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Health Care Trends and Issues for 2007

The health care industry continues to dominate our national consciousness, from politics to technology. In this month's issue, Wipfli's health care team again presents its forecast for some of the trends and issues that are most likely to command industry attention and affect health care providers in the coming year.

Patient Quality and Safety

Driven to some extent by pay-for-performance initiatives (see P4P below), patient quality and safety looms as a critical performance area for hospitals in the foreseeable future, not only for the impact on reimbursement, but also because consumers are becoming more attentive to these issues in making their choices of providers (e.g., Web-based performance reporting for consumers).

Expect to see more hospitals developing their quality programs and investing in data gathering, process improvement, and benchmarking programs (e.g., balanced scorecards, magnet nursing programs) in order to ensure they are continuing to offer the highest quality of care.

Pay-for-Performance (P4P)

What started as a trickle in 2005 is likely to take on greater significance as CMS starts to see the results of its Premier Hospital Quality Incentive Demonstration project. To date, the project has seen a four-percent improvement in acute MI patients, a nine-percent improvement in heart-failure patients, and a ten-percent improvement in pneumonia patients. The bottom line is that hospitals will begin to look at quality as not only a mission issue but also an economic one.

The focus has turned to the internal processes that result in high quality of care, and the trend is likely to continue not only with PPS hospitals but with CAHs as well. The Deficit Reduction Act of 2005 commits CMS to develop a value-based plan for awarding reimbursement based on defined quality measures and processes.

Consumer-Driven Health Care

Escalating health care costs will continue to force employers to look closely at employee health care benefit structures and redesign their health plans to make employees more responsible for the cost of care. With the advent of higher premiums and deductibles, more employees will be opting for Health Savings Accounts, or HSAs, which are portable savings accounts that use pre-tax dollars for medical care, and shopping more diligently for the best quality and economic value. Also, expect consumers to become more cost-conscious as health care costs increasingly shift to them.

The Community Benefit Debate

In what stands to be a landmark case for tax-exempt hospitals, the Illinois Department of Revenue in September 2006 overturned a recommendation from an administrative law judge and ruled that Provena Covenant Medical Center in Champaign, IL, should have its tax-exempt status revoked. The basis of the decision involves the percentage of charity care the medical center has been providing, as well as concerns about Provena's pricing policies.

The bottom line is that hospitals are coming under increasing scrutiny regarding how they provide community benefit in return for tax-exempt status. With the IRS and state attorneys general examining the potential gains in tax revenues from community hospitals, it will become increasingly important for hospitals to make sure they are documenting and implementing rigorous steps concerning how they provide benefits to their communities.

Legislative Relief for Rural Hospitals

House Bill 6030 (the Health Care Access and Rural Equity Act, or H-CARE) was introduced in October and is slated to be on the top of the legislative list when Congress reconvenes after the elections in November. The bipartisan bill is sponsored by Representatives Greg Walden, R-OR, and Earl Pomeroy, D-ND, co-chairs of the House Rural Health Care Coalition.

If passed, H-CARE will provide relief to rural hospitals by extending financial protections for rural hospitals. The H-CARE bill incorporates all of the provisions of the Rural Hospital and Provider Equity Act (S. 3500, HOPE Act) and contains many important rural health provisions, including:

- The creation of a Rural Community Hospital (RCH) program that will extend the option of Medicare cost-based reimbursement for inpatient and outpatient services for hospitals with 50 or fewer beds.
- The requirement that Medicare Advantage plans pay Critical Access Hospitals at least as much as they would receive under the traditional Medicare program.
- The authorization of $140 million over five years for grants to rural providers to help with the cost of implementing health information technology.
- Prompt payment to rural pharmacies by Medicare prescription drug plans.
- The re-authorization of Rural Outreach and Network grants.

Critical Access Hospitals

- **Quality monitoring and reporting:** Gathering and reporting of quality data will continue to be high on the agenda of CAHs as performance and reimbursement become increasingly tied together. Also expect to see the high performers use their data to "advertise" for patients, providers, and managed-care contracts. Because high performance doesn't usually occur without a methodically implemented continuous-improvement program, expect to see more CAHs employ formal processes like balanced scorecard as monitoring and measuring tools.
- **Hospital/physician integration:** As markets become more competitive, new physician graduates seek alternative professional/personal balances, and regional systems extend their reach and influence, look for more CAHs to seek integrative alignment with their physicians in structures ranging from ancillary joint ventures to full integration.
- **Information technology:** Updates to software and systems will be critical for quality improvement and overall operational efficiency. Both CAHs and community hospitals will continue to invest in new systems that are necessary to implement EMRs, CPOEs, and more sophisticated billing and reporting systems. If House Bill 6030 is passed and funded, look for new grants to CAHs and rural hospitals to upgrade IT systems.
- **Facility and capital improvements:** With many CAH facilities at the end of their useful lives, expect to see continued feasibility and financing studies to determine whether or not to renovate or rebuild.

Hospital Reimbursement

In August, CMS released its final rule for 2007 for inpatient reimbursement, which will result in urban hospitals seeing a 3.4-percent increase. Large urban areas should experience a 3.5-percent increase, while hospitals in other urban areas are expected to get 3.3-percent more. Hospitals in rural areas, meanwhile, should see a 3.9-percent payment increase.

On the outpatient side, CMS's final rule ties reimbursement to reporting quality measures and aligns payments for surgical procedures in ambulatory surgery centers with those in hospital outpatient departments. CMS's final outpatient rule will likely result in hospitals receiving an overall average increase of 3.0 percent in Medicare payments for outpatient department services in CY07.

Technology and Information

Some of the most significant innovations will be seen in the field of information technology, driven in large part by the interest in creating safer and more efficient patient care settings. We can expect to see technology improvements in virtually all areas of the health care provider spectrum, including but not limited to hospitals, physician offices, and long-term care.

Look for increasing introduction of electronic health records (EHRs) into small hospitals and physician practices. A serious roadblock for the introduction of EHRs into medical practices may have been eliminated with a recent federal decision to allow hospitals to donate medical record systems to physician practices. With a hefty price tag of more than $20,000 per physician, medical practices have been slow to adopt this technology until now.

Beginning in 2007, Indiana will become the second state publishing hospital-specific data on medical errors. The Indiana State Board of Health adopted rules identifying 27 mistakes that hospitals and surgery centers must report within 15 days of confirming they were at fault.

Technology trends anticipated in the next two years include continuing implementation of electronic medical records, single sign-on, bar code medication administration tools, and digital picture archiving communications systems.

Internal security breeches continue to be a primary security concern of health care technology executives and managers. Nevertheless, expect more use of the Internet in the areas of patient scheduling, patient billing, and physician portals.

We also expect the pace of clinical technology will not abate, especially in the fields of medical imaging and surgery. Hospitals will have to keep pace to ensure the widest bandwidth of services, and the need for long-range capital budgeting will become more important than ever.

Physicians and Medical Practices

As reimbursement pressures increase for both hospitals and physicians, we expect to see two phenomena appear. Some specialists will continue to align themselves more closely with specific hospitals, with relationships ranging from joint ventures to full integration. Meanwhile, others will compete with hospitals for surgical and ancillary services in order to create new sources of revenue for their practices.

A growing trend in hospitals is the use of "hospitalists," or physicians who practice inpatient medicine. Hospitalists free attending physicians to spend more time seeing patients in their offices and less time doing rounds. The Society of Hospital Medicine estimates there were 15,000 hospitalists practicing in 2005, and predicts the number will double by 2010.

Physician Reimbursement

Expect lots of changes in the Medicare fee schedule. In December, Congress voted to freeze the physician fee schedule conversion factor at the 2006 rate. While there is an opportunity for a 1.5-percent increase for physicians (starting in July 2007), the ability to obtain the fee increase will be linked to participation in a clinical quality-improvement program, the details of which are not yet worked out. It looks like pay for performance will increasingly be an issue not just for hospitals but for physicians as well.

CMS has also revamped the Medicare fee schedule relative value units (RVUs). The work component RVU will decrease by 10.1 percent because of the CMS requirement to include a budget neutrality factor when adjusting RVUs. The practice expense component RVU value has also been adjusted and will be phased in over a four-year period.

When fully implemented, there will be winners and losers across specialties, with the big winners being primary-care physicians and the losers being radiology and anesthesia services and pathology.

Physician Compensation

With changes in the individual RVU components (as described in the previous section), physician compensation plans will need to be revisited to ensure they are fair and equitable. For example, in primary care, the 99213 level-3 office visit is the most common CPT code utilized. The 37-percent increase in work RVU value will effectively increase the physician's compensation if his compensation is based on RVU production. Likewise, professional services agreements that are RVU-based will need to be modified to maintain consistency among individual components.

Another consideration is in the development of a physician practice fee schedule. The conversion factor used in determining this will need to be evaluated to account for internal relativity (specialty-specific) in the increase or decrease by specialty when setting fees.

Staffing Shortages

Health care staffing shortages may well become a permanent feature of the trends and issues landscape as the population ages and the Baby Boomers reach retirement age. AMN Health Care Services projects a deficit of 200,000 physicians and 800,000 nurses in the U.S. by 2020. However, the issue of health care staffing shortages goes beyond doctors and nurses and will likely put a premium on pharmacists, imaging techs, and medical technologists, to name a few. Look for more provider organizations to not only create financial incentives and in-house training programs to attract professional staff but also implement "healthy workplace" initiatives to ensure retention levels are kept high once staff members are recruited.

Senior Care

Strategic planning, senior living trends, and changes to the long-term care business model are the dominant issues facing the senior care industry.

- **Strategic planning:** With changing demands from seniors, providers are likely to continue to be challenged by the pressures of immediate, short-term operational needs and the desires of seniors for in-home, community-based options rather than congregate settings. Compounding the situation is the emergence of Medicaid managed care with lower reimbursement that threatens traditional, residential-based providers.
- **Senior living trends:** Key trends include: (1) more choices for both housing options and the amenities associated with them; (2) upscale housing options for those able to pay market rates; and (3) a continued lack of "affordable" assisted-living housing for those on limited incomes, except where providers can access Medicaid-waiver funds or Sec. 42 tax credits.

Facility and Building Trends

The health care construction boom shows no signs of slowing down. Over the past four years, $130 billion has been spent on health care construction. In 2006, health care construction dollars hit an all-time high of $40.2 billion, a 43-percent jump since 2002.

Hospitals are investing in privatizing inpatient beds, expanding overall capacity, adding new service lines, and fixing infrastructure and other age-related issues.

With the per-square-foot cost of new health care construction at an all-time high, spurred by provider competition and specialized health care construction, planning will be increasingly important to get the greatest return on investment.

Building with a flexible mindset will become imperative. As the impact of increased building costs are realized, providers will be less likely to build for merely peak utilization and will look at new space configurations that allow for the use of adjacent space for overflow situations.

Patient-safe and patient-centered design principles are, and will continue to be incorporated in facility construction. Some indicators of this include:

- Private rooms are becoming the standard for new hospital construction.
- Equipment and supplies are becoming less centralized so they are brought more easily to the patient.
- Family-friendly environments are being created to foster and encourage family assistance in care.
- Views to nature, use of natural light, and overall focus on a "healing environment" are all aspects of the new design trend.

Wipfli LLP
www.wipfli.com

Contributing authors to this report include Dave Hoffman and John Keefe in Wipfli's Madison office (608.274.1980); Janice Ahlstrom in Wipfli's Milwaukee office (414.431.9300); and Art Saunders, Perry Hanson, Jeff Johnson, John Dao, and Jill Myers, all in Wipfli's Minneapolis office (952.548.3400). Please feel free to contact any of these individuals with follow-up comments and questions.