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Bracing for the Failures of Healthcare Reform – And Preparing for the Inevitable “Fixes”

By Nathan Kaufman

The U.S. healthcare system needs to be reformed. What the healthcare system does not need is a patchwork of disconnected compromises between legislators and special interest groups that do not address the fundamental flaws in the system.

It is likely that the 2010 legislation will create more problems than it solves requiring significant revision by mid-decade. This was all but acknowledged by the Senate leadership when Senator Harkin (D-IA) stated “this is not the end of healthcare reform, it is just the beginning...” The Senator described the legislation as a “starter house” but many believe it is a “house of cards.”

Based on estimates from the Congressional Budget Office (CBO), the President and congressional leaders' claim that the 2010 healthcare reform legislation will “bend the healthcare cost curve” and reduce healthcare's contribution to the nation's deficit. But the CBO acknowledges that their “margin of uncertainty is 20 percent.” One should note that the CBO's original projection of the cost of the Medicare Part D Plan was off by 40 percent!

Not all government experts are as confident that the current healthcare reform legislation will achieve its intended goals. Richard Foster, Centers for Medicare and Medicaid Services' chief actuary, stated that the demand for services from the newly insured will be difficult to meet with existing provider resources leading to “price increases, cost shifting and/or changes in providers' willingness to treat patients with low reimbursement.”

If Wayne Gretzky is correct, that greatness requires one to skate to where the puck is going to be, then one must anticipate the true consequences of the 2010 legislation, prepare for the disequilibrium it will create in the market and begin positioning for the inevitable legislative “fixes” that will be implemented by mid-decade.

History Will Repeat

Rather than address critical flaws in the existing system such as appropriateness and effectiveness of care, the health insurance industry's anti-trust exemption and/or excessive pricing by pharmaceutical and device manufacturers, the government's primary response to escalating costs has been and will continue to be to reduce payments to providers.

Since 2001, the government has programmed rate increases for Medicare so that the average hospital's Medicare margin would decline by one to two percent per year. Medicaid cuts have been arbitrary and solely based on each State's fiscal condition. Today, the average community hospital is losing approximately 12 cents on every dollar they spend caring for Medicare patients and 35 cents per dollar of care for Medicaid patients.

While physician practice expenses have increased by three to five percent per year over the past decade, their payments from Medicare have increased by less than two percent and the meager payments to physicians from Medicaid have remained unchanged at best. It is expected that the 20+ percentage reduction in the Medicare fee schedule will be patched with a negligible increase, however many specialties including cardiology, endocrinology and radiology will face significant reductions in payments from Medicare

(Continued...)

Bracing for the Failures of Healthcare Reform (Continued)

as a result of the adjustments implemented in the 2010 fee schedule.

Making matters worse, the 2010 reform legislation is expected to expand the eligibility criteria for the government's worst payer, Medicaid. The Medicaid roles in California could be expanded by as much as two million lives. In Massachusetts, in order to compensate for increasing Medicaid enrollment resulting from expanded eligibility under their healthcare reform plan, the state reduced Medicaid payment rates to hospitals from 82 percent of cost to 70 percent of cost. The 2010 legislation does not deviate from this pattern of decreasing reimbursement in response of increasing costs. The legislation will include a \$155 million reduction in Medicare payments to hospitals over the next decade which the hospital industry has "volunteered" to forgo.

2010 Legislation Will Create Financial Problems for Hospitals

Historically, Hospitals have compensated for their deteriorating Medicare margin and underpayments from Medicaid with investment income and cost shifting to managed-care payers. However the economic downturn has limited the contribution from investments and the negotiating power of the health plans will probably be strengthened by the 2010 legislation:

- 1) There will be no viable alternative to commercial insurance companies in the near term,
- 2) The anti-trust exemption for health insurers will not be repealed providing these companies with unprecedented market power, and
- 3) Insurance companies who will be required to accept individuals with preexisting conditions will look to off-load this cost on the providers in the form of lower reimbursement.

Physicians have compensated for the underfunded Medicare reimbursement by 1) seeing more patients, 2) closing their practice to Medicaid and 3) investing in profitable office-based ancillary services that were formerly provided by the hospital. These compensatory tactics are having limited impact on stabilizing physician incomes as fee schedules are cut for physician services.

At the exact time that hospitals can least afford to invest in its physician workforce, physicians are demanding increased payments from hospitals in the form of emergency department call pay, joint ventures and employment in order to stabilize their incomes. Given the undersupply of physicians, hospitals cannot afford to under invest in their physicians. Nor can they afford to invest in physician engagement strategies without expecting an incremental return on the investment.

While the 2010 legislation reduces the fees to be paid to hospitals, medical device and pharmaceutical companies do not face similar pay cuts. Thus the cost of medical devices and drugs will continue to grow exponentially while hospitals fight for their fair share of the commercial premium and experience minimal increases and/or cuts in reimbursement from government programs.

Traditional means of subsidizing the under-funding (i.e., investments and cost shifting) will not be sufficient to achieve optimal performance in the future. The impact of theoretical models such as consumer-directed healthcare, medical homes and deployment of information technology, etc., may actually add cost over the next five years. Thus hospitals must begin re-sizing their "cost chassis" to approach break-even on Medicare.

The auto industry is on the verge of extinction because it ignored the realities of the market. At the same time Apple has demonstrated American ingenuity at its best by revolutionizing the music industry. The economic and market conditions impacting healthcare providers are of the magnitude that have impacted the financial and automobile sectors. In its recent industry downgrade, Moody's states, "Sound management decisions about operating costs and capital investments, coupled with skilled oversight and direction from hospital boards will be of special importance." Healthcare providers must embrace innovation and redesign to provide more and better care at much lower costs.

These strategies include:

- Investing in cost management and process redesign to approach breakeven on Medicare.
- Maximizing and rebalancing payer contracts.
- Investing in coding and revenue cycle.
- Employing and collaborating with physicians to add value.
- Investing in the components of clinical integration, i.e., IT, hospitalists and bundled programs.

Healthcare providers must begin today to prepare for the disequilibrium that will be created by the 2010 reform legislation, as well as, its ultimate failures and restructuring. Befriend the inevitable or it will become your worst enemy!

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"Meaningful Use" Debut

By Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) finally proposed the long-awaited definition of "meaningful use" on December 30, 2009. It provides a roadmap for physicians and hospitals to seek their share of \$34 billion of the American Recovery and Reinvestment Act (ARRA) stimulus monies to help fund "certified" electronic health records that demonstrate "meaningful use."

The proposed definition is open for public comment for 60 days, after which a final rule will be published and the race for stimulus funds will be officially on.

ARRA incentive payments may begin as soon as October, 2010, for eligible hospitals and in January, 2011, for physicians and other providers, so it's imperative that you and your hospital have already completed, or soon complete, an ARRA "meaningful use" readiness assessment and a timetable for implementing EHR technologies in accordance with the new definition.

A primary Stage 1 objective is to implement and use computerized physician order entry to achieve the following:

- Ambulatory – 80 percent of medications, laboratory, radiology/imaging and referrals; and
- Inpatient – 10 percent of medications, laboratory, radiology/imaging, blood bank, physical therapy, occupational therapy, respiratory therapy, rehabilitation therapy, dialysis, provider consultants and discharge/transfers.

Additional "meaningful use" requirements are too lengthy to list here but include:

- Implement drug-drug, drug-allergy, drug-formulary checks
- Maintain an up-to-date problem list of current and active diagnoses (at least one coded entry or "No Problems exist") in ICD9-CM or SNOMED-CT for at least 80 percent of all patients
- Generate and transmit permissible prescriptions electronically for 75 percent of all ambulatory prescriptions
- Maintain an active medication list (at least one coded entry or "No Medications taken") for at least 80 percent of all patients

- Maintain an active allergy list (at least one entry or "No Allergies reported") for at least 80 percent of all patients
- Record demographics including preferred language, insurance type, gender, race, ethnicity, date of birth and date of death/cause in the event of inpatient mortality for 80 percent of patients.
- Send reminders to at least 50 percent of all patients who are 50 years and over for preventative care/follow-up
- Implement five clinical decision support rules relevant to the clinical quality metrics
- Check insurance eligibility and submit claims electronically for at least 80 percent of patients

If the ARRA stimulus monies are wisely invested, they could encourage an epic improvement of our U.S. healthcare quality, efficiency and services. However, despite all of the popular bashing of U.S. healthcare in Washington, D.C., we must be careful not to "throw the baby out with the bathwater" by forgetting the outstanding quality and service that we already have in our U.S. healthcare system, as well summarized in this commentary by Dr. Mark B. Constantian, a surgeon, that appeared in the January 7, 2010, *The Wall Street Journal*:

"The WHO does rank the U.S. No. 1 of 191 countries for 'responsiveness to the needs and choices of the individual patient.' Isn't responsiveness what health care is all about?... (C)ardiac deaths in the U.S. have fallen by two-thirds over the past 50 years. Polio has been virtually eradicated. Childhood leukemia has a high cure rate. Eight of the top 10 medical advances in the past 20 years were developed or had roots in the U.S... The U.S. has some of the highest breast, colon and prostate cancer survival rates in the world. And our country ranks first or second in the world in kidney transplants, liver transplants, heart transplants, total knee replacements, coronary artery bypass and percutaneous coronary interventions. We have the shortest waiting time for nonemergency surgery in the world... Perhaps it's not that America spends too much on health care, but that other nations don't spend enough."



I would like to hear your comments.
Send them to:
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Are Doctors Ready for Virtual Visits?

Writing in *The New York Times*, Pauline Chen, M.D., stated that for over a decade now, healthcare experts have been promoting telemedicine, or the use of satellite technology, video conferencing and data transfer through phones and the Internet, to connect doctors to patients in far-flung locations. But are doctors ready for this form of technology, she wondered.

Telemedicine has the potential to improve quality of care by allowing clinicians in one "control center" to monitor, consult and even care for and perform procedures on patients in multiple locations. A rural primary care practitioner who sees a patient with a rare skin lesion, for example, can get expert consultation from a dermatologist at a center hundreds of miles away. A hospital unable to staff its intensive care unit with a single critical care specialist can have several experts monitoring their patients remotely 24 hours a day.

But despite its promise, Dr. Chen points out that telemedicine has failed to take hold in the same way that other and newer technologies have. Not because of technical challenges, expense or insufficient need. On the contrary, the most daunting obstacle to date has been a deeply entrenched resistance on the part of providers.

New technologies in healthcare always require a reassessment of how patients and doctors best relate to one another. While most doctors believe that technology can help to strengthen the doctor-patient

bond, that's not the case for telemedicine. Indeed, for many doctors, Dr. Chen suggests that telemedicine seems to depersonalize the relationship and sabotage trust.

A recent study by researchers at the University of Texas Medical School in Houston looked at the impact of telemedicine on patients in the intensive care unit.

Despite the seemingly obvious advantages and patient willingness, the majority of doctors in the study chose to have as little remote involvement for their patients as possible. Many were worried about telemedicine's effect on their relationships with patients and that it might adversely affect care.

Dr. Chen states that acceptance will first require redefining the patient-doctor relationship in light of this new use of technology. Telemedicine and the idea of unseen clinicians in a remote "control room" doling out care is scary. But with dire predictions of physician shortages, particularly in rural regions, and insufficient numbers of critical care specialists even in large metropolitan areas, telemedicine likely has an important role in improving the quality of patient care.

Dr. Chen believes telemedicine will only work if everyone – doctors and patients – accept care from a clinician working in conjunction with a team of providers, each of whom is deeply engaged and committed to the patient, and some of whom, on occasion, may not be anywhere near that patient's bedside, city or state.

About



PHNS provides IT services for hospitals, other healthcare providers and businesses. PHNS' IT services include application hosting, co-location and managed services; electronic off-site data back-up and data vaulting; business continuity solutions; disaster recovery services; and systems integration services. PHNS also provides comprehensive business process solutions for hospitals including admitting, HIM (including medical record management and storage, transcription, coding, release of information and electronic medical record services) and revenue cycle services. PHNS creates business-healthy hospitals by improving operations, enhancing technology and increasing cash on hand, which allows hospitals to focus on their core competency – patient care. PHNS has approximately 1,670 customers, including approximately 400 hospital IT and business process customers and approximately 1,270 IT customers. PHNS is headquartered in Dallas, Texas. See www.phns.com for additional information about PHNS.