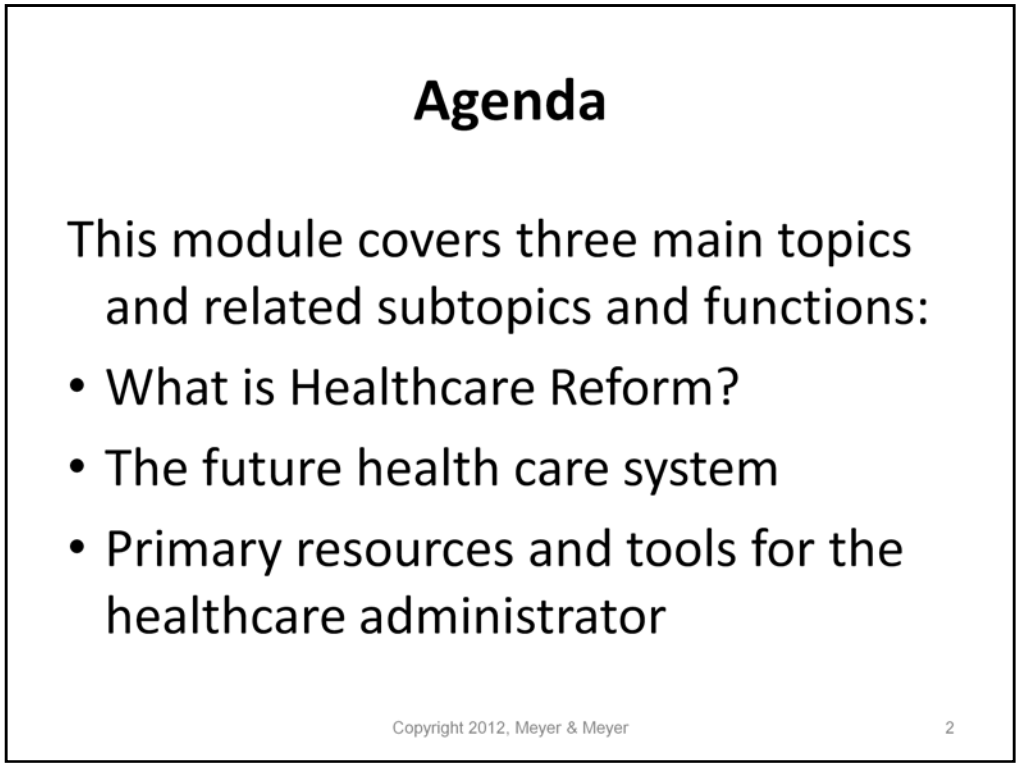
What is Healthcare Reform? Get a view of the future health care system in the US; learn about primary resources and tools for the healthcare administrator, and what are the success factors for healthcare administrators?

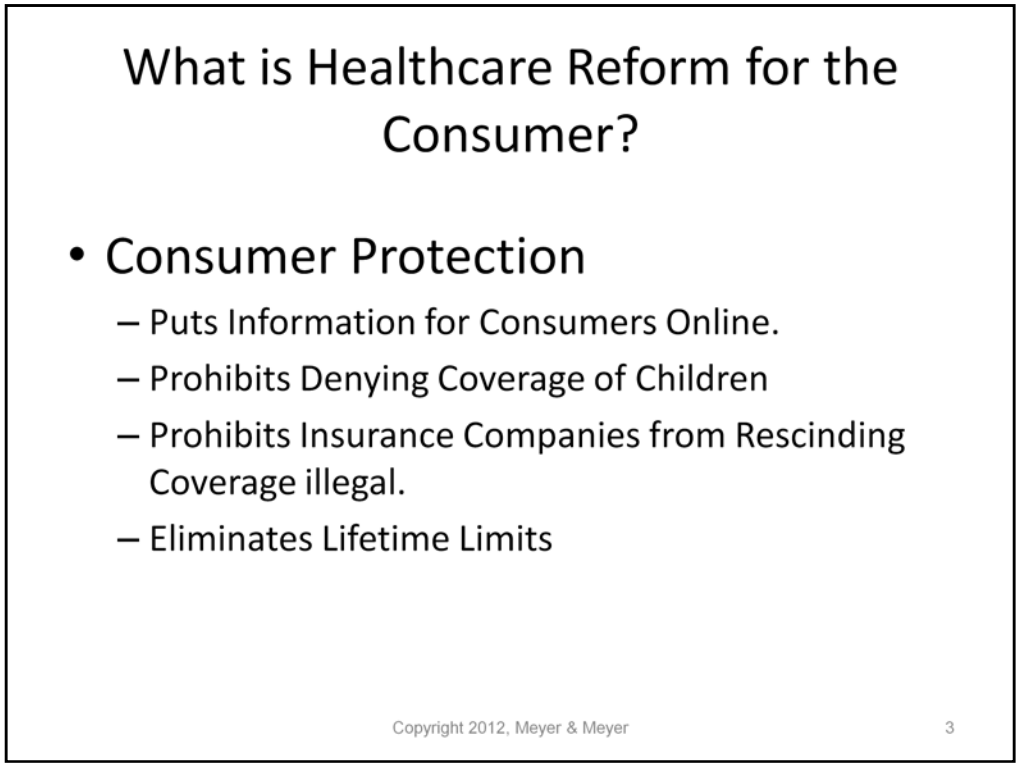


Agenda

What is Healthcare Reform for the
- Consumers?
- Employers?
- Health Services?
- Providers of Care?
- Payers?

The future health care system
- Market Consolidation
- Quality Initiatives
- National Electronic Medical Records
- Reimbursement Change Impact

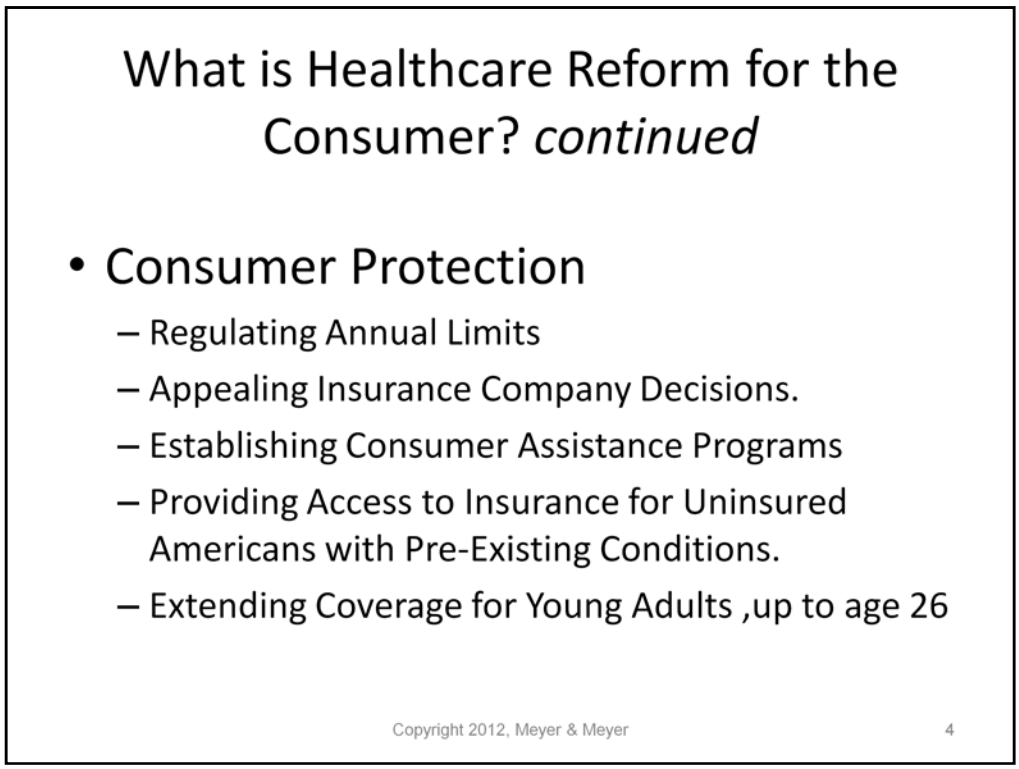
Primary resources and tools for the healthcare administrator
- Professional Associations
- Government & Regulatory Departments
- Success Factors for Healthcare Administrators



Healthcare reform under the Affordable Care Act has changed the way the healthcare industry meets the needs of the consumer. The new laws provide a website where consumers can compare health insurance coverage options and pick the coverage that works for them.

Additionally, under the new laws, insurance companies are prohibited from denying coverage of children based on pre-existing conditions under the age of 19.

Also, in the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny payment for services when they became ill. The new health care laws make this illegal.



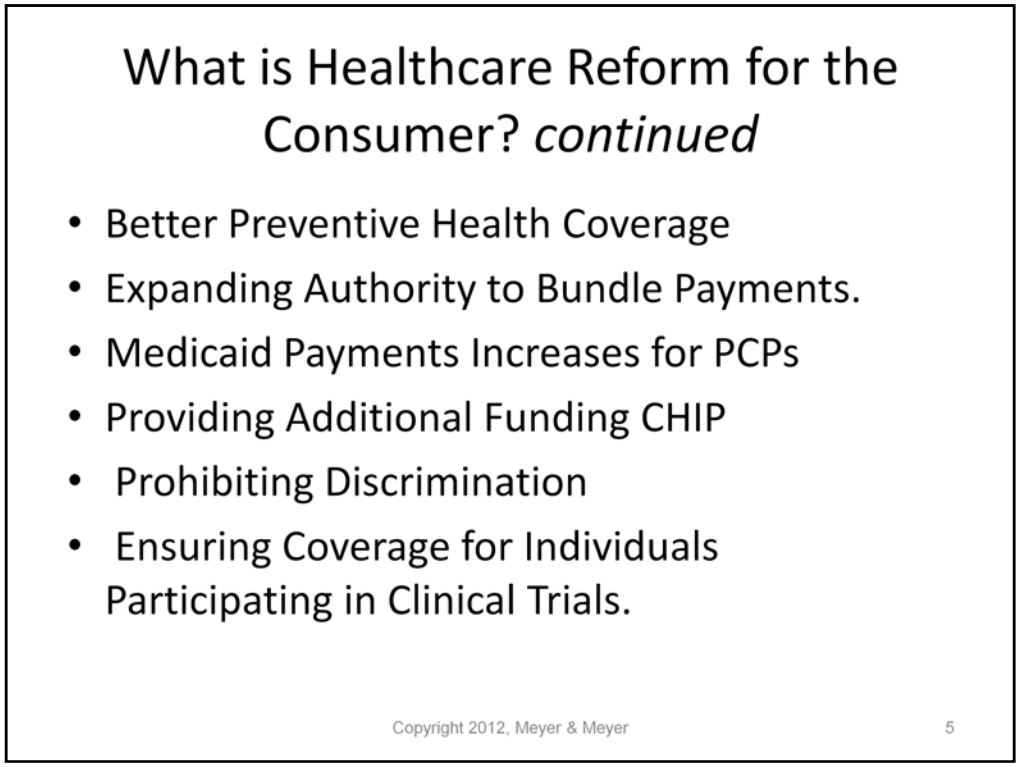
Lifetime limits on insurance coverage is now prohibited on essential benefits, like hospital stays. What this means is that if a patient is hospitalized and their reach their benefit maximum, the insurance company must still pay the full hospitalization according to the plan.

The new laws also set up federal grants to help set up or expand independent consumer advocacy offices to help them navigate the private health insurance system. These programs help consumers file complaints and appeals; enroll in health coverage; and get educated about their rights and responsibilities in group health plans or individual health insurance policies. The programs will also collect data on the types of problems consumers have, and file reports with the U.S. Department of Health and Human Services to identify trouble spots that need further oversight.

Before the Health Insurance Portability and Accountability ACT (HIPAA) of 1996, if a patient had a pre-existing condition, they may not be able to purchase insurance. If they had a pre-existing condition under an employer group, change jobs and got new group insurance, the pre-existing condition was not eligible for benefits. The HIPAA laws change that to allow portability of coverage from one employer to another without penalizing patients for preexisting conditions, and also limiting the time an insurance company could deny payments for a pre-existing condition to twelve months.

Under the new laws, there is a “Pre-Existing Condition Insurance Plan” that provides new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition. States have the option of running this program in their state. If a state chooses not to do so, a plan will be established for them by the Department of Health and Human Services in that state.

The Affordable Care Act extends coverage for young adults so they may stay on their parents’ plan until they turn 26 years old, or until they have their own employer, or insurance health plan.



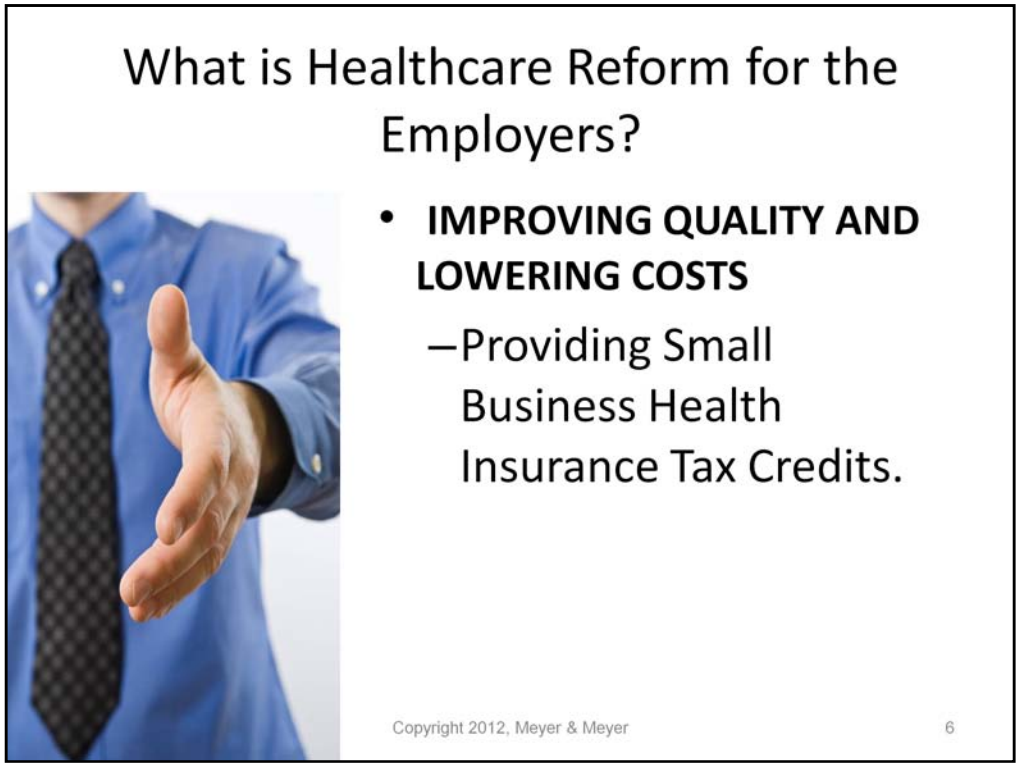
The new law expands the number of Americans receiving preventive care and provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost.

The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment "bundling," hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program.

Since, under these reforms, Medicaid programs and providers will need to care for more patients the Act requires states to pay primary care physicians (the PCPs) no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase in provider payments is fully funded by the federal government. Concurrently, states will receive two more years of funding to continue coverage for children not eligible for Medicaid.

The law implements strong reform language that prohibits insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions and eliminates the ability of insurance companies to charge higher rates due to gender or health status.

Finally, for those participating in Clinical Trials, insurance companies are prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. This applies to all clinical trials that treat cancer or other life-threatening diseases.



The new Affordable Care Act provides small business health insurance tax credits. Up to 4 million small businesses are now eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25% credit.

What is Healthcare Reform for Health Services?

- Medicare Prescription Drug "Donut Hole."
- Providing Free Preventive Care.
- Preventing Disease and Illness.
- Cracking Down on Health Care Fraud.
- Expanding Coverage for Early Retirees.
- Rebuilding the Primary Care Workforce.
- Practice Management System (Medical Billing software and EMR infrastructure support)

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There is an estimated four million seniors that will reach the gap in Medicare prescription drug coverage known as the "donut hole" this year. The "donut hole" is because the standard drug benefit required payment of a $310 deductible, then 25% coinsurance drug costs up to an initial coverage limit of $2,830. Once this initial coverage limit is reached, the beneficiary must pay the full cost of his/her prescription drugs up until the total out-of-pocket expenses reach $4,550 (excluding their drug premiums). This meant that seniors could pay over $5,500 in drug cost, plus their $40 +/- monthly premium.

Under the new laws, this donut hole is eliminated through a combination of measures including brand-name prescription drug discounts, generic drug discounts, and a gradual decrease of the gap, where the it will be completely eliminated by 2020

All new health plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. This encourages patient to seek out these life-saving services.

There is a new $15 billion Prevention and Public Health Fund! This will invest in proven prevention and public health programs and is an extension of the already HealthyPeople 2010, 2020 program.

To help pay for this, there will be an even bigger crack down on healthcare fraud and abuse. Current efforts are recovering $2.5 billion or more. The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and reduce fraud and waste in Medicare, Medicaid, and CHIP.

Too often, Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of inflated private healthcare fees. To preserve employer coverage for early retirees, until more affordable coverage is available through the new "Exchanges" by 2014, the new law creates a $5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents. Employers must apply to participate in this program.

Finally, a critical piece of the Affordable Care Act is having the capacity to care for more people, i.e., rebuilding the Primary Care workforce. Scholarships and loan repayments for primary care doctors and nurses working in underserved areas are now provided. Doctors and nurses receiving payments made under any State loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on those payments.

The law allows states that have, or plan to implement, measures that require insurance companies to justify their premium increases will be eligible for $250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014.

States are able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents.

The law increasing payments for rural health care providers. Today, 68% of medically underserved communities across the nation are in rural areas (defined as less than 100 people per square mile). These communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities.

Finally, the law includes new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country.

What is Healthcare Reform for the Providers of Care?

- Free Preventive Care for Seniors.
- Health Care Quality and Efficiency.
- Care for Seniors After a Hospital Stay
- New Innovations to Bring Down Costs.
- Increasing Access to Services at Home and in the Community.

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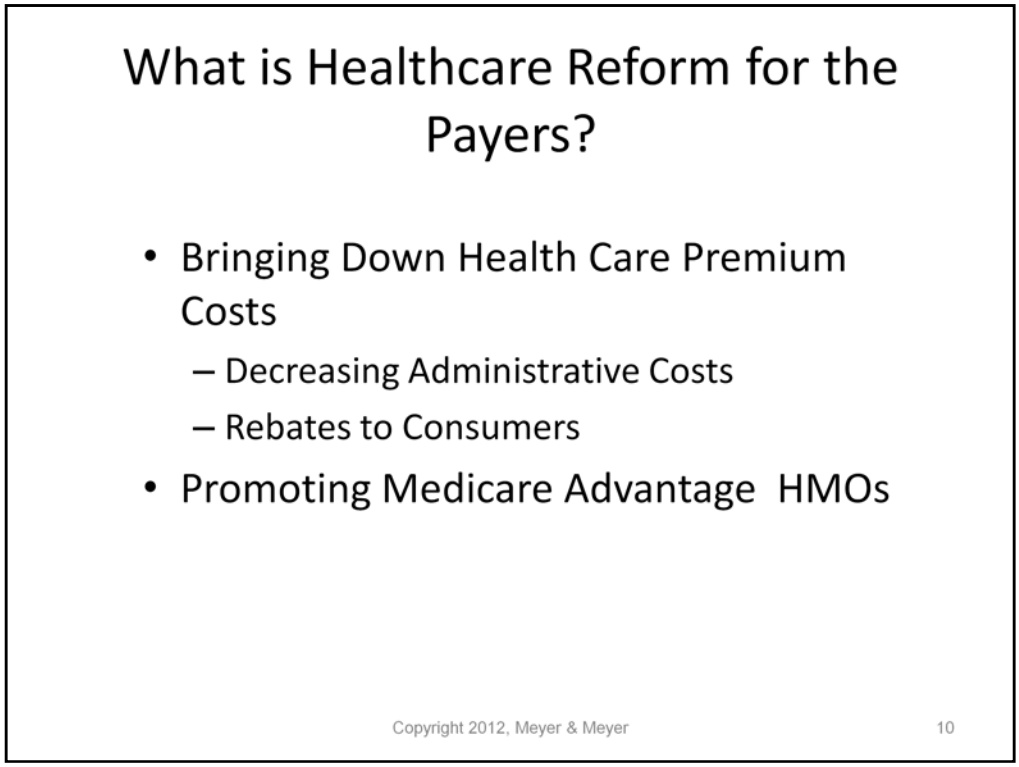
The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare. In the past, providers were paid only for a select few preventive care under the Medicare and Medicaid programs.

The law established a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. These methods are expected to improve the quality of care, and reduce the rate of growth in health care costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities by providing and improving care for seniors after they leave the hospital.

An "Independent Payment Advisory Board" began operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. The Board is expected to focus on ways to target waste in the system, and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care. This has a direct impact on providers' fees.

The "Community First Choice Option" allows states to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes.



Historically, the administrative costs for insurance companies were anywhere from 15-35% of the premium healthcare dollar. To ensure premium dollars are spent primarily on health care, the new law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers.

Under the managed care contracts with Medicare, Medicare Advantage insurance companies are being paid over $1,000 more per person on average than is spent per person in Traditional Medicare. The justification for this extra money is the HMO manages the patients' care, provides more and higher quality of care. However, the new law levels the playing field by gradually eliminating the additional premium dollars paid to Medicare Advantage insurance companies, (the $1,000). The new law provides for an increase in premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. This is to promote Medicare Advantage and encourage beneficiaries to join an HMO. The insurance companies will then make up the difference of volume (increased number of Medicare Advantage members).

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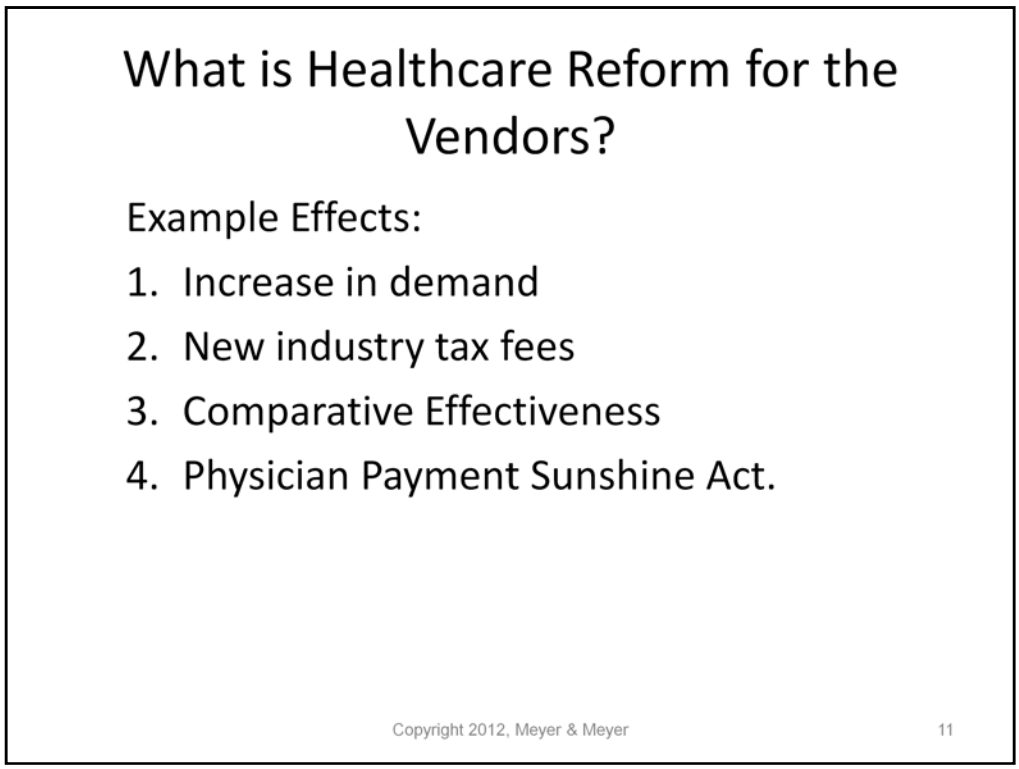

The ACA increases in access to care may result in a positive near-term impact on some device manufacturers, as a result of the increased demand for medical services. Medical devices and supply manufacturers, computer systems and other support services will see increases in demand.

The Act includes new "industry fees" or taxes that are applicable to pharmaceutical and medical device manufacturers, insurance companies, and pharmacy benefit managers. The medical device fee is effective 2012, and manufacturers of a medical devices will be required to pay 2.3% of the sales price for such device as an industry fee. The definition of a "taxable medical device" includes any device that is defined in Section 201(h) of the Federal Food, Drug and Cosmetic Act and is intended for human use. A limited number of medical devices, including eyeglasses, contact lenses, hearing aids and any other device that is determined by Centers for Medicare and Medicaid Services ("CMS") to meet the "retail exception," are exempted from this fee. Unlike the pharmaceutical fee, the medical device fee applies to all manufactures, regardless of size and revenue levels.

The Act laid the groundwork for future inclusion of comparative effectiveness measures when CMS makes payment decisions by funding a new independent entity called the Patient Centered Outcomes Research Institute ("PCORI"). The PCORI will study the effectiveness of various services, products and therapies and will issue reports regarding their effectiveness. The reports that are generated by PCORI may be relied on by CMS or other third party payors making decisions about payment, coverage and treatment. This will impact physician practice computer system vendors. They will need to provide systems that provide physicians and/or medical facilities the necessary reporting mechanisms to provide this information.

The Healthcare Reform Act included the Physician Payment Sunshine Act will require covered manufacturers that make a payment or other transfer of value to a physician or teaching hospital to report such payments annually in electronic form. Payments or transfers of value include consulting fees, payments for clinical trial participation, charitable donations, royalties and a variety of payments that may be made to physicians and teaching hospitals. There are some payments that are exempted from the disclosure obligations. These exempted payments include annual aggregate payments to a recipient of less than one-hundred dollars and individual payments of less than ten dollars, payments that are made entirely through market research organizations, and the provision of samples to a physician or teaching hospital for the benefit of patients.

The future health care system

- The future health care system
  - Market Consolidation
  - Quality Initiatives
    - Hospitals
    - Physicians
  - National Electronic Medical Records and Medical Billing Software Interfaces

A natural response of healthcare reform to achieve the goals of improving quality and decreasing costs is market consolidation. This is the best way to achieve economies-of-scale and build efficiencies if for individual providers and small groups to join forces and merge into larger groups (horizontal integration) to share resources, including allied professional staff. Hospitals are in the market to purchase primary care physician medical groups (vertical integration) to help provider necessary health system services and gain market share for managed care contracting advantages.

The Centers for Medicare and Medicaid have put into play Hospital Quality Initiatives (HQI) for reporting and meeting the HQI health services standards. The Affordable Care Act takes this a step further and establishes a hospital Value-Based Purchasing program (VBP) for Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care.

For physicians, the system in place is known as Physician Quality Reporting Initiative (PQRI). Physicians may earn up to an additional 2% of their annual Medicare income if they also report and meet PQRI health services standards.

The HQI, VBA and PQRI are all programs to help link payments to quality outcomes.

Finally, work has been in place since the implementation of Health Insurance Portability and Accountability Act (HIPAA) in 1996 to have a national electronic medical record (EMR). Under HIPAA the language of electronic computer codes, medical codes and nomenclature were all standardized and their use mandated. Today, CMS has created incentives for physicians to implement electronic medical records, which is an initiative to get providers closer to a National Electronic Medical Record system. Several States already use State-wide EMR for capturing prescription drugs, vaccinations and other health services coded data to build the necessary database for patient care and safety.

Summary for Success

"To succeed in today's and tomorrow's health care environment, we need to stretch and grow in directions that necessitate changes in how we think and act."

Source: Wendy Leebov, Gail Scott, (2002). "The Indispensable Health Care Manager: Success Strategies for a Changing Environment". Publisher, Jossey-Bass, San Francisco, CA.

To be successful in any dynamic industry, one must accept change. In healthcare changes come daily. To meet the challenges of the changes and the industry, healthcare organizations and their Administrators, Directors, Managers, Supervisors and staff must always put the patient services first above all else. There are no jobs without customers, even in healthcare. Similarly, there are no jobs without employees. Therefore, we must also care for our internal customers, which are our valued staff.

Success means arming yourself with primary resources so that information used is accurate and true. It is thinking outside the box, going beyond your own thoughts and solutions, beyond the organization and to the experts that have analyzed, benchmarked, and have the experience in best practice, i.e., professional organizations and quality vendors or consultants.

Most important it is important to lead by example, build an ethical culture and coach others to do the same within the healthcare organization.

Healthcare administrators must be honest, but not be afraid to take risks and embrace change. They need to be results oriented, i.e., getting jobs done efficiently (doing things right) and effectively (doing the right things).

Communication is key, and facilitating productive dialogue among staff builds a cohesive workforce. A strong cohesive multi-disciplinary team of clinical and administrative professionals is required in today's competitive healthcare markets.

Finally, successful Healthcare Administrators are not just functional task doers, they are business leaders. As we've pointed out earlier in this class, "Healthcare is a business and business is bottom-line driven". Financial, operational, and employee health are all critical to profitability.

Therefore, the successful healthcare administrator stays current in the industry with their primary resources, puts clinical operations and the patient first, runs a tight ship financially with accountability, and coaches their employees with the same care and respect that we give to patients.

PRIMARY RESOURCES

- Affordable Care Act .(2010). What's Changing and When. Retrieved December 22, 2011 from: http://www.healthcare.gov/law/timeline
- CMS. (2012). Physician Quality Reporting Initiative: https://www.cms.gov/PQRS/
- CMS. (2012). Hospital Quality Initiatives: https://www.cms.gov/HospitalQualityInits/
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