Health System Transformation and Acute Care in Alameda County

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Not all hospitals are alike
Table 1. Family income fell in every income category between 2007 and 2010

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>10th percentile</td>
<td>19,100</td>
<td>17,000</td>
<td>16,200</td>
<td>15,000</td>
<td>−15.2</td>
<td>−21.5</td>
</tr>
<tr>
<td>25th percentile</td>
<td>34,600</td>
<td>34,200</td>
<td>32,400</td>
<td>31,200</td>
<td>−6.4</td>
<td>−10.0</td>
</tr>
<tr>
<td>Median</td>
<td>68,400</td>
<td>66,000</td>
<td>64,700</td>
<td>61,100</td>
<td>−5.4</td>
<td>−10.7</td>
</tr>
<tr>
<td>75th percentile</td>
<td>122,000</td>
<td>122,300</td>
<td>115,600</td>
<td>112,400</td>
<td>−5.3</td>
<td>−7.9</td>
</tr>
<tr>
<td>90th percentile</td>
<td>188,300</td>
<td>187,500</td>
<td>183,700</td>
<td>179,100</td>
<td>−2.5</td>
<td>−4.9</td>
</tr>
<tr>
<td>95th percentile</td>
<td>246,000</td>
<td>232,100</td>
<td>235,600</td>
<td>226,300</td>
<td>−4.2</td>
<td>−8.0</td>
</tr>
</tbody>
</table>

SOURCE Authors’ calculations from the Current Population Survey of the U.S. Census Bureau.
NOTES: Family income is adjusted to 2010 dollars and normalized to account for family size. See Technical Appendix A for details.
What drives hospital costs up?

- Misaligned incentives
  - Toward volume not health
- Technology
- Higher prices for comparable treatments
- Personnel costs
- Medi-Cal underpayment
- Bargaining power of payers vs. providers
- Relatively minor factors: aging, disease
Bargaining Power Matters

Figure 1. Prices and Contribution Margins for Commercially-Insured Patients in Concentrated and Competitive Hospital Markets

<table>
<thead>
<tr>
<th>Service</th>
<th>Prices</th>
<th>Contribution Margins</th>
<th>Percent Contribution Margins</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Concentrated Markets</td>
<td>Competitive Markets</td>
<td></td>
</tr>
<tr>
<td>Angioplasty</td>
<td>$32,411</td>
<td>$20,173</td>
<td>62%</td>
</tr>
<tr>
<td>Pacemaker Insertion</td>
<td>$47,477</td>
<td>$23,872</td>
<td>50%</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>$30,399</td>
<td>$11,056</td>
<td>55%</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>$26,713</td>
<td>$6,467</td>
<td>55%</td>
</tr>
<tr>
<td>Lumbar Fusion</td>
<td>$29,140</td>
<td>$16,412</td>
<td>56%</td>
</tr>
<tr>
<td>Cervical Fusion</td>
<td>$51,998</td>
<td>$28,101</td>
<td>54%</td>
</tr>
</tbody>
</table>

Source: Dr. Jamie Robinson, UC Berkeley, November 2011
Affordable Care Act and Hospitals

- Health insurance reform
- Incentivizing health and paying for quality
- Transforming the safety net
- Promoting integration
Affordable Care Act: Health insurance reform

• New incentives for and pressures on payers (Govts, Exchanges, plans, and businesses)
  – Increasing prevalence of products where consumer pays marginal cost of system
    • “Private label” offerings
    • Tiered networks
    • Reference pricing
    • But not all systems are alike
  – Contracting with more measures for quality, efficiency
    • Private sector innovation empowered by regulatory reform
Affordable Care Act: Incentivizing health and paying for value

• Medicare reducing payments to hospitals in top tier for:
  – Healthcare acquired infections
  – Unnecessary Readmissions

• Hospital Value-based Purchasing initiative
  – Medicare rewards for achieving quality

• Temporarily higher payments for primary care
Affordable Care Act: Shoring up safety net

- Coverage expansion
  - Managing DSH reductions
- Medi-Cal Waiver
  - Delivery System Reform Incentives Payments (DSRIP)
- Increased funding for community clinics?
Affordable Care Act: Promoting Integration

• ACOs
  – Medicare Shared Savings Program
  – Pioneer ACOs
• California Health Benefit Exchange
  – “Change Agent” model
• Unintended consequences
  – Increasing provider leverage via ACOs?
  – Undermining integrated systems, Exchanges, high-value innovation through poorly-designed taxation?
You can’t “repeal and replace” reality

“There’s no back to go to.”

Ed Murphy, former CEO
Carillion Clinic, Roanoke Virginia
Thank you

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