American Hospital Association

Washington State Hospital Association
Association of Washington Public Hospital Districts
41st Annual Rural Hospital Leadership Conference

Providing Leadership for Vulnerable Communities in Uncertain Times
June 27, 2017

Mary Jane Wurth
EVP & COO, American Hospital Association
President & CEO, Health Forum

AHA Vision and Commitments

Our vision: A society of healthy communities where all individuals reach their highest potential for health

ACCESS: Access to affordable, equitable health, behavioral and social services

VALUE: The best care that adds value to lives

PARTNERS: Embrace diversity of individuals and serve as partners in their health

WELLBEING: Focus on wellbeing and partnership with community resources

COORDINATION: Seamless care propelled by teams, technology, innovation and data
Perspectives on ACA

Drop in Uninsured

Percentage Uninsured in the U.S., by Quarter
Do you have health insurance coverage? Among adults aged 18 and older.

SOURCE: GALLUP-HEALTHWAYS WELL-BEING INDEX
Perspective on ACA

- Coverage
  - Insurance reforms
  - Delivery system reforms
  - Payment reforms
  - Transparency
  - IT

  - Movement away from fee-for-service... toward "integration"
  - Emphasis on value vs. volume
  - Emphasis on quality vs. quantity

  - Accountable care organizations
  - Bundling
  - Medical homes
  - Gain-sharing
  - Value-based purchasing
  - Comparative effectiveness
  - Performance improvement
  - CMS Center for Innovation

Our message on ACA

- Maintain coverage for all individuals currently receiving benefits
- ACA should not be repealed without having a replacement guaranteeing adequate coverage
  ➢ If that doesn’t occur... then hospital and health system payment cuts for Medicare and Medicaid must be restored
- Support continued efforts to transform delivery system from FFS to FFV using coordinated care and integrated delivery mechanisms... key to affordability
- Enact regulatory relief that reduces burden... and allows more resources to be used for patient care vs. paperwork
- Medicaid restructuring—in the form of block grants and per-capita caps—should not be used as a vehicle to make budget cuts in an under-funded program
  ➢ Additional “flexibility” can be provided to the states through waivers with safeguards for adequate funding and coverage
  ➢ Expansion and non-expansion states must be treated equitably
- Prevent further reduction in payment for hospital and health system services
Lack of GOP Unity

Groups that Influence Action in the House

- **Tuesday Group**
  - Informal caucus of approximately 50 moderate Republicans in the House

- **Freedom Caucus**
  - Smaller, more agile group of conservative Republican members of the House

AHCA Passes the House

- **Final Vote**: 217-213
- No Democratic support
- 20 Republicans voted "No"
AHCA – Major Provisions

- Repeals individual mandate
  - Continuous enrollment requirement
- Repeals employer mandate
- Tax credits for private insurance
- Changes rating bands (age)
- Medicaid
  - Repeals increased match for expansion population on December 31, 2019
  - $10 billion over 5 years for non-expansion states – not hospital specific
  - Per-capita caps/block grants starting in FY 2020
- Authority for waiving EHBs & community rating given to states
- State innovation fund: $138 billion over 9 years
- Funding
  - Repeals certain taxes / delays “Cadillac tax” to Jan. 1, 2025
  - Medicaid DSH reductions (2018 vs. 2020)
  - Keeps in place other provider cuts

What’s at stake

Coverage for About 11 Million at Risk

CBO Score of AHCA

- 14 million fewer people will be insured one year after passage
  - 23 million fewer will be insured by 2026
- Cuts spending on Medicaid by $834 billion; covers 14 million fewer people
- Premiums will go up in 2018 and 2019; then significant variation depending on whether someone lives in a state that opts out of key Obamacare insurance rules
- In states that waive some Obamacare rules, premiums would decline by 20 percent over a decade compared to current law
- By 2020, one out of 6 Americans will live in an area with an unstable insurance market, where sick people could have trouble finding coverage; but 5 out of 6 would have access to relatively stable markets
- Poor, older Americans would be hit especially hard; the average 64-year-old earning just above the poverty line would have to pay about 9 times more in premiums
- Repeals $664 billion worth of taxes and fees

By 2026, an estimated 51 million Americans under age 65 would be uninsured...compared with 28 million under current law
Children with Medicaid - small towns and rural areas (2015): 53%

Adults with Medicaid - small towns and rural areas (2015): 21%

Source: "Medicaid in Small Towns and Rural America: A Lifeline for Children, Families and Communities," Georgetown University Center for Children and Families, and the North Carolina NC Rural Health Research Program, June 2017
Our Take…Cannot Support

- Coverage losses in general
- Use of Medicaid restructuring as vehicle for program cuts
  - Lack of equity among expansion vs. non-expansion states
  - Per-capita cap/block grant design
- Coverage
  - Effectiveness of tax credits
- Maintaining funding dedicated to coverage expansions
On to the Senate

• CBO Score: must save as much money as House bill - $119 billion
• Finish debate by July 4th or August recess?

Senate strategy…political math

3
**Senate scenarios**

- **House bill**
- **Changes to House framework**
  - Reduced Medicaid cuts
  - Longer phase-out of Medicaid expansions
  - Larger pool for non-expansion states
  - More targeted use of tax credits
  - Maintain certain taxes for fund coverage
  - Private market stabilization (cost sharing reductions)

- **Repeal and delay**
  - “Plan B”
    - Repeal employer mandate
    - Repeal individual mandate
      - Replace with incentives for individual coverage
    - Exclude Medicaid from package
      - Provide increased flexibility for state waivers
    - More targeted use of tax credits
    - Fix cost-sharing subsidies

**Talk to Your Senators**

**Action Alert**

Weigh in With Your Senators on Legislation to Repeal and Replace the ACA

*Senate Pledges to Take Action Soon*

**Key Messages**

- Maintain coverage for all individuals currently insured.
- Medicaid restructuring should not be used as a vehicle to make substantial budget cuts in an already under-funded program.
- The ACA should not be repealed without a simultaneous replacement guaranteeing adequate coverage.
Resources to Assist You

Podcasts with latest messages & updates
Summaries, factsheets and analysis
Congressional resources
Town Hall Webcasts
Downloadable PowerPoint slides

www.aha.org

President’s Budget FY 2018

Medicaid
- Cuts $627 billion over 10 years, of which $610 billion is attributable to per capita caps / block grants

Medicare
- No direct reductions
- Repeals IPAB
- Medical liability reform savings

CHIP
- Extends funding through FY 2019
- Cuts $5.8 billion

GME
- $295 million for CHGME ($5 million cut)
- $60 million for Health Centers GME (2 years)

NIH
- Decrease of $5.7 billion

CDC
- Decrease of $1.3 billion
Congress’s “To Do” List

• FY 2018 government funding
  - Four months behind schedule
  - Omnibus or CR likely
  - Budget Control Act cuts, Border Wall

• Debt Ceiling
  - End of July
  - Freedom Caucus, Democrats may exact concessions

• Tax Reform
  - Reconciliation?

• Infrastructure

Our strategy

Coming at us

- Offsets: regular menu…site neutral
- Tax reform…tax exempt status
- Physician-owned hospitals
- 340B
- ACA coverage provisions (regulatory)
- Appropriations (health and education programs)
- Annual Medicare payment regulations (Medicare DSH)
- Post acute care payment reform

Leaning forward

- Private market stabilization
  - Cost sharing subsidies
  - Risk adjustment
  - Reinsurance*
  - Risk corridors*
  - Fall back insurance options

- Extensions
  - VA Choice
  - CHIP
  - Medicaid DSH
  - Medicare payment adjustments

- Vulnerable communities
- Antitrust reform (SMARTER Act)
- Regulatory relief
- Drug pricing

Rural Adjustments
- Low-volume adjustment
- Home health add-on
- Therapy cap exceptions
- LTCH 25 percent rule & moratoria
Rural Hospital Policy Forum

Register now!

July 19-20 on Capitol Hill

Hear from legislators, make your voice heard

Visit aha.org/RuralHealth for more info

Rural Hospital Policy Forum

Register Now
2016 Regulatory Onslaught

- Program Integrity Rules
- Other Rules
- Medicaid Rules
- CoP Rules
- MA and Exchange Rules
- Delivery and Payment Reform Rules
- FY and CY Medicare Payment Rules

Number of Pages

2017 Regulatory Outlook

Executive Orders

- **Regulatory freeze**
  - New regulations, regulations currently at Federal Register, those that have not taken effect

- **Regulatory relief**
  - One in, two out

- **Enforcement**
  - Regulatory reform officers and task forces
Class 5 Rapids Ahead

Quality and Patient Safety

- Quality and patient safety must be top priority

- High reliability organizations
  - Zero tolerance for error

- Addressing disparities

- Looking over horizon
  - Under-utilization
  - Explosion of measures
  - Diagnostic error
  - Measuring clinical teams vs. individual providers
Affordability

- Business
- Individuals
- Government pressures

Competing priorities

Major Themes - Affordability

- Complex issue: Many factors and stakeholders influence affordability
- Primary goal: Consumers can afford to access needed care and services to promote health
- We must own the part of the issue we control...and work with others to address the parts we do not control
- Address the issue through the lens of value

Value = Outcomes + Patient Experience

Cost
**Consumer Voice: Household Income on Healthcare**

**A Bigger Bite**

Middle-class families’ spending on healthcare has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

**Percent change in middle-income households’ spending on basic needs (2007 to 2014)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care</td>
<td>24.8%</td>
</tr>
<tr>
<td>Food at home</td>
<td>-3.6%</td>
</tr>
<tr>
<td>Housing</td>
<td>-6.0%</td>
</tr>
<tr>
<td>Total</td>
<td>-6.3%</td>
</tr>
<tr>
<td>Transportation</td>
<td>-6.4%</td>
</tr>
<tr>
<td>Total food</td>
<td>-7.6%</td>
</tr>
<tr>
<td>Food away from home</td>
<td>-13.4%</td>
</tr>
<tr>
<td>Clothing</td>
<td>-18.8%</td>
</tr>
</tbody>
</table>

Sources: Brooking Institution analysis of Consumer Expenditure Survey, Labor Department

The Wall Street Journal

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**Government Voice: Health Care Spending**

**Per capita health care expenditures have increased, though the growth is more modest when adjusted for inflation.**

**Per Capita National Health Expenditures, 1980 – 2015**


(1) 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.

(2) Expressed in 1980 dollars; adjusted using the overall Consumer Price Index for Urban Consumers.
Employer perspective

More Employers Describe Company Healthcare Costs As “Out Of Control” This Year

Inflation of Company’s Healthcare Costs


Under control
Out of control

Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare and Medicaid, 1994 – 2014

Trends in Hospital Financing

Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

(1) Includes Medicare Disproportionate Share payments.

(2) Includes Medicaid Disproportionate Share payments.
**Value-Based Strategies to Address Affordability**

- Redesign delivery system
- Improve quality and outcomes of care
- Payment reform and managing risk
- Implement operational solutions

**Medicare’s Value-Based Payment Framework**

In January 2015, CMS adopted a framework categorizing of health care payments:

**Value-Based Payment Categories**

1. Fee-for-service with no link of payment to quality
2. Fee-for-service with a link of payment to quality
3. Alternative payment models built on fee-for-service architecture
4. Population-based payment

Medicare’s roadmap to value-based payments:

- 30% of Medicare payments in categories 3 and 4 by the end of 2016
- 50% in categories 3 and 4 by the end of 2018
- 85% in categories 2-4 by 2016
- 90% in categories 2-4 by 2018

**Fragile infrastructure**

- Hospital financial performance

![Diagram showing hospital financial performance with sections for 'Razor Thin Margins', 'Negative Position', and 'Doing Well'.]

**Delivery System Redesign**

- Delivery system models that ensure every hospital has opportunity be an “access point” or “anchor of service” in their communities
  - Task Force on Ensuring Access in Vulnerable Communities
Chronic care management

The next epidemic?

On the Rise

The number of Americans with chronic conditions is rapidly rising

(number in millions)

Consumes 84% of Care Dollars

The access gap

- ACA is not universal coverage
- Health insurance exchanges
- Behavioral health

Behavioral Health Roadmap

1. Remove Barriers to Access
   - Influence changes in legislative and regulatory areas
   - Address workforce shortage and training issues
   - Promote development of better behavioral health care quality measures

2. Promote & Support Field Leadership
   - Highlight case studies on the integration of behavioral & physical health
   - Provide best practices on how hospitals are dealing with the issue
   - Establish an AHA Behavioral Health Care award

3. Create Greater Public Awareness
   - Collaborate with key behavioral health stakeholders to reduce stigma
   - Convene community conversations & develop tools to promote community partnerships
   - Develop national and social media campaigns to highlight proven efforts

Shaping the Future Workforce

- New skills:
  - Care coordination
  - Information management
  - Services outside hospital setting

- Unionization implications

- Employees as ambassadors
  - Broadening political base

- Workplace safety
  - Behavioral health implications

Consumerism

New economics of health care

- Consumer expectation
  - What are they going to pay?
  - What are they going to get?

- Care on demand...convenience
  - Same day appointments
  - Walk-on care
  - ED fast tracks
  - Home visits or house calls
  - Patient portals or telehealth

- Episodic to continuous engagement

- Pricing transparency

- Managing and/or embracing the “disruptors”...patient loyalty

- Subsidizing social goods
Social determinants and behavioral factors (diet and exercise) combined drive 80% of health outcomes.

### Figure 2

**Social Determinants of Health**

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Community engagement</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Discrimination</td>
<td>Provider competency</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td>Quality of care</td>
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<td>Support</td>
<td>Walkability</td>
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**Health Outcomes**
- Mortality, Morbidity, Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

**So where are we going?**

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6/15/2017
Hospitals at intersection

Redefining the “H”

Ensuring Access in Vulnerable Communities
To learn more about the work of this AHA Task Force, please visit www.aha.org/ensuringaccess

**Themes in the Report**

While they identified a few differences, the task force found the characteristics and parameters of vulnerable communities were similar for rural and urban areas.

- **Characteristics and Parameters of Vulnerable Rural Communities**
  - Declining population, inability to attract new businesses and business closures
  - Aging population

- **Characteristics and Parameters of Vulnerable Urban Communities**
  - Lack of access to primary care services
  - Poor economy, high unemployment rates and limited economic resources
  - High rates of uninsured or underinsured
  - Cultural differences
  - Low education or health literacy levels
  - Environmental challenges

- **Characteristics and Parameters of Vulnerable Urban Communities**
  - Lack of access to basic "life needs," such as food, shelter and clothing
  - High utilization burden
Themes in the Report

Task force focused on preserving access to essential health care services

<table>
<thead>
<tr>
<th>Essential Health Care Service</th>
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<tbody>
<tr>
<td>Primary care</td>
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<tr>
<td>Psychiatric and substance use services</td>
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<td>ED and alternative care</td>
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<td>Preventive care</td>
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<tr>
<td>Transportation</td>
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<td>Diagnostic services</td>
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<tr>
<td>Home care</td>
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<tr>
<td>Dental services</td>
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<td>Tribal referral services</td>
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<th>Emerging Strategy</th>
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<td>Addressing the Social Determinants of Health</td>
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<td>Global Budget Payments</td>
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<td>Inpatient/Outpatient Transformation Strategy</td>
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<td>Emergency Medical Center</td>
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<td>Urgent Care Center</td>
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<td>Virtual Care Strategies</td>
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<td>Frontier Health System</td>
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<td>Rural Hospital-Health Clinic Transformation Strategy</td>
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<td>Indian Health Services Strategies</td>
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AHA Strategy

“The best way to deal with the future is to create it.”

Abraham Lincoln
16th President of the United States of America
Class 5 Rapids Leadership

- Stay connected to your purpose
  - Be good community stewards
  - Quality, patient safety and high performance is job #1
- Be courageous and see what lies around the bend
  - Assess the harsh realities
  - Ask the right questions
  - Shift! Look for new solutions
- Count on your team
  - Governance, management and clinicians
  - Build new relationships
- “Ride the Bull”
  - Celebrate and tell the story