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February 16, 2011

Mr. Dale Galassie, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson, 2nd Floor
Springfield, IL 62761

**Re: Illinois Department of Public Health CON Public Hearing 10-090 Centegra Hospital-Huntley, Huntley**

Dear Mr. Galassie:

I am speaking at the request of Sherman Health, located in Elgin, Illinois, which is opposing the need for Project 10-090, Centegra Hospital-Huntley, Huntley. This testimony provides a national perspective of the impact of healthcare reform and value-based care delivery on utilization trends and bed need calculations, including the determination of need for this proposed project.

As payment reform moves toward more outcomes-based payment (e.g., bundled payments, Pay-for-Performance), legislation is aimed at creating clinically integrated care delivery models and reimbursement. Traditional utilization study and bed need calculations are now becoming obsolete as healthcare continues this movement toward value-based care delivery over traditional volume-driven care. A case in point is the findings[1][2] of the impact on utilization of health reform in Massachusetts. Treatment intensity as measured by length of hospital stays decreased by one percent, while expanded insurance coverage resulted in a two percentage point decrease in the fraction of hospital admissions from the emergency room. Hospital inpatient admissions for treating preventable conditions also fell almost three percentage points.

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[1] Wright, Sarah H. The Impact of Health Insurance Reform in Massachusetts. *The NBER Digest*. The National Bureau of Economic Research. November 2010.
[2] Kolstad, Jonathan T. and Kowalski, Amanda E. The Impact of Health Care Reform on Hospital and Preventive Care: Evidence from Massachusetts. *NBER Working Paper*, No. 16012, May 2010. © 2010 by Jonathan T. Kolstad and Amanda E. Kowalski.

The emergence of patient-centered medical homes, bundled payments, clinical integration, and accountable care organizations are directing the organization and delivery of healthcare away from the traditional fee-for-service, volume-based model. In the next few years, providers will begin to experience the impact from this paradigm shift in care delivery and reimbursement away from the inpatient, acute care hospital-driven delivery system towards one that is more clinically integrated, coordinated, and ambulatory-based. Examples of where this change has occurred include Brown & Toland in San Francisco, California; Greater Rochester IPA ("GRIPA") in Rochester, New York; and Advocate Health Care in Oak Brook, Illinois.

These trends are also supported by the latest future trend reports published by leading national healthcare research firms. Sg2 forecasts[3] health reform will result in a decline in inpatient utilization and increase in outpatient utilization. The HFMA report "*Ambulatory Stands Out Under Reform*"[4] states that inpatient utilization and margins have stagnated, with rate of inpatient admissions declining by ten percent from 1987 to 2007. A recent Thompson Reuters™ report[5] notes the "demand for outpatient services will grow and ambulatory care will be prioritized" as a result of payment reform initiatives such as bundled payments, Pay-for-Performance, and episode-based payments. The Advisory Board issued a report[6] last year that discussed the changing role of the traditional acute care model and the reduction in inpatient utilization that is likely to result. In this report, The Advisory Board notes that inpatient admissions were already deteriorating before the worst of the downturn of the economy. In addition, Pay-for-Performance initiatives are targeting cuts on hospital-based care, "making specialty care less lucrative, more efficient, and penalizing lack of coordination." In this post-reform healthcare landscape, providers will face new payment methodologies that will fundamentally change their business models and organizational design and further drive the need to leverage interdependency with physicians and value-based alignment.

Market consolidation of providers will accelerate in 2011 and beyond. Payment reform will drive regional health system consolidation at the service line level for high resource intensive services. The HFMA report[4] sites reform legislation aimed at reducing costs of episodic care for

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[3] Sg2 Forecasts Inpatient Services to Decline 1.9% and Outpatient Services to Grow 30% Over the Next Decade. *Press Release*, June 9, 2010.
[4] Johnson, T.K. Ambulatory Care Stands Out Under Reform. *HFM. Healthcare Financial Management*, 64(5):56-63, May 2010.
[5] Dunn, D., Lewandowski, D., and Pickens, G. The Influence of Reform on Local Coverage and Utilization: White Paper. Thompson Reuters™, September 2010.
[6] *Future Strategy, Future Growth: How the Recession and Reform Will (and Won't) Change Hospital and Health System Economics. White Paper.* May 19, 2010. © 2010 The Advisory Board Company.

chronic conditions that should be managed proactively outside of the acute care setting. Therefore, providers should expect increased mergers, closures, and conversions with surviving health systems restructured to provide high value (high quality, low cost). These restructured systems will be clinically integrated across facilities and with physicians, have geographically distributed primary care physicians ("PCPs") and access points, and be operating at 90 to 95 percent occupancy with high throughput.

The emergence of new care delivery and payment models reflect this trend toward value over volume incentives (Centers for Medicare & Medicaid Services ("CMS") demonstrations, commercial payer pilots, etc.). Pay-for-Performance and bundled payment programs will drive further physician alignment and collaboration as a mechanism to improve efficiency and improve overall quality by moving beneficiaries to participating acute care episode ("ACE") demonstration providers. The goal of these programs is to reduce or stabilize growing costs to Medicare for acute care services by maximizing the use of available capacity in high quality providers. Clinical integration and accountable care organization ("ACO") focus will be to improve population health and preventive care. As a result, the projected inpatient utilization per capita will decrease.

Benefit design is now focused on high deductible, high copay health plans that will soften demand for diagnostic testing and procedures as consumers become accountable for a larger percentage of their healthcare costs.[7] Efforts to "bend the cost curve" will result in doing less (i.e., lower utilization) and paying less. This trend is demonstrated in recent changes in Medicare payments, or actually reduction in payments. Medicare is no longer paying for hospital-acquired infections.[8] Medicare is also reducing payment for all hospital readmissions[9] for heart attack, heart failure, and pneumonia (up to one percent reduction in FY 2013, up to two percent in FY 2014, and up to three percent in FY 2015 and beyond). Beginning in FY 2015, Medicare can expand this list to include an additional four conditions, such as chronic obstructive pulmonary disease ("COPD"), cardiac and vascular procedures, and other conditions or procedures as the Secretary of Health and Human Services determines appropriate.

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[7] Syre, Steven. Picturing lower costs. *The Boston Globe*. January 25, 2011.
[8] Paddock, Catherine. Medicare Will Not Pay For Hospital Mistakes And Infections, New Rule. Medical News Today. August 20, 2007. © Medical News Today http://www.medicalnewstoday.com/articles/80074.php
[9] Patient Protection and Affordable Care Act. Title III, Subtitle A; Part 3, Sec. 3025. Hospital readmissions reduction program. May 1, 2010.

Patient Centered Medical Home pilot programs have also demonstrated significant declines in inpatient admissions and readmissions, improved quality, lower costs, and overall better value through adoption of medical homes. For example, Geisinger Health System saw a 15 percent decrease in hospital admissions for a savings of $3.7 million. Community Care of North Carolina experienced a 40 percent reduction in Medicaid hospital admissions.[10]

Employers are also developing innovative programs to manage health costs, many in partnership with local insurers. Boeing partnered with Regents Blue Cross in Washington to work with three clinics to build "Ambulatory ICU" models for 700 predicted high cost employees and dependents. This program resulted in a 28 percent decline compared to baseline in hospital admissions.[11] IBM and UnitedHealthcare have collaborated on a primary care medical home initiative in Arizona[12] with the goal of enhancing patient access to quality care and improving the care of chronic conditions.

Insurers are also making a move toward global payment and value-based care reimbursement. Blue Cross Blue Shield ("BCBS") of Massachusetts is driving a move toward global payments.[13] Blue Cross Blue Shield of Illinois ("BCBSIL") and Advocate Health Care signed an accountable care agreement[14] to improve performance and delivery of quality healthcare service. BCBSIL is also partnering with the Illinois Hospital Association to reduce readmission rates, as Illinois ranked 44th among states for Medicare 30-day readmission rates.[15] Commercial insurers in Michigan are collaborating to use BCBS of Michigan's Physician Group Incentive Program for medical home to manage chronic diseases through the CMS Innovation Center.[16]

Based on these results, it is clear that the emerging payment and care delivery models have significant implications on current and projected capacity for inpatient, acute care market

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[10] Fields, D., Leshen, E., and Patel, K. Driving Quality Gains and Cost Savings Through Adoption of Medical Homes. *Health Affairs*, May 2010; 29(5):819-826. Appendix Exhibit 1.
[11] Milstein, A. and Kothari, P. Are Higher-Value Care Models Replicable? *Health Affairs Blog*, October 20, 2009. http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/
[12] cmeans. IBM, UnitedHeatlhcare collaborate on medical home initiative for Ariz. Docs. *Healthcare IT News*, February 9, 2009. http://www.healthcareitnews.com/news/ibm-unitedhealthcare-collaborate-medical-home-initiative-ariz-docs
[13] Weisman, Robert. Blue Cross CEO says providers must control costs or else. *The Boston Globe*. January 23, 2011. © 2011 Globe Newspaper Company.
[14] Jaspen, Bruce. Blue Cross, Advocate raise bar on accountability. *Chicago Breaking Business*. October 6, 2010. http://chicagobreakingbusiness.com/2010/10/blue-cross-advocate-deal-raises-bar-on-accountability.html
[15] Page, Leigh. Illinois Blues, Hospital Association Partner to Reduce Readmission Rates. *Becker's Hospital Review*. February 2, 2011.
[16] Paul, Shannon. Michigan Health Insurance Payers Collaborate in National Program to Improve Health Care. *Blue Cross Blue Shield of Michigan Blog: Blues Perspectives*. November 17, 2010. http://bcbsmblog.com/2010/11/17/michigan-health-insurance-payers-collaborate-in-national-program-to-improve-health-care/

providers. Closer alignment, collaboration, and clinical integration with physicians by hospitals will be critical to long-term success, in demonstrating better value through improved outcomes, lower costs, and reduced variation in care. Physicians make or break the care model, and new incentive models are also directly impacting physician practice patterns and utilization. These market forces will drive decreased inpatient utilization by physicians, creating more capacity at existing facilities or restructuring existing capacity to meet reduced inpatient demand (i.e., smaller acute care/inpatient footprint).

In summary, the traditional volume-based demand and utilization projection methodologies in use today do not account for these innovations in care delivery and payment models. These models focus on chronic disease management and care coordination that are designed to keep patients out of the higher cost, acute care inpatient setting and therefore consume fewer resources. Decision-making based on this outdated approach will result in an overestimation of future inpatient need. This will drive unnecessary capital investment and create additional inpatient capacity that will continue to underperform financially and clinically in a value-based reimbursement environment.

Sincerely,

Steven T. Valentine
President