Health Care Transformation
September 21, 2011

Oregon Office of Rural Health

Information from National Rural Health Association

- Today President Obama called for $6 billion in cuts over 10 years to rural hospitals, claiming that the proposal eliminates “higher than necessary reimbursement.”

  Higher than necessary reimbursement? Currently, 41 percent of small rural hospitals, known as critical access hospitals (CAHs), operate at a financial loss. If the President’s proposal to cut billions in Medicare reimbursements hits these facilities, over half of CAHs would lose money. Such devastating cuts will cause rural hospital doors to close, resulting in loss of access to health care and needed rural jobs.

  CAHs account for only 5 percent of Medicare hospital inpatient expenditures, yet they provide critical care and jobs – it’s a sound investment not a “higher than necessary reimbursement.”

  The President’s proposal included changes to the following:

- Reduce bad debt payments to 25 percent, down from the current 70 percent, for eligible providers. This would save $20 billion over 10 years.
- Beginning in 2013, reduce the IME adjustment by 10 percent, saving $9 billion over 10 years.
- FY 2013, end add-on payments for physicians and hospitals in frontier states.
- Reduce CAH reimbursement to 100 percent of cost, down from the current 101 percent.
- End CAH reimbursement for facilities located 10 miles or less from another hospital.
- Strengthen the Independent Payment Advisory Board with more aggressive goals and additional enforcement tools.
- Limit the use of provider taxes beginning in FY 2015, but not eliminate them entirely.

3 key components of health care

- 1. Cost
- 2. Access
- 3.Quality

The goal is to make changes to shift funding from high cost programs to lower more effective programs.

Discrepancy between health determinants and spending

Factors influencing health

- Genetics- 20%
- Lifestyle and behaviors- 60%
- Environment- 10%
- Access to care- 10%

National health spending

- 2.3 trillion spent on health care.
- Only 4% is directed toward prevention and health promotion.
- 96% spent on medical services.

(Centers for Medicare and Medicaid Services. Office of the Actuary. National Health Statistics Group. 2010)

Laws changing health system

- 2005- Hospital Inpatient Quality Reporting (IQR).
- 2005-Physician Quality Reporting System (PQRS).
- 2009-Health Information and Technology for Economic and Clinical Health (HITECH). This is where EHR defined measures for meaningful use.

Affordable Care Act

- March 23, 2010-Patient Protection & Affordable Care Act was enacted (Pub. L. 111-148). March 30,2010 Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) amended provisions of Pub. L. 111-148 to Affordable Care Act.
- 2010- Affordable Care Act- states it will improve quality of Medicare services, align payment model with provider cost and put Medicare on a firmer financial footing.

Provisions in Affordable Care Act

- Value-Based purchasing- links payment directly to the quality of care provided.
- Examples already in place- Hospital Inpatient Quality Reporting, Health Information and Technology for Economic and Clinical Health (HITECH).
- Value-based purchasing seeks to reduce growth in health care expenditures.

More provisions

- Medicare Shared Saving Program- promotes accountability for patient population and coordinates items and services under parts A and B.
- Promotes new approach to delivery of health care.

- This new approach is the **three-part aim-**

1. Better health care for individuals
2. Better health for populations
3. Lower growth in expenditures “lower costs”

Mechanisms to achieve shared savings include:

- Accountable Care Organizations (ACO)- “Groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO”.
- ACOs will begin January 1, 2012.
- Eligible to participate include- ACO professionals in group practice arrangements, networks of individual practices of ACO, partnerships or joint venture arrangements between hospitals and ACO.

ACO further defined:

- ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

- ACO must enter into an agreement with Secretary for a minimum 3-year period.

- ACO shall have a formal legal structure allowing organization to receive and distribute payments for shared savings.

ACO continued:

- Assignment of beneficiaries must be based on utilization of primary care services provided under Medicare by an ACO professional who is a physician.

- ACO must meet quality performance standards established by Secretary.

ACO continued:

- ACO will face sanctions if Secretary determines the ACO has taken steps to avoid at risk patients in order to reduce the likelihood of increasing costs to the ACO.
- ACO professional is defined as a physician, physician assistance, nurse practitioner, or clinical nurse specialist.
- ACO must have 5,000 assigned beneficiaries.
- Several references in rules regarding RHC, FQHC, and CAH participation.

Shared Savings Program will focus on three-part aim:

- Better care, better health, and lower cost.
- ACO will put the beneficiary and family at the center of all its activities and engage people in shared decision-making about diagnostic and therapeutic options.
- ACO will ensure coordination of care regardless of its time or place.
- ACO will attend carefully to care transitions from one system to another.
- ACO will manage resources carefully and respectfully.

ACO principles continued:

- ACO shall reduce patients dependence on inpatient care.
- ACO will be proactive to help them stay healthy.
- ACO will monitor and compare performance to other ACOs and examine processes for improvement.

Four programs authorized by Affordable Care Act

1. **Establishment of Center for Medicare and Medicaid Innovation-** pilot programs to reduce cost. Explore alternative payment programs.
2. **Independence at Home Medical Practices-** physician and nurse practitioner directed home-based primary care teams.
3. **State option to provide Health Homes-** health homes for patients with chronic conditions. Includes comprehensive case management, care coordination and health promotion, referral to community and social support; and use of HIT to link services.

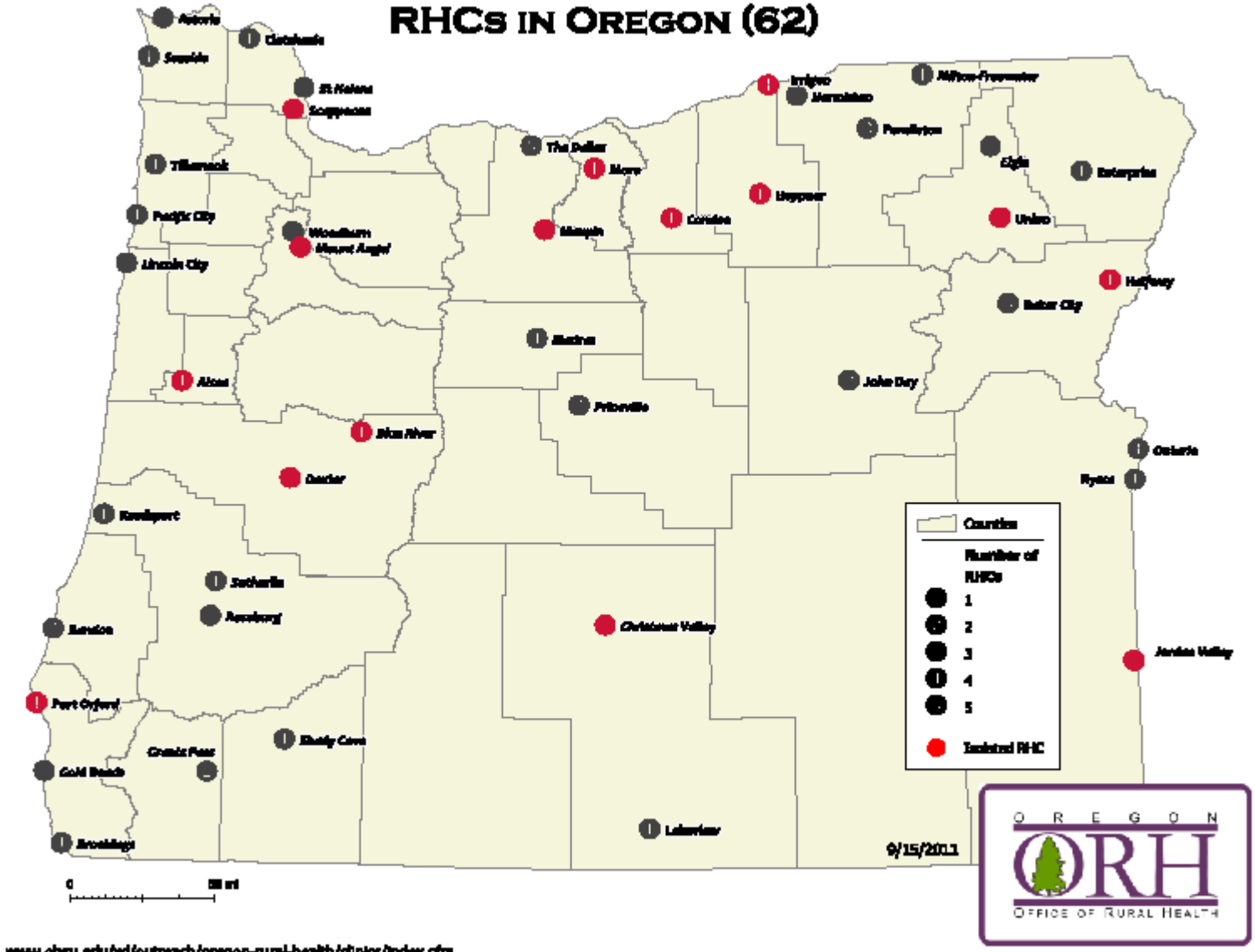
Affordable Care Act programs continue:

4. **Community Health Teams-** establish grant programs with eligible entities to create community based interdisciplinary, inter-professional teams to support primary care practices. The teams must support patient-centered medical homes

Patient-Centered Medical Home mode of care that includes:

1. Personal physician
2. Whole person orientation
3. Coordination and integrated care
4. Safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous improvements
5. Expanded access to care
6. Payment that recognizes added value from additional components of patient centered care

RHCs in Oregon (62)



www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/index.cfm

Lets begin generating some potential issues:

- Volume issues for isolated and rural regarding medical home and CCO, ACO?
- Where and how do you fit in to health care reform?
- Quality reporting and benchmarking for hospitals and clinics
- Regionalization of health services
- Purchasing primary care practices and covering the cost of physicians