Healthcare Reform

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Lecture Objectives

1. To develop a greater understanding of the potential outcomes of health care reform and how the anesthesia provider can position themselves for future changes.

2. To identify the key provisions in the health care legislation and how they will affect care delivery in the future.

3. To define the future changes in reimbursement and what are the approaches CRNAs can take to continue to add value at their respective sites of employment.
Socio-Economic Context

- In 2005 the U.S spent $2 trillion in total healthcare expenditures or about $6,700 per person and 16% of GDP.
- This is expected to rise to $4 trillion by 2015.
- 47 million Americans are uninsured.
- Employer provided healthcare insurance costs are rising at double the rate of inflation and more than 4 times the average workers earnings.
- The average employee’s out-of-pocket expenses have increased more than 143% since 2000
CBO Projections

- CBO Data
  - Social Security spending is expected to increase almost 50% by 2014.
  - Medicare and Medicaid spending will increase 8-9% per annum during that period.
  - By 2014 these three programs will account for almost 50% of federal spending, up from 40% currently.
Economic Crisis in Healthcare
Permanent Whitewater

Gross Federal Debt
US from FY 1792 to FY 2015

pct GDP

1800 1820 1840 1860 1880 1900 1920 1940 1960 1980 2000

usgovernmentspending.com
U.S. Federal Spending – Fiscal Year 2010 ($ Billion)

- Total: $3,456 B

- Social Security: $701, 20%
- Defense Department: $689, 20%
- Other Mandatory: $416, 12%
- Net Interest: $197, 6%
- Medicare & Medicaid: $793, 23%
- Discretionary: $660, 19%

Source Data: CBO Historical Tables
Chart 1.8: National Health Expenditures (1) 1980 – 2017 (2)


(1) Years 2007 – 2017 are projections.

(2) CMS completed a benchmark revision in 2006, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.hhs.gov/NationalHealthExpendData/downloads/benchmark.pdf.
Hospital care is shrinking as a share of total health care spending.

Chart 1: National Expenditures for Health Services and Supplies\(^{(1)}\) by Category, 1980 and 2009\(^{(2)}\)


- Hospital Care, 42.7% in 1980, 32.6% in 2009
- Physician Services, 20.3% in 1980, 21.7% in 2009
- Other Medical Durables and Non-durables, 5.9% in 1980, 3.4% in 2009
- Prescription Drugs, 5.1% in 1980, 10.7% in 2009
- Home Health Care, 1.0% in 1980, 2.9% in 2009
- Other Professional,\(^{(4)}\) 7.1% in 1980, 7.3% in 2009
- Nursing Home Care, 6.5% in 1980, 5.9% in 2009
- Other,\(^{(3)}\) 11.4% in 1980, 15.5% in 2009

\(^{(1)}\) Excludes medical research and medical facilities construction.
\(^{(2)}\) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf.
\(^{(3)}\) “Other” includes net cost of insurance and administration, government public health activities, and other personal health care.
\(^{(4)}\) “Other professional” includes dental and other non-physician professional services.
Chart 1.29: Operating Margins of the Top Insurers, 2004 – 2006


(1) 2004 operating margin data for WellPoint include both pre- and post-merger data for the merger with Anthem in November 2004.
Chart 1.9: Consumer Out-of-pocket Payments for National Health Expenditures, 1990 – 2006\(^{(1)}\)


\(^{(1)}\) CMS completed a benchmark revision in 2006, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.hhs.gov/NationalHealthExpendData/downloads/benchmark.pdf.
Social, Economic and Political Environment

Chart 1. Unemployment rate, seasonally adjusted, June 2009 – June 2011
Employment has not recovered as quickly as in past recessions

Figure 4: Change in unemployment from start of recession

- November 1973 to March 1975 (17 months)
- March 2001 to November 2001 (9 months)
- July 1981 to November 1982 (17 months)
- December 2007 to June 2009 (19 months)
- July 1990 to March 1991 (9 months)

Source: Sizing Up the 2007–09 recession: comparing two key labor market indicators with earlier downturns

PwC Health Research Institute
In comes:

Health Care Reform
An Overview of Health Care Reform

Health Reform Explained Video: "Health Reform Hits Main Street"
State Level Woes-Healthcare Effects
The worst recession since the 1930s has opened up large budget shortfalls in nearly every state. Nationally, states are projecting shortfalls for the coming fiscal year (2012) totaling $1.03 billion.
Local Pressures Mounting

State Revenue Losses Far Exceed Other Recent Recessions

Percent change in state tax revenue since start of recession, adjusted for inflation

The main cause of states' budget shortfalls is the steep drop in tax receipts. State revenues typically weaken during recessions, as the incomes of residents and businesses decline and so they pay less in income, sales, and other taxes. But despite recent improvement, the revenue loss during this recession remains much worse than the loss in recent recessions.
One Year Change in Health Spending

Exhibit 7. Year-Over-Year Percentage Change in Health Spending

Source: Altarum monthly NHE estimates; monthly GDP is from Macroeconomic Advisers and Altarum estimates
Note: Lightly shaded bars denote recession periods
Hospital Volumes

Chart 3: December 2011 - Unadjusted Hospital Volume Survey Results

- Overall Inpatient Admissions: -0.6%
- Commercial Admissions: -1.2%
- Outpatient Visits: 0.4%
- ER Visits: 0.8%
- Inpatient Surgeries: -0.4%
- Outpatient Surgeries: -0.2%
- Uncompensated Care Volumes: 1.7%
Pennsylvania Hospital Margins

Pennsylvania Acute Care Hospitals

Average Total Margin

-1.0%

July-Sept 2010
July-Sept 2011

% Pennsylvania Acute Care Hospitals with a Negative Total Margin

24%
46%

July-Sept 2010
July-Sept 2011
Effects of Economic Trends
Chart 6.3: Impact of Community Hospitals on U.S. Economy

Wages and benefits for caregivers and support staff represent 60 percent of spending on hospital care.

Chart 11: Percent of Hospital Costs\(^{(1)}\) by Type of Expense, 4Q09

- Wages and Benefits, 59.5%
- Other Services, 20.4%
- Prescription Drugs, 5.9%
- Other Products (e.g., Food, Medical Instruments), 14.2%

Source: AHA analysis of Centers for Medicare & Medicaid Services data, using base year 2006 weights.

\(^{(1)}\) Does not include capital.

\(^{(2)}\) Includes postage and telephone expenses.
Shortages of workers with the required specialized skills have pushed up wages and benefits for hospitals relative to other industries.

Chart 13: Percent Change in Employment Cost Index, (1) All Private Industries and Hospitals, March 2001 to March 2010


(1) The ECI is a measure of the change in the costs of labor.
Advances in medicine contribute to longer lives.

Chart 3: U.S. Life Expectancy at Birth, 1940-2007

Hospitals are treating sicker patients who require more specialized care.

Chart 10: Inpatient Case-mix\(^{(1)}\) Index (CMI) for the Medicare Population, 2000-2007


\(^{(1)}\) Case-mix is defined as the mix of patients across diagnosis-related groups (DRGs) in a hospital.
Emerging technologies advance care delivery, but can be costly.

Chart 5: Operating Room Costs\(^{(1)}\) per Case for Three Radical Prostatectomy Techniques


\(^{(1)}\) Measured at one institution, the University of Rochester Medical Center.
An Unusual Decline

The number of doctor visits and filled prescriptions in the U.S. has fallen in recent quarters, not just slowed in growth.

Year-to-year change in prescriptions filled, quarterly data

<table>
<thead>
<tr>
<th>Year-to-Year Change</th>
<th>12%</th>
</tr>
</thead>
</table>

Monthly U.S. physician office visits, 12-month rolling avg., in millions

Source: IMS Health
Even people are cutting back on care.

- Knee replacements per 1000 people fell 18.6% between March 2007 and March 2010.
- Despite an aging and growing U.S. population doctors office visits have fallen 1.2% since the end of 2010.
- Growth in the use and intensity of services represented just 0.1% point of the 3.7% growth in personal health care spending in 2010.
- Private insurance spending on hospital care grew by 2.2% a drop from the 4.8% growth in 2009. Slowest rate of growth since 1996.
Hospitals are one of the most highly regulated sectors and face sizeable administrative costs.

Chart 15: Illustration of Agencies Regulating Hospitals

Reimbursement Reform: The Long Run Challenge

- Growing cost of care
  - Cost of Care Greatest Driver of Overall Cost
- Demographics
  - Aging Society

[Diagram: Sources of Growth in Projected Federal Spending on Medicare and Medicaid]

Effect of Cost Growth Faster Than GDP and Aging of Population

Effect of Aging Population

Driving Changes

HEALTHCARE REFORM
Providers

- Hospitals facing high fixed cost, decreased utilization, reduced margins, and productivity.
- Cutting administrative costs. Delaying capital, reducing staff to relieve financial pressures.
- Coordination of care—hospitals and physicians exploring ways to coordinate services.
- Increase in provider consolidation.
- Cost sharing—high deductible plans
- Health care reform driving cost consciousness.
Medical cost inflator: provider consolidation

Figure 6: Physician interest in alignment by type of model

Level of interest in more closely integrating with a hospital

- Uninterested: 42%
- Interested in closer hospital alignment: 58%

Models physicians are interested in pursuing

- Directorships, stipends, and management contracts, 51%
- Employment, 46%
- Joint venture of services, 38%
- Co-management, 34%
- Leasing, 21%

Revolution in How Healthcare is Paid?

- Bundling payments - Medicare Payment Advisory Commission has explored bundling payment for episodes of care in ways that include a single payment to all providers treating a patient for one illness or condition over a period of time, including pre and post operative visits.
  - Provides incentives to increase efficiency, coordinate in-hospital and post-hospital care, improve quality.
  - Hospital and Health Networks 2008
Reimbursement Changes

- Value based purchasing-based on CMS hospital compare data
  - Quality indicator core measure trends-heart attack, pneumonia, SKIP (antibiotics one hour before surgery, appropriate selection, stopped 24 hours after surgery), glycemic control, beta blockers embolism prevention. 70% of payment
  - HCAHPS patient satisfaction-30%

- Insurance exchanges-established on the State level by January 2014—access to affordable health coverage

- Re-admission-decrease reimbursement for 30 day-heart failure, heart attack, pneumonia
Preventable Errors

NQF-never events are errors which are identifiable, preventable and serious in consequence.

- Retained object
- Air embolism
- Blood incompatibility
- UTI
- Pressure ulcer
- Central line infection
- Surgical site infection
- Hospital acquired injuries-falls
On the Same Map

- Payment Model that uses financial incentives to encourage providers to follow evidence based clinical protocols.
- 12 evidenced based case rates for certain forms of cancer, cardiology, orthopedics and preventative care. Will begin with a base payment for uncomplicated care and be severity adjusted to account for complications with a financial incentive for sticking to the clinical guidelines.
Financial bonuses, penalties, or withholds assessed based on outcomes or process performance.

- Single payment disbursed to cover hospital, physicians and other services.
- Based on:
  - Cost of care—episodic efficiency, readmission reduction, care standardization.
  - Quality of care—process reliability, clinical quality, patient experience.
  - Volume of care—chronic care management, care substitution, disease prevention.
Gain Sharing

- Alignment of physicians and hospitals to encourage more efficiency and allowing MD to share in the cost savings.

- Cannot effect patient care
Accountable Care Organizations ACO

- Patients assigned to ACO based on terms of contract.
- Providers bill normally receive standard fee-for-service payments.
- Total cost of care compared to risk adjusted target expenditures.
- If total expense less then target portion of savings returned to ACO.
- ACO responsible for dividing payments among stakeholders.
2012 election one of the most important in the history of the health care system as it will determine whether ACA is implemented or repealed.

Most of ACA takes place in 2014-including guaranteed coverage, ban on caps, exchanges, and subsidies.

Repealing will become harder by 2016 as key provisions will be baked into the system.
Medicare Reimbursement

- Each year for the past five years physicians and other clinicians have faced cuts in Medicare reimbursement under the Physician Fee Schedule (PFS) as a result of the Sustainable Growth Rate (SGR) formula. (SGR is used to contain the growth of spending for provider services.)
- Congress passed an extension on SGR through December 31, 2012. Without the extension there would have been a 27% cut to physician and extenders reimbursement. The stop gap measure was paid for by cuts to hospitals, clinical laboratories and public health prevention fund.
## Medicare Anesthesia Reimbursement

### Medicare FFS payment Trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Change</th>
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<tbody>
<tr>
<td>2004</td>
<td>+1.5%</td>
</tr>
<tr>
<td>2005</td>
<td>+1.5%</td>
</tr>
<tr>
<td>2006</td>
<td>No change</td>
</tr>
<tr>
<td>2007</td>
<td>-8% (not -14% as originally proposed)</td>
</tr>
<tr>
<td>2008</td>
<td>-10% (projected, not realized)</td>
</tr>
<tr>
<td>2009-12</td>
<td>-25 to -30% (projected)</td>
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In 2010 Medicare paid anesthesia 40% of private payments. Other physician services were paid about 87% of private payments. CRNAs predominate where there are more Medicare beneficiaries. CRNAs predominate where the gap between Medicare and private pays is less.
Commercial Carrier Payment Challenges

- Non-payment for GI endoscopy cases by Humana, Aetna, Coventry Health America, Wellpointe (Blue Cross intermediary).
- Non-recognition of CRNA providers.
- Non-payment for CRNA provided, Medicare recognized surgical codes, ie CVP, Swan-Ganz, arterial line insertion.
- Non-payment of CRNA provided pain services, acute and chronic.
- Disproportionate CRNA/MDA payment splits.
The Big Question...

- In the context of:
  - Diminished governmentally sponsored health plan reimbursement,
  - Rapidly rising healthcare insurance costs,
  - Record federal budget deficits,
  - Growing numbers of uninsured and
  - High provider costs despite accelerated production rates of anesthesiologists and CRNAs,

How do anesthesia groups continue to provide increasing levels of service???
Facility Provided Subsidies

MGMA data indicates that 60% of all anesthesiologist groups receive some sort of subsidy or guarantee. This does not include those groups which medically direct hospital employed CRNAs operating at a net loss. When one considers the operating loss on CRNA services as an anesthesiologist subsidy, the number of anesthesiologist groups receiving financial support no doubt exceeds 80%.
Ten Trends that will Continue to Impact Healthcare Sector

- Insurance membership will take a hit from the slow recovery-unemployment, high deductible plans.
- No easing on payment pressure-private payers will not make up for declining Medicare Medicaid rates.
- Patients will postpone care keeping volume soft.
- Focus on cost-increased bad debt, focus on efficiency, move toward lower cost providers.
Trends

- Capital will be difficult to secure—lenders want to see: physician alignment, clinical integration and cost reduction models, IT plans, plans to capture more market share.
- Physicians will make or break new models—reducing variation in care will be essential for success of ACO, medical home, CI.
- Construction focus is on fast returns—fast ROI scaled down projects.
2012-2013

- IT becomes more pervasive—underpins ability to shift to new care models.
- Mergers and acquisitions—increased activity: hospital to hospital, hospital to MD, MD, to payers, payers to hospital. Increase value for primary care.
- Market share—more volume generates incremental revenue and decreases cost per unit. Underperforming assets cut.