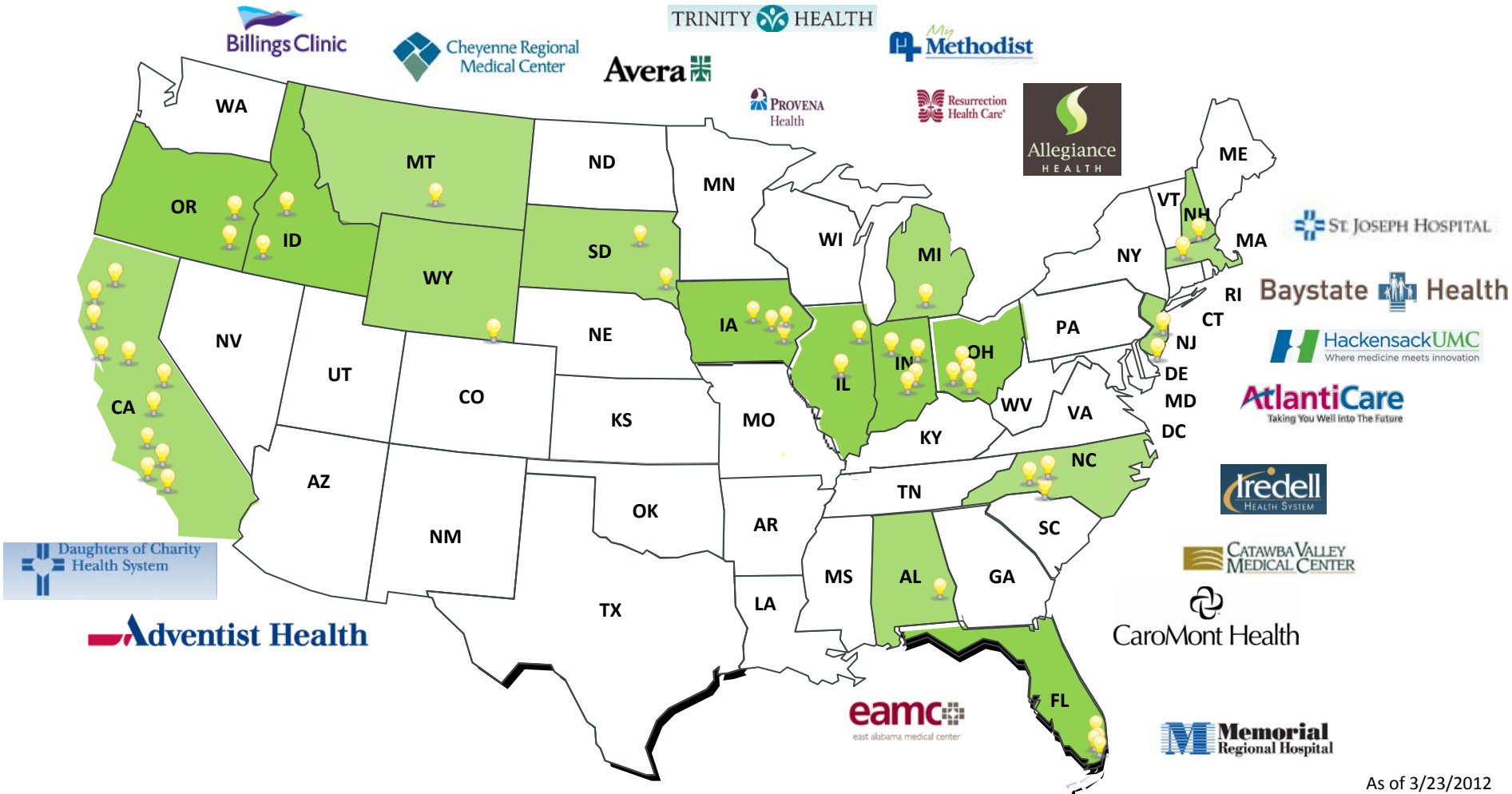
▶ QUEST continues to raise the bar





Premier's bundled payment services

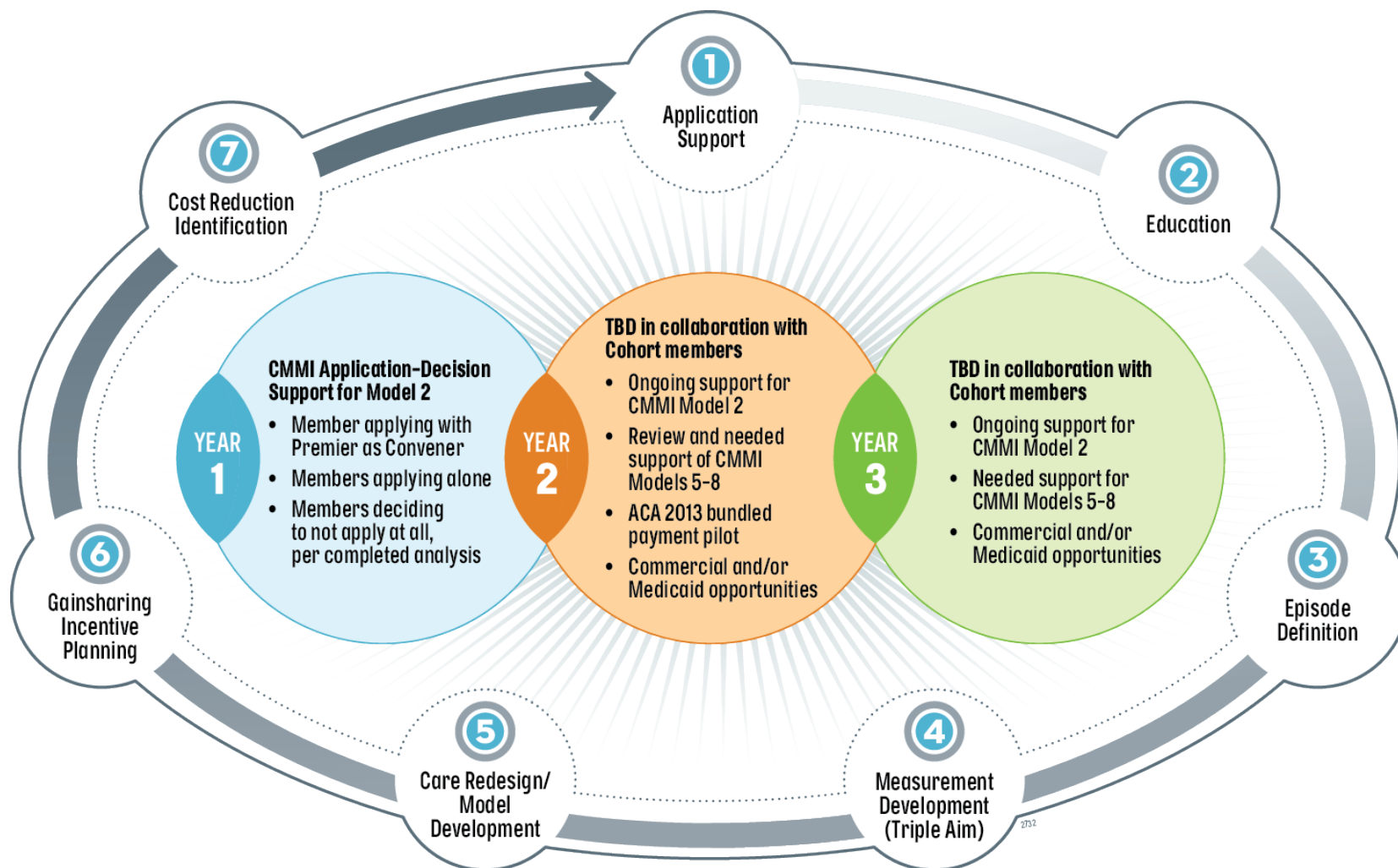
The largest bundled payment collaborative



As of 3/23/2012

Premier's Bundled Payment Collaborative

Core services and collaborative offerings



Premier's bundled payment services

- ▶ Education sessions
 - ACE Demonstration
 - Legal considerations
- ▶ Established Episode definitions:
 - Knee/hip joint replacement
 - Lumbar spine fusion
 - PTCA with stents
 - CABG
 - Heart valve replacement
 - Colon resection
- ▶ Gainsharing model developed
- ▶ Provider contract templates
- ▶ Methodology/strategy development
- ▶ Claims analysis conducted
- ▶ Care Redesign
 - Educational workshops on clinical care redesign and care model development
 - Tools
 - » Care improvement application guidelines
 - » Governance considerations guide
 - » Care redesign capabilities assessment
 - » Current state opportunities grid
 - » Care model intervention grid
 - » Detailed bibliography and reference guide

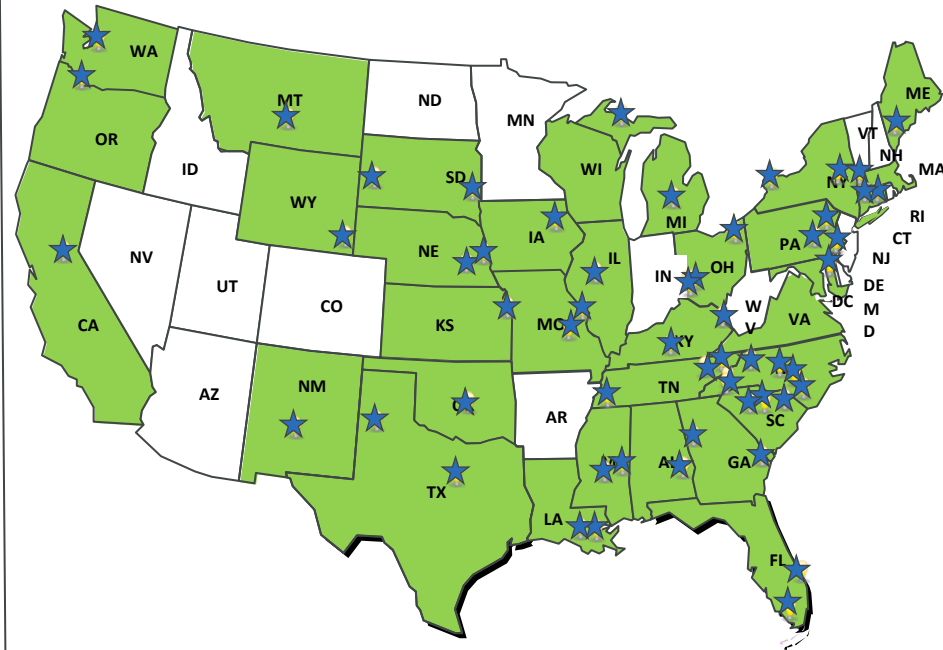
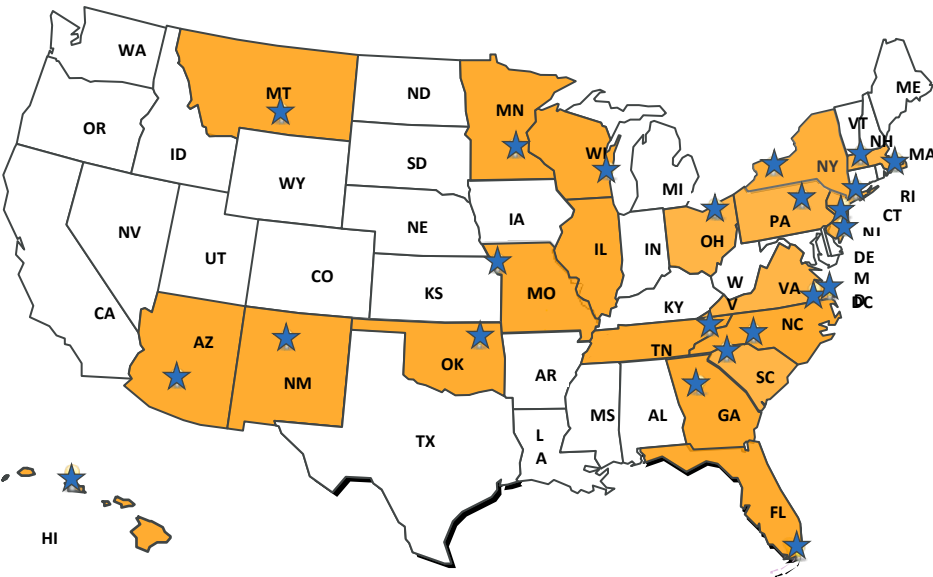


PACT (accountable care) collaborative participants

As of 6/8/2012

PACT > IMPLEMENTATION COLLABORATIVE

PACT > READINESS COLLABORATIVE



What is an Accountable Care Organization?

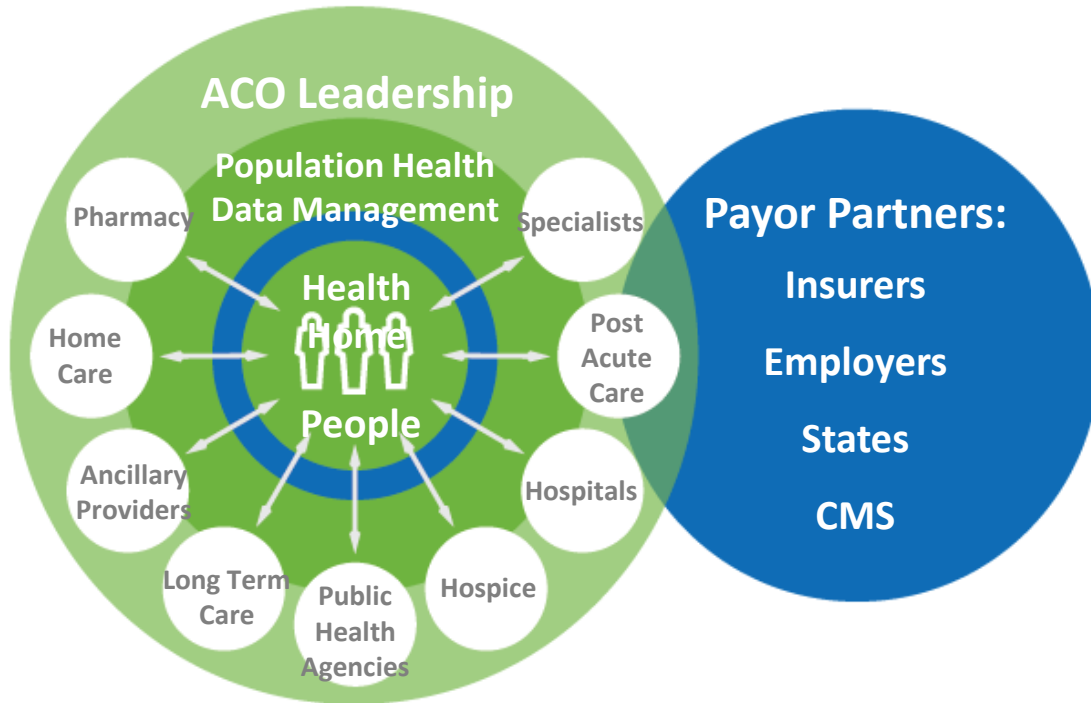
An ACO is a legal entity, typically comprised of a health system or independent provider organization, that contracts with CMS under the Shared Savings Program with an objective of creating efficiency against historical benchmarks for service delivery

In exchange for their efforts, CMS will share a portion of the savings generated by the ACO with the organization

ACOs were designed with a three-part objective:

- 1. Better Care** – in a safe environment, equitable to all who seek it and available when needed
- 2. Improved Health** – accomplished through prevention and chronic care management
- 3. Lower Per Capita Costs** – intended to reduce the trend of cost increases associated with the Medicare FFS population

▶ Innovating to drive coordinated care

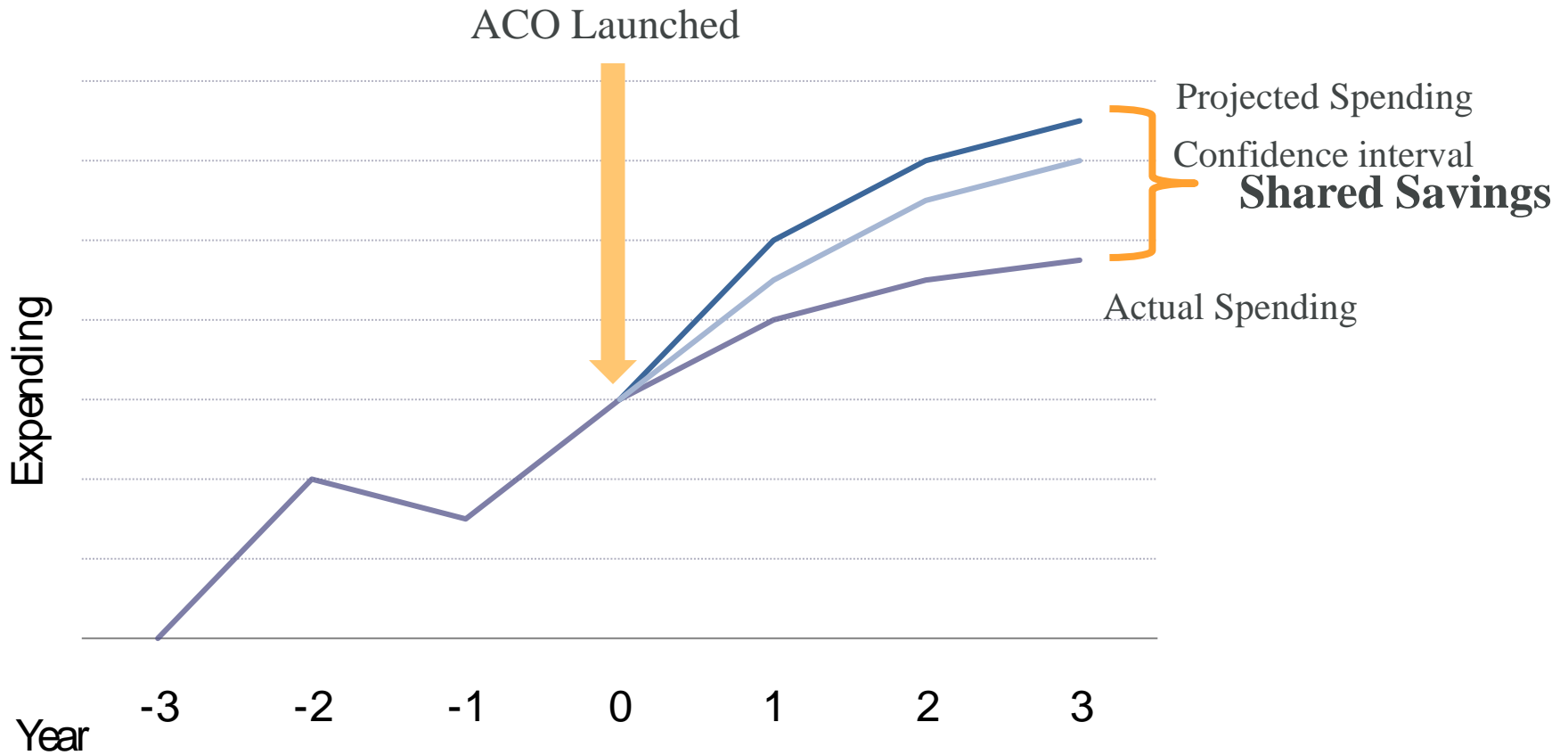


- ▶ **Coordination and collaboration** – Overcome fragmentation so care is convenient and coordinated
- ▶ **Data collection and use** – Consistent data across settings to measure progress
- ▶ **Measure value** – Need to measure savings, quality and satisfaction
- ▶ **Population health focus** – Reward wellness rather than services provided
- ▶ **Time** – Long-term commitment, so efforts toward transformation need to start now
- ▶ **Shared savings** – Aligning reimbursement so providers can capture income based on savings delivered

Medicare ACO basics

- ▶ Patients are assigned to the ACO based upon their pattern of utilization
- ▶ (No election or lock-in)
- ▶ Minimum 3 year agreement
- ▶ Required to have structure to receive and distribute payments for shared savings
- ▶ Enough Primary Care Physicians (PCPs) and other providers to care for assigned patients (minimum 5,000)
- ▶ Program effective January 1, 2013
- ▶ Participation voluntary for providers
- ▶ PCPs can only participate in one ACO
- ▶ Providers paid fee-for-service payments by CMS
- ▶ Shared savings payments distribution made by ACO

ACO Shared Savings



Source: Lewis, Julie. "What Could be Next for Health Reform? The Debate In Washington" Presentation. The Dartmouth Institute for Health Policy & Clinical Practice. 2009-07-02.



Medicaid programs implementing or planning to apply accountable care principles

Implemented

- ▶ California
- ▶ Colorado
- ▶ Minnesota
- ▶ North Carolina
- ▶ New York

Planning

- ▶ Massachusetts
- ▶ New Jersey
- ▶ Oregon
- ▶ Washington
- ▶ Utah

ACO WANNABES

Status of plans for ACOs or similar models in 11 states searching for ways to control Medicaid costs



Source: Modern Healthcare reporting

MODERN HEALTHCARE GRAPHIC



How you can help advance needed change

- ▶ Ask your hospitals how they perform on QUEST measures
 - Measures are publicly available and achieved by all hospital types
- ▶ Advance payment reforms
 - Reforms that reward quality improvement and cost reduction
 - Reforms that enable providers to be accountable for targeted populations
- ▶ Encourage participation in best practice sharing collaboratives
 - Means to speed performance improvement
 - Encourages transparency and healthy competition
 - Counters the not-invented-here perspective

Specific information interest?

If you would like a copy of organizations participating in these collaboratives, email:

Susan_Ueberroth@premierinc.com

To learn about QUEST measures and results:

<https://www.premierinc.com/quest/year3/quest-year-3-collaborative-findings.pdf>



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Thank you.

Questions? Comments?

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APPENDIX

State Legislation: Payment reform

Alabama	Arizona	Arkansas	Colorado	Florida	Illinois
<p>Implemented a self-reporting mechanism for hospitals in FY 2011 to reduce payments for preventable events by reporting 'never events/serious preventable events.' Replaced local technical specifications for data collection with HEDIS measures.</p>	<p>Implemented flexible payment options to encourage the development and implementation of health homes, ACOs, or other programs to reward quality care and efficiencies in care delivery.</p>	<p>Implemented Inpatient Quality Incentive Program in which hospitals meeting criteria receive bonus payments.</p>	<p>Created the Medicaid Payment Reform and Innovation Pilot Program in the Dep. of Health Care Policy and Financing for the purpose of implementing payment reform projects in Medicaid within the framework of the accountable care collaborative. Provides that the Department shall allow for payment proposals that include, but need not be limited to, global payment, risk adjustment, risk sharing and aligned payment incentives for health benefits.</p>	<p>Phasing in managed care over the period Jul. 2012 to Oct. 2014. Developing a P4P program that will award enhanced assignments to higher performing health plans, using HEDIS and other quality metrics to identify higher performing plans.</p>	<p>Implemented the "Integrated Care Program" to improve health care quality and outcomes for approximately 40,000 beneficiaries. MCOs are required to establish an integrated care delivery system connected with EMRs where care is organized around the needs of patients. Systems will use nationally recognized P4P measures that reward providers with incentives based on select measures.</p>

State Legislation: Payment reform

Massachusetts* (PENDING)

After two years of discussion and debate, the Massachusetts Legislature must now deal with two huge pieces of payment reform and cost control legislation.

Each bill states that overall health care costs should rise in concert with the growth in the state's economy. The **House's** benchmark is 3.6 percent for 2012 and 2013. In 2014 and 2015, it would be equal to the growth in the state's economy (as measured by the Gross State Product, or GSP). From 2016 to 2026, it would be equal to a half percentage point below GSP from 2016 to 2026, and equal to one point above GSP after 2027. The **Senate's** cost benchmark is a half point below GSP through 2015, and equal to GSP from 2016 to 2026.

The **House** imposes a penalty on providers who costs are 20 percent higher than the benchmark. It establishes rate setting for governmental units. The House gives the state the ability to force providers to reopen contracts that it considers contributing to excessive spending. The House gives the attorney general to block unreasonable increases in rates, and block changes that adversely affect patient access and the quality of care. In the **Senate** bill, groups that exceed the benchmark must file improvement plans.

The bills define ACOs and their requirements. They provide a 2 percent bonus in Medicaid payments to providers starting in July 2013, if they move to alternative payment methodologies.

Minnesota

The Commissioner of Human Services is required to contract with an independent vendor with demonstrated expertise in evaluating Medicaid managed care programs to evaluate the value of managed care for state public health care programs. Requires the evaluation to be completed and reported to the Legislature by January 15, 2013. Requires the determination of the value of managed care to include consideration of the following, as compared to a fee-for-service program: (1) the satisfaction of state public health care program recipients and providers; (2) the ability to measure and improve health outcomes of recipients; (3) the access to health services for recipients; (4) the availability of additional services such as care coordination, case management, disease management, transportation, and after-hours nurse lines; (5) actual and potential cost savings to the state; (6) the level of alignment with state and federal health reform policies, including a health benefit exchange for individuals not enrolled in state public health care programs; and (7) the ability to use different provider payment models that provide incentives for cost-effective health care.

Thank you for participating in NACo's webinar

**For more information about
NACo's Healthy Counties Initiative, visit
www.naco.org/healthycountiesinitiative**

**For questions about this webinar, please contact
acardwell@naco.org**

