PLAN FOR INTEGRATED AND COORDINATED CARE

Significant Cost Savings and Health Improvements Will Require Fundamental Change

We believe that the ultimate success of health care reform depends on whether the health care delivery system throughout the United States, in large cities and in small towns, can change. This change must be sufficient to greatly improve the coordination and cooperation of all caregivers, especially physicians and hospitals.

The objective of the Congress and the Administration to improve payment mechanisms, coverage of the uninsured and access to care are laudable and essential. But they require changes in the way care is organized and delivered. These changes can come only from the care system itself through clinical integration and the changes it requires.

Accountable Care Organizations (ACOs) have been proposed as a method for altering the delivery of care. As described in the Senate Finance Committee Option Paper of April 29, 2009, ACOs make it possible for integrated providers to share in efficiency gains resulting from joint responsibility and care for Medicare beneficiaries. An ACO, as described, must already be a fully integrated organization at the time of qualification. Organizations that qualify as ACOs are likely to be large institutions that long ago made the transition towards integration, often through the employment of physicians.

Community Hospitals Require Transitional Support

At present, most community hospitals and rural hospitals and free-standing larger hospitals will not be able to qualify as ACOs, nor will they be able to independently achieve the sort of change that is necessary to allow them to transition into ACOs in a short time.

There is no program to encourage community and rural hospitals and other providers to begin the process of clinical integration. The present organization of health care is built around hospitals and fee-for-service medicine practiced by independent physicians. Providers have not begun to clinically integrate, do not provide coordinated care, and while many community and rural hospitals employ some physicians, their culture remains rooted in the fee-for-service practice of

medicine. There is no organizing center of care, either for individuals (especially those with chronic disease) or for a population, nor is wellness, prevention or the promotion of health organized or stressed within the system. Our current system is basically a 1960's system for the delivery of care.

Integrated Health Clinics Provide a Viable Way to Transition to ACOs

Merely changing reimbursement methods or amounts will not change the health care system unless the incentives and diminished payments are so great that they put care at risk. What we believe is needed is a process to move community and rural hospitals towards qualification as Accountable Care Organizations. We propose what we call an Integrated Health Clinic serve as a transitional model of integrated care delivery. The Integrated Health Clinic would be established as a separate organization from the hospital or other provider, but as a part of the same health care organization governed by a common parent board. The Integrated Health Clinic would connect to the hospital for inpatient services and itself serve the outpatient needs of the local community.

An Integrated Health Clinic could start small, employing nurse practitioners, physician assistants and others to coordinate and provide care along with employed and contract physicians. As the Clinic's patients grew in number, so would employed and contracted staff. All physicians used in the clinic would be either employed or with contracts. And so would its ability to add coordinated chronic care, wellness, and prevention programs for the promotion of health. The Clinic would accept bundled payments for ambulatory, acute and post-acute care.

New means of payments other than bundled payments would be possible as the number of clinic patients grew closer to the number necessary to qualify as an ACO. The Integrated Health Clinic would be able to quickly and efficiently serve individuals and families newly covered as a result of the health reform bill in a patient-friendly environment. Or, the clinic could begin to function without the need to wait for regulations from any federal agency.

And the clinic could begin to use an electronic medical record system, at its beginning, and with less cost or problems of transitioning all the hospital and all the physician records at the same

time. As the clinic grew, the hospital and physicians in the community would begin to transition as well. Eventually, experience would permit the Clinic to contract for care with the federal government and perhaps others.

The Legislation Can Facilitate Integration in Community Hospitals and Rural Hospitals

To facilitate the establishment of such clinics and their eventual qualification as ACOs, two new programs would accelerate the process.

(1) Present federal and state laws and regulations that would inhibit or prevent the progress of the transition to ACOs would not be applicable to those Integrated Health Clinics that meet certain criteria to be set forth in the Act. This would enable Integrated Health Clinics to grow rapidly without legal challenge and experiment to deliver care in new organizational ways.

(2) Most community and rural hospitals would have difficulty in finding sufficient working capital to transition from their present situations and to qualify eventually as an ACO. Since finding working capital loans under present economic circumstances is unlikely, a grant program to facilitate the organization and operation, including information technology, of the clinic until its business grows sufficiently would be needed and would have the effect of jump starting the transition. Grants would be made to those hospitals and local systems that meet certain criteria to be set forth in the Act.

(3) In order to persuade present hospital organizations to move to take cost out of the system by beginning wellness, promotion of health, these concepts could be required if health organizations wanted 501(c)(3) exemption.

Hospitals must have flexibility to change the way in which they provide care and move toward a qualified ACO. Establishing Integrated Health Clinics is a way to begin this process. More and more disorders that, in the past, required the skill and judgment of physicians and hospitals can be done in many cases by less expensive caregivers in less costly environments. A clinic will permit care for many conditions to move from the highest cost to the lowest cost commensurate

with safety and the reasonable competence of the caregiver and to begin population wellness, prevention and the promotion of health.

This will also permit further change as more and more providers qualify as ACOs. The aim is to reduce cost to all, not just reduce the rate that costs increase. The aim is to care efficiently and with dignity for a large group of people not now adequately cared for as they receive coverage under health reform. And the aim is to break out of the present cultural situation and legal impediments to the accomplishment of these goals.

Language for the Health Reform Bill

Following is language to insert into the Health Reform Bill to begin to accomplish the objectives of changing the organization of the way care is delivered to make it more able to serve the newly covered population, deliver care more effectively and eventually at less cost and begin the process of allowing new methods of payment such as bundled and global payments.

We believe this is a way to transition community and rural hospitals with little risk. And, we believe it will work to allow transition to the kinds of practices that the President discussed in the first paragraph of his June 2, 2009 letter to Senators Kennedy and Baucus as follows. We should ask why places like the Mayo Clinic in Minnesota, the Cleveland Clinic in Ohio, and other institutions can offer the highest quality care at costs well below the national norm. We need to learn from their successes and replicate those best practices across our country. That's how we can achieve reform that preserves and strengthens what's best about our health care system, while fixing what is broken.

(a) DEFINITIONS. –

(1) INTEGRATED HEALTH CLINIC. – In this subsection, the term "Integrated Health Clinic" means an organization that meets the following organizational and operating criteria:

(A) is owned or controlled by, or comprised of, two or more institutional providers or groups of health care professionals that are eligible for participation in Medicare Part A or Part B;

(B) is organized for the purpose of providing health care, improving the quality of health care, and reducing costs associated with the provision of health care provided to Clinic patients;

(C) participates in Medicare and Medicaid;

(D) requires all of its participating providers to participate in Medicare and Medicaid;

(E) is not excluded or precluded from participation in any federal or state health care program;

(F) is organized to receive payment from government and private health plans in a manner that promotes cost reductions, including:

(i) accepts "global" or "bundled" payments; and

(ii) accepts fixed-fee or capitated payments;

(G) accepts all patients enrolled in Medicare and Medicaid;

(H) accepts all patients newly insured pursuant to the Health Reform Act of 2009;

(I) does not discriminate on the basis of any prohibited criteria;

(J) does not discriminate with respect to the provision of care to patients of the Clinic on the basis of the patient's insurance status or ability to pay;

(K) has a contract with a full-service acute care hospital for care of Clinic patients;

(L) maintains an affiliation with health care providers as necessary to meet the needs of its enrollees;

(M) maintains a qualified workforce;

(N) has a qualified medical director;

(O) coordinates inpatient and outpatient care for its enrollees, including coordination of wellness and prevention services and care for chronic disease;

(P) offers wellness, prevention, and health promotion services;

(Q) develops, and requires its participating providers to follow, guidelines, protocols, evidence-based medicine, and clinical pathways;

(R) uses electronic medical records by the deadline set forth in the American Recovery and Reinvestment Act of 2009;

(S) requires its participating providers to use electronic medical records by the deadline set forth in the American Recovery and Reinvestment Act of 2009;

(T) qualifies as an "organized health care arrangement" pursuant to the Health Insurance Portability and Accountability Act regulations, 45 C.F.R. Parts 160, 162, and 164; and

(U) has contracts for post-acute patient care to permit bundling such payments.

(2) SECRETARY. – In this subsection, the term "Secretary" means the Secretary of the Department of Health and Human Services.

(b) LISTING. – Integrated Health Clinics may obtain the benefits of this subsection by becoming listed by the Secretary. The Secretary shall list Integrated Health Clinics that:

(1) certify to the Secretary that they satisfy the definition of Integrated Health Clinics set forth in subsection (a); and

(2) every three years, demonstrate to the satisfaction of the Secretary that the Integrated Health Clinic continues to meet the criteria set forth in subsection (a).

(c) CONFLICTING LAWS. —

(1) FEDERAL LAWS PREEMPTED. – Federal laws and regulations which would prevent an Integrated Health Clinic or any of its participating providers from carrying out the objectives of the Integrated Health Clinic, as set forth in this subsection, are preempted and shall not apply.

(2) STATE LAWS PREEMPTED. – State laws and regulations which would prevent an Integrated Health Clinic or any of its participating providers from carrying out the objectives of the Integrated Health Clinic, as set forth in this subsection, are preempted and shall not apply, except the following laws shall not be preempted:

(A) building codes;

(B) life safety codes; and

(C) wage and hour laws.

(3) ACCREDITATION STANDARDS. – Federal laws and regulations granting deemed status, for purposes of Medicare, Medicaid, or other federal health care program

participation, on a facility that has demonstrated compliance with approved accrediting organizations' standards shall be preempted to the extent that those laws would prevent an Integrated Health Clinic or any of its participating providers from carrying out the objectives of the Integrated Health Clinic, as set forth in this subsection. As a condition of obtaining and maintaining deemed status, accrediting organizations shall not require Integrated Health Clinics to abide by any accreditation standard if the standard would prevent the Integrated Health Clinic or any of its participating providers from carrying out the objectives of the Integrated Health Clinic, as set forth in this subsection.

(d) INTEGRATED HEALTH CLINIC ASSISTANCE. –

(1) ELIGIBLE INTEGRATED HEALTH CLINIC. – The term "Eligible Integrated Health Clinic" means an integrated health clinic that has been listed as an Integrated Health Clinic by the Secretary of the Department of Health and Human Services pursuant to subsection (a).

(2) GRANT PROGRAM. –

(A) Of the funds of the Health Reserve Fund, the Secretary shall use not more than $500,000,000, to remain available until September 30, 2012, to carry out a program of grants to assist Eligible Integrated Health Clinics with start-up and operating costs.

(B) The Secretary shall make grants to Eligible Integrated Health Clinics, under this subsection on a first-come, first-served basis, that demonstrate to the satisfaction of the Secretary that the Clinic will:

(i) use the funds to –

(I) promote the integration of health care providers;

(II) promote coordination of patient care;

(III) provide greater access to health care for patients within the Clinic's geographic service area;

(IV) reduce the cost of providing care; and

(V) improve the quality of care provided to patients within the Clinic's geographic service area; and

(ii) not later than 12 months after the date on which the Secretary provides assistance to the Eligible Integrated Health Clinic, submit to the Secretary a report that describes –

(I) the manner in which the assistance was spent;

(II) the manner in which the factors outlined in subsection (d)(2)(B)(i) have been monitored; and

(III) any measurable change in the factors outlined in subsection (d)(2)(B)(i) as a result of the Clinic's receipt of assistance.

(C) Timing. – Not later than 120 days after the date of enactment of this Act, the Secretary shall make grants to provide assistance under this subsection.

(3) REPORT TO CONGRESS. – Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report that –

(A) describes in detail the manner in which this grant program has been carried out; and

(B) includes the information reported to the Secretary under paragraph (d)(2)(B)(ii).

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