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Meeting the Challenge of Healthcare Reform: The Clinically Integrated Network

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This Time Is Different

The baby-boomer generation is now turning 65 at the rate of 10,000 a day and will continue to do so for the next 18 years. According to the 2010 census, 40.3 million citizens are 65 or older, an increase of 5 million since the 2000 census. This segment of the population is growing faster than the population as a whole. The average 65-year-old spends approximately four times as much on healthcare services as the average 40-year-old. These changing demographics, and the increasing healthcare costs associated with them, create a healthcare environment that differs from the past.

While "healthcare reform" may mean different things to different people, there is now fairly unanimous agreement that our current system of providing and paying for healthcare services is not financially sustainable. Regardless of what the Supreme Court may decide with respect to the 2010 healthcare legislation, "healthcare reform," directed at the manner in which we provide and pay for healthcare services, is already well underway.

Providers may escape the 27.4 percent Medicare reimbursement reduction that was scheduled for January 2012. But any escape from declining fee-for-service reimbursement, in which providers and facilities are paid based on volume of procedures and tests, is only temporary. The Medicare Payment Advisory Commission has recommended a freeze on primary-care-provider reimbursement rates, with a 5.9 percent annual reduction for all others for three years followed by a freeze on these reimbursement rates.

In 2013, some Medicare payments will be subject to a further 2 percent cut as a result of the failed Joint Senate Committee effort to

Please see> Challenge, page 4

Inside This Issue

Article	Page
Meeting the Challenge of Healthcare Reform: The Clinically Integrated Network	1
Healthcare Finance: Capitation Isn't a Four-Letter Word	6
Healthcare Administration: Self-funded Plans in the Environment of Healthcare Reform	10
Healthcare Administration: Delivering World Class Healthcare	12
Career Opportunities	15

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Dear Reader,

We publish Healthcare News web sites and/or hard copy publications in 12 states ranging from Alaska to Texas. Our combined readership is 45,000 and mainly consists of hospital, clinic, health insurance industry and provider organization professionals.

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There are several benefits to Washington Healthcare News readers and customers from our expansion to other states.

- Recruiters who use our job posting services will benefit as we increase the potential pool of applicants.
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- Articles submitted by readers in others states may find their way to the Washington Healthcare News web site.

Thanks for your continued support. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2012 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2012	Hospitals	December 1, 2011	December 26, 2011
February 2012	ASCs	January 3, 2012	January 30, 2012
March 2012	Hospitals	February 1, 2012	February 27, 2012
April 2012	Insurance	March 1, 2012	March 26, 2012
May 2012	Clinics	April 1, 2012	April 30, 2012
June 2012	Human Resources	May 1, 2012	May 28, 2012
July 2012	Hospitals	June 1, 2012	June 25, 2012
August 2012	Hospitals	July 2, 2012	July 30, 2012
September 2012	Clinics	August 1, 2012	August 27, 2012
October 2012	Human Resources	September 3, 2012	September 24, 2012
November 2012	Hospitals	October 1, 2012	October 29, 2012
December 2012	Clinics	November 1, 2012	November 26, 2012

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Challenge, from page 1

come up with a deficit-reduction proposal. One analysis suggests that hospitals and providers will absorb 32 percent and 12 percent, respectively, of this overall reimbursement cut.

In addition to absolute reimbursement reductions, Medicare reimbursement rates will increasingly be conditioned on meeting certain performance or value criteria. Over the next several years, providers and facilities may have reimbursement rates reduced up to 3 percent for failure to meet a variety of performance or value criteria. Commercial payers are also experimenting with outcome-based payment models.

In this environment of decreasing reimbursement amounts and changing criteria for calculating reimbursement amounts, the challenge for most healthcare facilities and providers is how best to continue making high-quality healthcare services accessible to all members of the communities they serve.

The Responsive Healthcare Delivery Model

As the reimbursement model for healthcare services moves away from fee-for-service through reduction of reimbursement rates and conditioning of reimbursement on performance and outcomes, the healthcare services delivery model is going to have to adapt. Whatever delivery model ultimately emerges, it will have to be more efficient in delivering consistently higher quality healthcare services than the currently predominant model of separate independent providers, provider groups, and facilities.

Integrated networks of interdependent providers, provider groups, and facilities, in which healthcare services are coordinated within the network across the entire continuum of care, appear to represent the emerging delivery model for the new reimbursement environment. The Medicare Accountable Care Organization ("ACO") is only one example of an integrated healthcare network. Oregon intends to provide services to Medicaid and dually eligible Medicaid and Medicare beneficiaries through integrated networks referred to as Coordinated Care Organizations. Both Oregon and Washington are in the process of setting up health insurance exchanges under the federal healthcare reform legislation that, among other things, will require insurer-participants to provide a form of integrated network for their members.

Integrated networks have proved that they can reduce the overall cost of healthcare and improve its quality. For an integrated network to succeed, however, it must successfully address cultural, financial, and legal issues. Since an integrated network often involves a combination of otherwise competing providers, provider groups, and facilities that intend to jointly negotiate reimbursement rates with healthcare plans and insurers, antitrust laws provide the predominant legal issue. Cultural issues arise from the necessary transformation of the delivery system from one of distinct, independent providers, provider groups, and facilities to an interdependent, coordinated system. Last but not least is the financial issue of what payment model will replace, in whole or in part, the current fee-for-service model. It is particularly on this issue that the clinically integrated network may offer some advantages over other integrated network models.

Under the recently adopted final rules, the Medicare ACO may offer advantages in addressing legal issues, but seemingly falls short on financial issues, except perhaps for the largest of networks. In addition to the initial cost of application and approval, a small ACO may have to achieve as much as a 3 percent saving from a historical cost benchmark for its assigned beneficiaries before it will share in the savings. Furthermore, an ACO must accomplish these savings with beneficiaries who have no incentive to limit their healthcare services to their assigned network. This is a significant disadvantage for achieving cost savings and quality improvement. In fact, in the antitrust analysis of integrated networks contracting with commercial payers, "leakage"(network patients obtaining healthcare outside the network) is sufficiently important that the networks must have a plan to address it.

Since well before the introduction of the ACO, federal agencies responsible for antitrust enforcement have issued policy statements and advisory opinions describing the conditions under which networks of otherwise competing providers could jointly negotiate with commercial payers and still comply with federal antitrust laws under the rule-of reason-approach. Generally, this required a network to

demonstrate that its members were truly integrated, committed to and capable of providing the competitive benefits of reduced healthcare costs and improved quality for which joint price negotiation was a necessary but ancillary factor.

The necessary integration may be either financial or clinical. In a financially integrated network, all members share significant financial risk, as under a capitation or bundled payment model. Such risk-sharing ensures commitment of network members to cooperate in managing healthcare services to control costs and improve care.

In a clinically integrated network, commitment to and potential for the success of the network are typically provided through participation contracts under which each member agrees to devote significant personal time and effort to the network and its operational components, including such things as (1) assisting in the development of and adherence to evidence-based clinical protocols; (2) participating in systems to make patient treatment information readily available throughout the network; (3) assisting in the development of an agreed set of quality and performance measures; (4) participating in the collection and sharing of data regarding outcomes and performance; (5) subjecting himself or herself to performance evaluation against the agreed measures; and (6) participating in and being subject to procedures for remediation and sanctions, including expulsion from the network.

While virtually all networks require the cultural shift from clinical independence to clinical interdependence, the clinically integrated network retains the flexibility to negotiate reimbursement contracts that do not require the same degree of financial interdependence required in other network models. Thus, the clinically integrated network may provide the least challenging model for entry into the world of integrated, coordinated delivery of healthcare services.

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Capitation Isn't a Four-Letter Word

By Karl Rebay
Director
Moss Adams LLP

Yes, of course, it's a 10-letter word. But those of us who have been in the health care industry for a while can remember the days of managed care, when capitation was marred by many negative characteristics including an intense and distracting bottom-line focus, inadequate technology that didn't always facilitate data capture and care management, and a shortage of clinical oversight and involvement.

Nevertheless, many believe that capitation was simply an idea ahead of its time. And, given the trends we're now seeing, this may well be true. It's a vastly different health care world today, and the industry is in the midst of a sweeping transformation. Indeed, success going forward will depend on the focused involvement of health care providers as well as strong management of the health care dollar.

Financial Responsibility

So, capitation – which involves sending a fixed per-patient payment to a health care provider in return for medical services – could be part of the solution, because the payment for the most part is the same no matter how many services, or what type of services, each patient actually gets.

Capitation offers provider organizations an opportunity for greater sustainability, more control over their own destiny, and enhanced business possibilities in a way that complements the accountability that this model requires. In addition, capitation, in an environment where enhanced quality is rightfully a requirement, incentivizes provider organizations to center their efforts on proactive long-term health management – rather than quick short-term bottom-line "wins" – in order to realize profitable gains.

The net result is that capitation forces providers to be financially responsible. And this financial responsibility could serve a very positive purpose in today's truly troubled economy, which is severely impacted by inefficient health care spending.

Fixing the Value Equation

Increasingly, people are asking about the value we're actually getting when one out of every five dollars in our overall economy is going to health care. This explains why there is such an emphasis today on fixing the value equation by providing quality care. Instead of having gatekeepers who limit care, it's now about delivering the right care, in the right place, for the right price.

It all sounds so logical, and yet this has been an elusive goal in the health care industry. Maybe this is because the people responsible for providing and authorizing care were not properly incentivized to understand the financial ramifications of their requests; and maybe this is because additional patient visits resulted in separate payments every time, thus perversely incentivizing more visits. Whatever the reason, it's now clear to almost everyone in the health care industry that rewarding volume over value just isn't viable anymore.

This radically altered world view may help capitation succeed in the rapidly changing health care industry; but improved IT and administrative infrastructure will also play

a role. To be sure, we now have robust tools and capabilities that can accurately capture clinical and financial data and then turn it into extremely useful information that reinforces quality outcomes. Another key factor that's playing a role is the significant change in health care reimbursement that's putting a whole new series of financial incentives in place to support improving patient health.

Core Drivers

An emphasis on quality, next-generation technology infrastructure, enhanced coordination techniques and revamped reimbursement could help improve the tarnished reputation that capitation acquired back in the previous managed care era.

Today, many people, especially those in our government, believe that shared savings are the answer to our health care problems, with Accountable Care Organizations (ACOs) representing a current, almost trendy, approach. Even though ACOs have their strong points, more effective models exist. Another option is the bundled payment, which allows shared savings, yet in a targeted and more manageable form.

Both ACOs and bundled payments are a step in the right direction for entities that currently employ a fee-for-service business model, or for entities that have product lines based on this payment model, because they put decisions in the hands of providers and drive these health care decision makers to do more with less. Also, pure managed care entities can also use ACOs and bundled payments to expand their businesses. For instance, an independent practice association could create an ACO to gain market share by pulling in non-managed seniors, as we are currently seeing in pilot programs.

Aligning Incentives

Overall, it's my view that capitation, when designed and deployed effectively, does a far better job of aligning incentives and providing financial sustainability than the ACO and bundled-payment models.

The key elements that help capitation flourish include a provider network with adequate breadth and depth, appropriate funding, a large enough membership complement, sophisticated care coordination systems, enough knowledgeable

Please see> Capitation, page 8

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< Capitation, from page 7

administrative support, the proper physical and IT infrastructures, a culture of high quality, and proper leadership. Of course, providers must also be vested in the success of the model and have good business disciplines that include strategic planning, detailed financial modeling based on actuarial projections, mentorship, and succession planning.

But there are still risks, which is why the industry is still hesitant about capitation. Because health care costs have been out of control for so long, many organizations are reluctant to work with finite financial resources in order to achieve goals. However, the organizations that can learn how to manage costs via the provision of high-quality, coordinated care, can mitigate capitation's risk and enjoy a more viable business model.

From my perspective, there are several essential elements that can help capitation pay off in a financial sense. First, you need to know where your patients are. Second, you must have programs that are designed to coordinate the provision of care and keep people healthy. Third, you need effective contractual relationships and communication mechanisms with outside providers. And lastly, you need to have collaborative relationships with payers. If we really want to accomplish something remarkable for our system, then the time for uncompromising, adversarial relationships has ended.

The Physician's Role

The capitation model asks providers to be more engaged in the financial side of health care. But it's unrealistic to expect that all health care practitioners will be versed in this complicated business. Still, many physicians have exceptional leadership capabilities, and organizations can implement educational programs to help them become more conversant in business. Physician leadership will ultimately provide one of the greatest contributions towards capitation's success because of their authority over allocation of health care resources.

We're entering a new era in health care, and a host of organizations are busy at work trying to solve the value equation. Capitation is complex, and it's hardly without flaws. But it offers a funding mechanism that drives incentive alignment where it's needed most—at the provider level. If market dynamics and provider organizations consent, this could be a tremendously valuable response to the big issues that continue to loom large over the industry.

Karl has been in the health care industry since 1993. He leverages his deep expertise in strategic business planning, financial operations, turnarounds, feasibility studies, development of capitation models, negotiation and analysis of managed care agreements and service line analysis and development for both hospitals and physician organizations. He also has experience with risk bearing organizations and management services organizations. Karl holds a BS in accounting from California State Polytechnic University, Pomona and an MBA from the University of California Irvine. Karl can be reached at Karl.Rebay@mossadams.com. Visit the Moss Adams LLP web site at www.MossAdams.com

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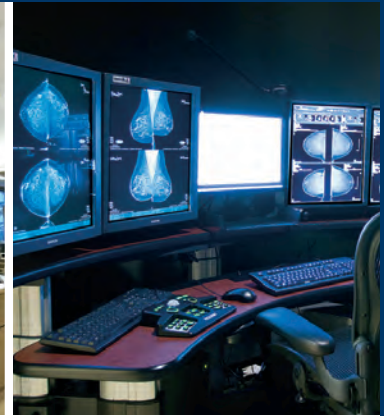

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Self-funded Plans in the Environment of Healthcare Reform

By Mike Burns
Vice President, TPA Sales
First Choice Health

According to a Price Waterhouse Coopers report, the number of groups self-funding their health benefits increased by 20% between 2008-2010. The average increase in premiums for plan years 2009 to 2010 was $808 per employee per year for fully-insured plans versus $248 for self-funded plans.

Approximately 150 million Americans are covered under private employer sponsored health insurance programs. Over half of them, more than 77 million, are insured through self-funded health plans. According to the 2011 Kaiser Family Foundation Employer Health Benefits report, premiums continue to increase. For example, in 2011, premiums for family coverage increased by 9% versus 3% the prior year. Given cost increases, what are employers doing in the self-funded market?

Questions to consider:

Why do employers elect to self-fund their health coverage? What are the trends in self-funding in light of the passage of the Patient Protection and Affordable Care Act (PPACA)? What should employers who self-fund health coverage consider when selecting an administrator to pay their claims?

Reasons for self-funding:

1. Control over costs

Self-funded plans generally have lower administrative costs. Claims are paid as incurred, creating better cash flow. Immediate savings are realized when claims are lower than expected. Insurance carrier profit margins and risk charges are eliminated/reduced.

2. Control over plan design

Self-funded plans are regulated by ERISA and generally are not required to cover state mandated benefits. Therefore, employers have more flexibility in benefit plan design and have more control over quality, price, and service levels for each component of their plan.

3. Access to data

Employers have greater access to reports and claim information which can influence future plan design and funding decisions.

4. Elimination of most state premium taxes (savings of 2-3%)

Generally, state premium tax on a self-funded plan, if any, is based on a fraction of the plan's total cost rather than the entire premium.

Selecting a claim administrator:

Due to market consolidation there are fewer claim administrators for self-funded plans. As employers think about moving to self-funding, selecting the most appropriate type of payor is an important consideration.

1. Administrative Services Only (ASO)

Insurance companies sometimes offer self-funded plans the same administrative services that they provide fully-insured clients, but no risk is taken. This is known as an ASO arrangement. The advantage of ASO is that the administrative services are packaged. The disadvantage is little flexibility to

carve in or out specialty vendors for best in class performance.

2. Third Party Administrator (TPA)

A TPA specializes in healthcare administration. There are a range of TPA's that offer a variety of services. Some TPA's only pay claims while others offer a wide array of services such as Case Management, RX, Provider Network Management, etc. First Choice Health, for example, owns core services which are fully integrated: Preferred Provider Network, Third Party Administration, and Medical Management. The self-funded employer has the flexibility to carve in or out all non-core services to best meet their unique needs.

3. Self-Administration

Some plans self-fund their health benefits and pay their own claims. This is rare and occurs primarily with very large plans due to the capital investment needed to operate.

Questions for selecting a potential claim administrator:

1. Is the administrator local or national?

2. What services are integrated?

3. Is the recommended PPO network leased or owned?

4. Is Medical Management in-house?

5. Does the administrator have flexibility to carve in or out important programs?

6. Do they handle Health Savings Account/Flexible Savings Account/Health Reimbursement Account and COBRA administration?

7. What reporting is available?

8. What flexibility exists to handle tiered-plan designs?

9. Does the administrator have strong relationships with Stop Loss carriers or Pharmacy Benefit Managers?

Please see> Self-funded, page 14

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By Ruth I. Hansten RN PhD FACHE
Principal Consultant
Hansten Healthcare PLLC

2012 healthcare leaders must streamline processes, avoid uncompensated hospital acquired conditions, optimize the patient/family experience, compete for top tier patient satisfaction and quality, and provide the best value healthcare in the midst of unprecedented uncertainty in reimbursement along with policy turmoil. Although doing our best to fulfill our covenant with the public, we often overlook the actual healing interface between patients and their care providers. Fundamental tasks and processes at the point of care are crucial to avoiding patient safety errors, tragic complications, lengthened stays, disappointed and noncompliant consumers, and dissatisfied, disengaged employees.

Recent research related to omitted care processes is particularly disturbing because of the reported prevalence, and the potential impact on patient safety, mortality and morbidity. Nine types of missed care are most frequently reported including ambulation, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance or assessment (Bittner, Gravlin, Hansten, Kalisch 2011).[1] The impact of gaps in task completion can be severe, especially in vulnerable populations, leading to hospital acquired conditions as pressure ulcers, deep vein thrombosis, pneumonia, failure to rescue, falls with injury, and uncompensated readmissions. Patients receiving deficient care would not be apt to score highly on their satisfaction surveys, thus driving the hospital's percentiles below their competitors. A sample of 4,086 staff revealed that missed ambulation topped the frequency charts at over 70%, mouth care at >60%, team conferences at >60%, turning at ~60%, focused reassessments at 30%, with patient assessments performed each shift being missed at ~10% (*the mean of "missed frequently, always, or occasionally" at 10 hospitals;* Kalisch et al., 2011)[2]. The reasons behind these serious treatment gaps include insufficient (or perhaps inadequately deployed) labor resources, materials, or communication.

2012 leaders cannot afford these lapses in basic care that Florence Nightingale used to improve mortality by 40% in the Crimean War.

Field experience from my national consulting work in approximately 170 healthcare organizations, focusing on care delivery models, professional practice and RN leadership at the bedside, and teamwork practices, offers evidence of several major issues that prevent best clinical outcomes and allow basic patient care breaches.

1) Lack of a shared mental model for team practices at the point of care: Without a clear map in mind for expert hand-offs, for inclusion of all interdisciplinary team members in the plan of care including patient/family short and long term goals, gaps will occur that are filled with lack of accountability, role confusion, and missed care. Chaotic environments are inevitable; therefore plans that provide structure for initial instructions, checkpoints, and debriefing will allow flexibility along with creativity to meet emerging demands. For example, all members of an expert team envision a blueprint that clarifies hours the patient will be repositioned, who

will round and when.

2) The Team's lack of experience or education: Some team members are unclear on their statutory practice responsibilities and are ineffective delegators and clinical supervisors. Some expect that assistive personnel will just "do their jobs" without leadership. Often, improbable patient care assignments designed so that assistive personnel (nursing assistants and technicians) report to more than two team members create further hurdles to the patient experience. The patient/family's real life outside of the acute care setting is often unknown or disregarded due to the team member's lack of experience or education in home health and ambulatory care. Discharge planning is not coordinated or individualized for the particular patient's needs. Leadership, delegation, supervision, and coordination are complex clinical reasoning skills that include expert social intelligence and require seasoned expert professionals.

3) Lack of knowledge about maximizing healing encounters that emphasize patient results: Physicians, nurses and other healthcare providers are often born with the capacity for expert emotional, social, and appreciative intelligence, but whether or not this talent flowers is a function of years of practice, or from being taught distinct, evidence-based skills. Creating a healing environment goes beyond rote "service excellence" courtesy. Best practice providers choose to become an empathetic, authentic presence, helping the patient focus on his priorities and goals. Diminished pain and better patient compliance with discharge instructions are correlated with expert patient interaction practices. Satisfied healthcare professionals report that it is truly a practice gift to learn to help patients engage in their own healing processes by focusing on important outcomes.

Action steps for 2012 healthcare leaders, whether skeptical or convinced, begin with assessment of quality indicators and patient satisfaction results. Question whether some of your basic care is being missed. Evaluate the current level of patient care and teamwork. Teach nurses to lead at the point of care, and assess for reasonable, planned, deployment of assistive personnel. Coach RNs to develop the complex skills necessary to lead and coordinate individualized

Please see> World Class, page 14

< Self-funded, from page 11

10. What is their ratio of Account Executives to the number of clients served?

These questions are a starting point for an employer when evaluating a claim administrator for self-funding. One thing is certain in this new era of PPACA, more employers will look seriously at self-funded health plans as a way to obtain control over costs.

With the passage of PPACA and its requirements, it is likely that employer sponsored health plans will experience increasing costs. Healthcare is a significant line item in the budget for any organization. This environment has never been more suitable for employers to consider self-funding. The most likely determinant to drive employers towards self-funding is potential cost control.

Mike Burns has nearly 20 years experience in sales leadership roles, including nine years as a sales manager, consultant and national sales trainer. He has expert-level knowledge of the self-funding and stop loss reinsurance marketplace. He can be reached at mburns@fchn.com or 800-467-5281. Visit the First Choice Health web site at www.fchn.com.

< World Class, from page 13

nursing care. Evaluate your care model for inclusion of all disciplines and a structure for proceeding through the shift or case with teamwork principles including initial direction, periodic inspection, reciprocal feedback, and debriefing. Develop results-oriented healing conversation skills for patient care providers.

In the words of former Marriott leaders Dow and Cook, *"You must be brilliant at the basics to become world class."*[3] In healthcare, we must progress beyond hotel service skills, again focus on basic patient care tasks and processes, participate as an interdisciplinary team in patients' healing processes, choosing authentic presence as we navigate patients and families safely through the most challenging times in their lives.

That's world class health care.

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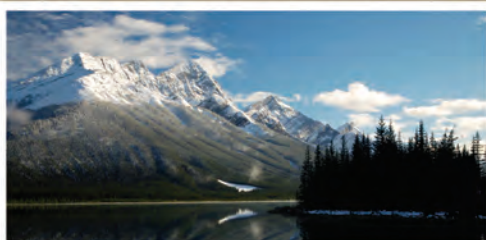

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