



Concurrent Session 2 - Delivery & Quality Track

12:40 p.m. to 2:10 p.m. – Triple Aim & Academic Medical Centers

Professor Farringer will address: A little more than four years after enactment of the Patient Protection and Affordable Care Act of 2010 (“ACA”), daily headlines still abound on newspapers and websites across the country highlighting both successes and failures of the ACA. In analyzing those successes and failures, especially in the context of care delivery, it is important to take a step back to consider the stated goals of the ACA, which goals have their origins in a premise first proposed by Dr. Donald M. Berwick and the Institute for Healthcare Improvement (“IHI”) in 2006 referred to as the “Triple Aim.” The Triple Aim is a framework for healthcare that, at its origin, was intended to “optimize population health, care experience, and cost.” It was with this Triple Aim in mind that legislators and policy makers established the framework for accountable care organizations (“ACOs”) and the Medicare Shared Savings Program (“MSSP”). Professor Farringer will discuss the origins of the Triple Aim and its impact on the development of ACOs under the ACA. She will then analyze why academic medical centers and other integrated delivery systems such as the Mayo Clinic, which are leaders in research, innovation, and quality care, are opting out of a model of care in the ACO structure that was designed with the goal of functioning more like these entities. With that in mind, she will examine the potential risks of maintaining an ACO structure that is not open, available, and accessible to academic medical centers such as the Mayo Clinic, suggesting that such a structure that does not encourage participation by entities such as the Mayo Clinic will be unable to achieve the goals of the Triple Aim that the ACA set out to accomplish. Finally, Professor Farringer will offer some suggestions for amendments to the ACO model that might make ACO participation possible for the Mayo Clinic and entities like the Mayo Clinic and move the U.S. healthcare delivery system closer to its goals of achieving the Triple Aim.

Professor Marciarille will address: Academic medical centers in Minnesota and elsewhere are grappling with their own internal transformation under health care reform as they pursue their traditional goals of clinical care, research, education, and community health. Simultaneously, they must confront the role they play in the health insurance marketplaces – often as relatively high cost providers. We, as citizens, must decide what it is we want from academic medical centers (“AMCs”) and at what price. Although this is not a problem peculiar to Minnesota, it is framed nicely by the commercial insurance products being sold through the Minnesota Exchange at <https://www.mnsure.org/>, where southeast Minnesota’s higher cost Exchange-offered health insurance products have sparked a conversation about the future of AMCs in a post health reform world that will have resonance throughout the Midwest. I propose to offer a presentation that explores this tension between what we have asked AMCs to be and what we are asking them to become.

Professor Marciarille’s presentation offers an introduction to the establishment of AMCs in the United States as well as consideration of their two dominant delivery and finance models: a fully integrated model and a split/splintered model, the former the child of 1960’s enthusiasm over wholly integrated care and the latter expressive of 1990’s interest in separating the clinical enterprise from other goals.

The Mayo Clinic serves as the modern example of a relatively older AMC nonetheless subject to the modern pressures of horizontalization and consolidation.

The Mayo Clinic's influence on Exchange-offered insurance products in southeast Minnesota highlights the concerns the financial management of AMCs raise in this new world. Health care and health insurance are full of cross-subsidizations and so it is that the margins from clinical care at AMCs have historically been used to subsidize research, education, and work on community health. AMCs, in short, have different cost structures. The struggle is to determine if, in a post health reform world, we should embrace this cross-subsidization as just or discard it as perverse. Even those within the AMC world cannot fully agree. This makes it all the more important to study and discuss.

Mr. Massa will address "Risks and Rewards of Detangling Graduate Medical Education Financing from Hospital Payment Methodologies." Teaching hospitals deliver hands-on clinical training experiences for physicians and an array of other caregivers during their journey from students to practitioners. These training experiences come at a cost to the teaching hospitals.

Medicare and Medicaid payment methodologies evolved to account for these costs, at least in part, by providing supplemental add-on payments to teaching hospitals' reimbursement rates. None of these supplemental payment streams fully compensate teaching hospitals for their actual costs of providing medical education and training experiences. Therefore, many teaching hospitals negotiate higher reimbursement rates from commercial insurers.

This multi-faceted, indirect and complex cost recovery system presumes a traditional fee-for-service payment environment in which individual patients have little incentive to compare providers based on costs. New payment reforms use measures of efficiency or costs of care to vary hospitals' reimbursement amounts, so these supplemental payments and higher negotiated rates create significant challenges for the long-term viability of residency and clinical programs. Teaching hospitals find themselves at a competitive disadvantage because they appear to be more expensive, less capable of earning shared savings or other incentives for low-cost care, and more vulnerable to narrow-network plan designs.

Without addressing the different functions of the care delivery payment system and building a medical education financing structure that is separate from calculations of providers' costs of care, teaching hospitals will face mounting pressures to reduce or even eliminate their training programs. On the other hand, detangling medical education funding from care delivery reimbursement could make medical education funding more vulnerable politically if it is not regarded as part of the Medicare or Medicaid programs. Therefore, new financing systems need to be accompanied by policies or safeguards that establish long-term sustainability and predictability so teaching hospitals can appropriately plan ahead and make reliable commitments to the residents, nurses, pharmacists, and other professionals who agree to train in their facilities.

Ann Marie Marciarille, JD

Ann Marie Marciarille is an Associate Professor of Law at UMKC School of Law specializing in health care law. Her research interests include health care antitrust, health care regulation, and a particular interest in health care organization and finance. Before joining UMKC, she had a long career as a health law attorney, including serving as a health care antitrust prosecutor for the California Attorney General's office and several years as a legal services attorney specializing in health care matters. Professor Marciarille is a Phi Beta Kappa summa cum laude graduate of Amherst College and a cum laude graduate of Harvard Law School. She also holds a Masters in Theology, specializing in ethics, from Harvard Divinity School. She has published articles on

Medicare reform, Medicaid reform, health care finance reform and health care provider quality issues. Professor Marciarille taught Health Law, Health Care Reform, Health Care Regulation and Finance, Elder Law, Disability Law and Public Health Law at the University of California, Hastings College of the Law, Boalt Hall/Berkeley Law School, and Pacific McGeorge School of Law.

Deborah Farringer, JD

Deborah Farringer is an Assistant Professor of Law at Belmont University College of Law. Professor Farringer teaches Health Law, Health Care Fraud and Abuse, Health Care Business and Finance, and Health Law Practicum. Prior to joining the faculty at Belmont, Professor Farringer served as Senior Associate General Counsel in the Office of General Counsel at Vanderbilt University, where her practice focused primarily on transactional matters for Vanderbilt University Medical Center, including analysis of contracts for compliance with applicable healthcare laws such as the Stark Law, Antikickback Statute, Civil Monetary Penalties Law, and the False Claims Act, physician practice acquisitions, joint ventures, general corporate governance and corporate maintenance issues, hospital operations, and real estate leasing and purchasing issues. Prior to her role at Vanderbilt University, Professor Farringer was an associate at Bass, Berry & Sims PLC where she practiced in the firm's Healthcare Industry group. Professor Farringer graduated summa cum laude from the University of San Diego with a B.A. in History and received her Juris Doctorate from Vanderbilt University School of Law where she was a member of the Order of the Coif. While in law school, Professor Farringer served as the Senior Notes Editor for the Vanderbilt Law Review. Immediately following law school, she completed a judicial clerkship for Judge H. Emory Widener, Jr. of the United States Court of Appeals for the 4th Circuit in Abingdon, Virginia. Professor Farringer is a member of the American Health Lawyers Association and is also licensed to practice in the state of Tennessee.

Lawrence Massa

Lawrence J. Massa became president and CEO of the Minnesota Hospital Association (MHA) in October 2008, continuing a 25-year career as a prominent hospital and health-care leader in the Upper Midwest. Serving as a policy-maker, hospital executive and grassroots advocate, Massa most recently led Rice Memorial Hospital in Willmar, Minnesota. There, he acted as CEO of the municipal organization for almost 15 years. Rice provides integrated acute care, long-term care, rehabilitation and pre-hospital emergency medical services for residents in Willmar and 14 surrounding counties. During his tenure, he oversaw the completion of a \$52 million renovation and expansion project. Before that role, Massa gained more than 10 years of for-profit and nonprofit health-care executive experience in South Dakota, Iowa and Minnesota. He also served as South Dakota's secretary of health under Governor William J. Janklow.



Minnesota Hospital Association

Detangling Medical Education from Hospital Payments: Risks & Rewards

Lawrence Massa
Minnesota Hospital Association

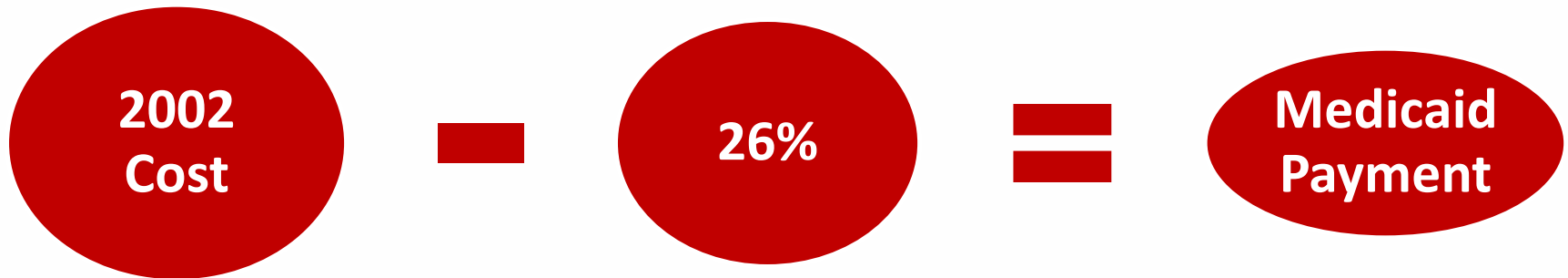
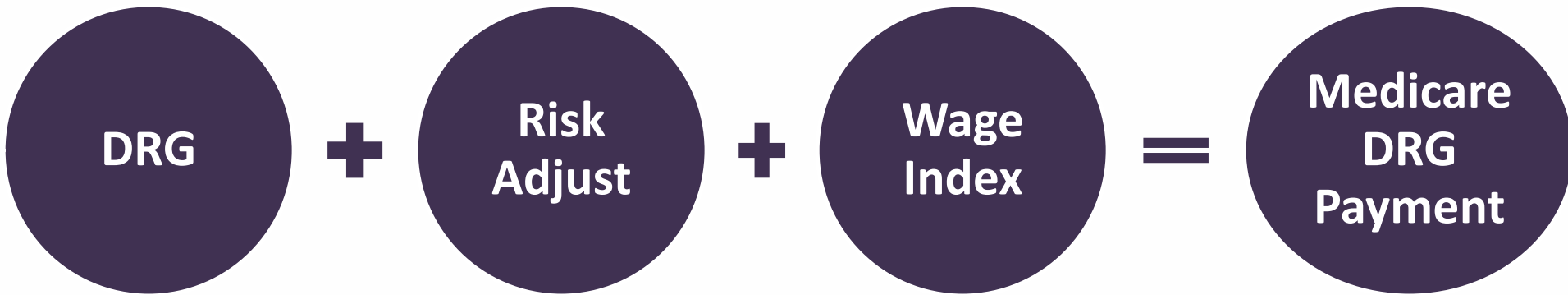


October 24, 2014

Medical education funding in jeopardy

- Recent federal proposals to cut graduate medical education funding
 - Simpson/Bowles Commission (60% cut recommended)
 - MedPAC (40% cut recommended)
 - Obama Administration (10% cut recommended)
 - US House Budget (Rep. Ryan) (10% cut recommended)

Traditional Fee-For-Service Inpatient Payment Methodology



Medicare Adjustments for Teaching Hospitals

- Direct Graduate Medical Education (GME)
 - Add-on payments
 - Intended to offset part of residents' salary and benefit costs
 - Estimated costs = \$100,000+ per resident
Average GME add-on = \$25,000 per resident

Medicare Adjustments for Teaching Hospitals

- Indirect Graduate Medical Education (IME)
 - Add-on payments
 - Intended to offset additional costs due to more complex, acute patients served
 - Additional costs estimated to be 1.4% to 28% higher than non-teaching hospitals

Medicaid Adjustments for Teaching Hospitals

- Medical Education & Research Costs (MERC)
 - Minnesota grant program
 - Payments to teaching hospitals based on volume of Medicaid services delivered (not residents trained)

Commercial Adjustments for Teaching Hospitals

- Higher negotiated rates to help offset medical education costs

Teaching Hospitals' Traditional Fee-For-Service Inpatient Payment Methodology

Medicare
DRG
Payment

+

GME

+

IME

=

Medicare
Payment

Medicaid
Payment

+

MERC

=

Medicaid
Revenue

Higher
Negotiated
Rate

+

Risk
Adjust/P4P

=

Commercial
Payment

New Payment Methodologies and Impact on Teaching Hospitals

- Medicare Value Based Purchasing (VBP)
 - Adjusts payment +/- 2% for combined score based on Quality, Patient Satisfaction and Costs of Care (3 days before admission through 30 days post-discharge)
 - More complex patients make quality and patient satisfaction more difficult
 - Add-on payments/teaching costs make costs of care appear higher

New Payment Methodologies and Impact on Teaching Hospitals

- Medicare Physician Value Modifier
 - Adjusts physician payment based, in part, on patients' total cost of care
 - Decreases physicians' interest in referring to teaching hospitals with higher cost structures

New Payment Methodologies and Impact on Teaching Hospitals

- Accountable Care Organizations, Total Cost of Care
 - Savings/risk sharing based on total cost of care
 - Add-on payments, higher negotiated rates all add to total cost of care
 - More difficult for teaching hospitals to generate shared savings or avoid shared risks given higher cost structures

New Payment Methodologies and Impact on Teaching Hospitals

- High deductible health plans and calls for greater price transparency are beginning to drive patients to make more price-sensitive decisions regarding their providers
- Commercial payers no longer willing to pay higher rates to subsidize medical education, Medicaid underpayments, etc.
- Commercial payers utilizing similar value or efficiency based payment methodologies

Difficult Options for Teaching Hospitals

- Continue academic portion of mission
 - Absorb cuts in commercial payments
 - Absorb cuts from VBP
 - Adjust to revenue loss from physician referrals
 - Avoid ACO, total-cost-of-care arrangements

OR

- Adjust to and adopt new payment models
 - Pressure for cost-cutting to become more competitive jeopardizes medical education programs

Simple Conclusion

- Society must develop medical education financing systems that are independent from care delivery payment mechanisms
 - Allow teaching hospitals to compete on cost and quality of care delivered, with medical education costs and activities entirely separate
 - Create more accountable/traceable medical education activities and expenses

Risks and Complexities

- Separate medical education payment system would be more vulnerable politically
 - GME and IME payments are difficult for Congress to cut because they are part of Medicare payments
 - Political vulnerability or fluctuation in appropriations undermines educational programs because they depend upon predictability and sustainability to cover training costs that span many years

Risks and Complexities

- Medical education costs are difficult to separate from care delivery
 - Role of residents in patient care is essential for educational experience
 - Role of residents in patient care inherently makes that care more expensive to deliver
 - Role of residents in staffing and coverage is part of the teaching hospitals overall cost structure

Is there a way forward?

- Accurately account for actual costs of medical education and training
- Utilize Medicare and Medicaid programs for political security of medical education financing
- Collapse GME and IME into payment formula that makes medical education portion of reimbursement transparent
- Prohibit use of medical education payments in public or private total cost of care calculations
- Adjust medical education payment amounts according to number of residents trained, not the number of Medicare or Medicaid patients served

Is there a way forward?

- Combine Medicare Parts A and B to more closely resemble other familiar health insurance structures with single deductible and co-pay
 - Estimated savings of \$4 billion without cutting benefits or provider reimbursements
 - Redeploy savings to underwrite medical education costs without cross-subsidization
 - Use financing for multiple caregivers, including APRNs, PAs, psychologists, pharmacists, RNs, etc.

Is there a way forward?

- Redesign medical education programs to enhance clinical training experience
 - Clinical training on care team basis
 - Clinical training in sites most appropriate for specialty or field (e.g., outpatient, primary care settings, etc.)
 - Develop rural-targeted training programs
 - Leverage simulation and other technologies to decrease “drag” on efficiency of care from clinical training programs