Critical Access Hospitals and Health Care Reform

What’s in it for you?
Patient Protection and Affordable Care Act (ACA)

• Fundamental changes
  – Moving Medicare from payment for services to payment for outcomes
  – Expansion of Medicaid
  – Changes health insurance

• Few direct CAH provisions
ACA legislation

- Clarifies 101% reimbursement for Method II outpatient billing
  - Method II is no longer an annual election.
  - In effect until request for termination
  - Must notify MAC 30 days prior to start of cost reporting period for election or termination
ACA legislation

• Extends Flex program to 2012
• Additional grant funds to assist rural hospitals in value-based purchasing, accountable care organization, payment bundling and other reform programs
ACA legislation

• Extends 340B discount program to CAHs for outpatient drugs
• Numerous workforce strengthening and improvement provisions
Payment methodologies

• CAHs will be consulted regarding participation in Payment Bundling pilot program (§3023)
• CAHs are exempt (for now) from hospital readmissions payment reduction program
ACA legislation – CAH challenges

• Independent Payment Advisory Board
• Changes to Medicare Advantage
• Medicaid DSH cuts
• Commercial health insurance changes
• Payment cuts in related entities
  – SNF, HHA, hospice, physicians, DME, ambulance
Value based purchasing

- PPS hospital program begins 10/1/12
- CAH program will start as a demonstration (§3100 (b))
  - Begins 2012
  - Three year program
  - Earliest implementation 2017

Begin to monitor this NOW!
ACA legislation – CAH challenges

• Quality reporting and payment impacts
• Compliance and enforcement
• Competition
  - PPS hospitals in accountable care organizations
  - FQHC increased funding
  - Physician recruitment
ACA legislation – CAH responses

• Report and monitor quality measures
• Improve revenue cycle processes
• Review staffing levels
  – Hospital staff AND medical staff
• Evaluate profitable and unprofitable services
HCOs vs. CAHs

Q3 2009 PHA Quality Index for 137 Hospitals
HCO’S vs CAH

Non CAH Hospitals
n = 108

CAH Hospitals
n = 29

Quality Index Score

Hospitals

Non CAH Hospitals Q3 2009
CAH Hospitals Q3 2009
Core Measure Composite Scores for Georgia CAHs 2001 - 2009

Composite Scores are the weighted average of the Core Measures Data that a hospital has submitted.
Georgia CAH’s Gaining on National CAH’s
CAH Hospitals are Improving!

CAH Patients Not Receiving "the Right Care"
Q107-Q407 thru Q1 2009-Q4 2009

R² = 67.6%
Very Strong Linear Trend
Accountable Care Organizations (ACO)

- Organization of health care providers
- Accountable for the quality, cost, and overall care of Medicare beneficiaries assigned to ACO
ACO - beneficiaries

• Assigned
  – beneficiaries for whom the professionals in the ACO provide the bulk of primary care services

• Assignment
  – invisible to the beneficiary
  – will not affect their guaranteed benefits or choice of doctor
ACO participants

- Group practice physicians/professionals
- Networks of physicians/professionals
- Partnerships or joint venture arrangements of physicians/professionals and hospitals
- Hospitals employing physicians/professionals
- Other forms that the Secretary of Health and Human Services may determine appropriate.
ACO requirements

• Formal legal structure
• Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
• Participate for a minimum of three years
ACO benefits

• Receives a share of savings each 12 month period
  - Actual per capita expenditures of assigned Medicare beneficiaries compared to benchmark amount
  - Must meet quality performance standards to receive benefit

• No penalties if targets not met
ACO costs

- ACO participation is costly.
- Physician Group Practice demonstration (GAO-08-65)
  - Model for ACO program
  - Average initiation costs were $489,000
  - One year operating costs of $1.26 million
  - Eight of ten participants did not receive any shared savings in first year
Commercial involvement

• Although CAHs may be exempt from many of the ACA provisions, commercial insurers are beginning adoption of accountable care provisions.
  – Aetna, Cigna, United
Accountable Care Organizations - Implications for Rural Hospitals

A. Primary Care Physicians –
   Current programs focus on PCP services. Who controls your local PCPs? Are they independent, your employees, the employees of a major medical center, or the employees of a large regional practice group? How will you assure the commitment of the PCPs to your facility?

B. Specialty Physicians –
   Specialist services continue to be crucial: their diagnostics and procedures are crucial to hospital profit. They are not excluded from the ACO world; their services are to be coordinated with the PCP services. Do you have a suitable base of specialty physicians? Do they use your locality as a source to export services they conduct at their home base or do they support and use your hospital?
Accountable Care Organizations -
Implications for Rural Hospitals

C. Rural Hospitals –

   The role of the major medical centers is obvious. What is the role for your CAH? Consider: the CAH will be a lower-cost facility. The CAH – the local hospital - is also closer and more convenient for the local patient and family. Does your population expect to come to your hospital? Does your population perceive you as a preferred hospital provider?

D. Medical Centers –

   Typically providers of the full spectrum of hospital care. Also frequently are major employers of physicians. They are often engaged in heavy competition with other medical centers and consequently exhibit a tendency to want to stuff their own pipeline. This can have either negative (loss of patients, loss of revenue) or positive (your orientation to the medical center as a source of referrals) implications for rural hospitals. Is your relationship with a medical center positive for your revenues?
Accountable Care Organizations -
Tentative Conclusions

E. What actions should a rural hospital take to make its role crucial to a successful ACO?
   – Ensure status of the local PCPs
   – Develop appropriate specialty services; build your business and increase variety of services to local population
   – Be important to a major medical center; be sure you are at the table when ACO decisions are being made.
   – Consider joining with other like-minded hospitals and form an ACO which you have a major voice in. Relate to the medical center on terms favorable to the network hospitals.
And finally . . .

- Community health needs assessments
- Financial assistance policies

Apply to 501(c)3 hospitals only

CHNA – must be performed between March 23, 2010 and March 31, 2013

FAP – in effect for fiscal years beginning after March 23, 2010

Awaiting IRS responses to comments
Healthcare Reform and CAHs

• Find a dance partner
• Focus on quality
• Remember, patients have a CHOICE – give them reasons to choose your facility!