The Impact of the Affordable Care Act on UC Irvine Health

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Overview

• About UC Irvine Health
• An Overview of the Affordable Care Act (ACA)
• UC Irvine Health’s strategy in response to the ACA
About UC Irvine Health
What is UC Irvine Health?

UC Irvine Health comprises the clinical, medical education and research enterprises of the University of California, Irvine.

UC Irvine Medical Center is a 411-bed acute care hospital providing tertiary and quaternary care, ambulatory and specialty medical clinics, behavioral health and rehabilitation. It is the primary teaching location for UC Irvine School of Medicine.

The School of Medicine is located at the UC Irvine campus and is comprised of 25 departments, 540 clinical faculty, 56 residency and fellowship programs and 640 trainees.
Mission & Vision

Our Mission
Discover. Teach. Heal.

Our Vision
To be among the best (top 20) academic health centers in the nation in research, medical education and excellence in patient care.
## Awards & Accolades

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<tr>
<th>More than 100 physicians are listed as Best Doctors in America by Best Doctors, Inc.</th>
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<td>UC Irvine Medical Center, ranked No. 1 in Orange County, is rated among the country’s best hospitals by U.S. News &amp; World Report — for 13 years and counting.</td>
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<td>Chao Family Comprehensive Cancer Center is one of 41 comprehensive cancer centers in the United States and the only one in Orange County.</td>
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<td>Joint Commission awarded advanced certification as Orange County's first Comprehensive Stroke Center, an advanced designation reserved for hospitals capable of receiving and treating the most complex stroke cases.</td>
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<td>UC Irvine Medical Center is Orange County's only Level I adult and Level II pediatric trauma center</td>
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<td>UC Irvine Health School of Medicine, one of the top U.S. medical schools for research, is where our groundbreaking research and treatment advances are imparted to the rising practitioners of tomorrow.</td>
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# UC Irvine Health: by the numbers

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<th><strong>561,021</strong></th>
<th><strong>13,332</strong></th>
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<td>Visits to the emergency room, and hospital and physician practices. (FY 2012)</td>
<td>Surgeries (inpatient and outpatient) (FY 2012)</td>
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<th><strong>3,600</strong></th>
<th><strong>411</strong></th>
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<td>Trauma patients treated annually – more than half of Orange County’s traumas</td>
<td>Licensed beds</td>
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<th><strong>450</strong></th>
<th><strong>4,800</strong></th>
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<td>Primary and specialty care physicians</td>
<td>Medical center employees</td>
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The Affordable Care Act
• Unsustainable growth in U.S. healthcare costs is the underlying impetus behind the ACA and its initiatives:
  o Industry waste and misaligned incentives
  o Growing senior population
  o Smaller ratio of workers to beneficiaries
  o Strains U.S. economic competitiveness

Beyond the Obamacare debate -- why does health care cost so much?
By John Robbins, Published June 28, 2012 - FoxNews.com

“The cost of health care just keeps on rising. In fact, medical care now represents nearly 20% of total US GDP.

Health care spending is so far out of control that not only individuals and families, but the entire economy is buckling under the strain. General Motors spends so much money for its employees’ health care that Warren Buffet has called the corporation “a health and benefits company with an auto company attached.” Each year, General Motors, like Ford and other U.S. automakers, pays more than $1,500 in health care costs for every car they make. Japan’s Honda pays only $150.

The chairman and CEO of Starbucks, Howard Schultz, says that his company spends more money on insurance for its employees than it spends on coffee.”
Enter: Triple Aim

Health of a Population

Experience of Care

Per Capita Cost

The *Triple Aim*
ACA Overview and Timing

Hospital Regulatory Timeline

- **October 1, 2011**: MU year 2 starts for hospitals that attested in 2011
- **July 3, 2011**: Last day to begin 90 days of MU attestation for first time
- **September 30, 2011**: End of MU year for attesting in 2012
- **October 1, 2011**: MU year begins for all hospitals that have previously attested
- **November 1, 2011**: Meaningful Use (MU) Payments
- **July 1, 2012**: Last date to attest to Stage 1 of MU and avoid 2013 penalties
- **July 3, 2013**: Last time to begin demonstrating MU and receive maximum incentive amount
- **October 1, 2013**: Stage 2 of MU begins
- **July 1, 2014**: Last date to attest to Stage 2 of MU and avoid 2015 penalties
- **July 1, 2015**: Last date to attest to Stage 3 of MU and avoid 2016 penalties
- **October 1, 2015**: MU penalties of 50% of update begin
- **October 1, 2016**: MU penalties of 26% of update begin
- **October 1, 2016**: MU penalties of 76% of update begin

**Notes:**
- Performance measurement periods for hospital readmissions not yet established for 2013 and beyond
- Performance measurement periods and penalties for HAC not yet established
- ICD-10 deadline of October 2013 has been delayed for certain entities. Entities affected and new timeline not yet confirmed
- For hospitals, penalties for not meeting Meaningful Use are a % of the CMS annual payment update incentives and penalties for HAC, VBP, and Readmissions are a % of Medicare reimbursement
- This is accurate as of 3/30/2013
### Drivers / Forces of Change

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<th>Category</th>
<th>Details</th>
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| Population health/focus on high-cost populations | - Redesigning access and care delivery  
- Targeted / proactive management of chronic conditions  
- Application of innovation / technology  |
| Payment reform                   | - Transition to “risk” payment models  
- Primary care required  
- Competencies to manage lower utilization  
- Lower cost of care settings  |
| Insurance expansion              | - Material expansion of coverage / newly insured aggressive price and “value” emphasis  |
| Empowered Purchasers             | - Demanding price and outcome transparency | “value”  
- Price sensitivity increasing |
| Quality initiatives              | - Systemic monitoring and management of outcomes  
- Clinical protocols, pathways, and process adherence  
- Material incentives and penalties (government now, private to follow) |
| Declining reimbursement          | - Strategic cost transformation / reduction strategies |
UC Irvine Health Strategies
Network Development Affiliation
Network Development: Affiliation

Key Strategy: Establish a community based primary care network that utilizes UC Irvine Health services (Medical Center & MDs)

Objectives

• Market share growth through a stable and loyal referral base which targets commercial and Medicare lives.

• Secure volume which is at risk of being locked into large area networks.

• Repatriate UC Irvine Health employees that currently utilize other providers.

• Primary and secondary care offerings that complement existing tertiary / quaternary strategies.

• Obtain competencies and programs to manage and administer population health.
Network Development: UC Health & UC Care

UC Health
• Improved market share through contracting
• Identifying synergies and collaboration between services
• Leveraging expertise and centers of excellence

UC Care
• UC Care is a three-tier PPO plan just for UC
• Care from UC physicians and medical centers as well as the entire Blue Shield PPO network of providers
• Coverage for non-network providers
Portfolio Analysis

Key Strategy
A detailed performance analysis and prioritization of 16 of our top service lines.

Objectives
• Engage key stakeholders in the process to develop and gain consensus on the criteria used for ranking and prioritizing.

• Determine which programs should be considered “priority” for investment, which should be maintained at current performance levels, which should be repositioned, and which should be considered for partnering/divesting.
UC Irvine Health Strategies
Facility Master Plan
Facility Master Plan

Inpatient volume over the next 10 years is expected to decline while outpatient volume is forecasted to grow considerably.
Facility Master Plan

Key strategy
Develop a comprehensive Facility Master Plan to evaluate aging facilities, the comprehensive plan identifies new and innovative models of care delivery that are patient-centric, efficient and high quality.

Objectives
To achieve a new care delivery model that is patient centric, cost effective, high quality and efficient. The FMP will be the vehicle for this transformation.
Key strategy
An enterprise-wide initiative toward a comprehensive, electronic medical record (EMR), aligned with meaningful use requirements of ACA.

Objectives
• Provide clinical information to caregivers whether they are on-site or remote
• Complete transition to an electronic medical record
• Improve patient safety through the use of improved functionality, safeguards and data
• Enhance the patient experience by providing faster appointments and registration and improving communication among caregivers
Thank you.