Report On The Financial Benefit of Partnering for Health Services Clinic to the Altoona Regional Health System.

The study is an analysis of Partnering for Health Services which started in 1999 as a free clinic, then was transformed into an insurance administration free office in 2002 covering all services at the local network of Altoona Regional Health System. These services include the same provided by any traditional health plan (prescription, primary care, specialty care, DME, radiology, lab etc.). We set out to show the financial benefit to Altoona Regional Health System by investing into the outpatient clinic.

Program Cost

The clinic is designed to move the treatment of the uninsured from the inpatient setting to the outpatient setting. The funding for the clinic is provided by a subsidiary company, Partnering for Health Services (PHS), which is part of the Altoona Regional Health System (ARHS) Lexington holding company. There is a pediatric and adult Medicaid dental clinic that is part of PHS, its budget is not reported in this study. Here are the last three years budgets of the medical clinic:

(Figure 1) Partnering for Health Services Operating Budget

Budget Years	2009-2010	2010-2011	2011-2012
Cost to ARHS	$300,938	$413,937	$468,158

The increase in budget from 2010-2012 was due to construction and a $24,000 medical director salary. We also added psychology services as part of grant we received from The Robert Wood Johnson Foundation as result of a national award won in 2011. PHS also provided free outpatient testing, radiology, admissions, ER visits for 1100 patients in the practice. Most of these services are for prevention and chronic disease management. We believe it is much more cost effective to invest those dollars into cost controlling our sick uninsured patients with aggressive outpatient management.

(Figure 2). Gross charges of all procedures, radiology, admissions, ER visits, and all other services provided by Altoona Regional Health System. Fiscal year July 1 through June 30th.					
Budget Year	**2009**	**2010**	**2011**	**2012**	**2013**
Gross Billed Charges	$ 2,285,786	$ 2,323,200	$ 2,760,594	$ 3,606,084	$ 3,773,463
Actual Cost at 37%	$ 845,740	$ 859,584	$ 1,021,419	$ 1,334,251	$ 1,396,181
Percent Change	N/A	12.3%	15.8%	23.4%	4.6%

In 2012, we instituted a policy that testing would be standardized using ACP guidelines and saw a drop of the growth rate downward to just below 5%.

Revenue and Savings Center

From 2009-2012 the average sick call visits to the clinic instead of the emergency room was 55 a month over the four year period. A sick call was defined as a visit to the clinic that would end up being an ER visit as defined by our providers and patients. Most of these visits were acute bronchitis in our COPD population that is 16.6% of the clinic's 1100 patient population. The rest of the visits were back pain, diverticulitis, acute headache, acute gastroenteritis, dehydration, atypical chest pain, anxiety attacks, fractures, shortness of breath and cellulitis.

(Figure 3) Visits to ARHS Emergency Room from 2005 -2013 from clinic patients			
Total ER Visits	**Total Billed Charges**	**Actual Cost at 37%**	**Actual Cost Per Visit**
375	$2,009,847	$ 743,643	$ 1,983.04

Total avoided average cost to the ER for the years 2009-2012 was $1,308,780 average per year.

(Figure 4) Visits to Partnering For Health Services in lieu of "ER" likely visits		
Total ER Visits Redirected to Clinic Per Year	**Actual ER Cost Per Visit**	**Actual Cost Avoided Per Year**
660	$1,983.04	$ 1,308,780

Hospital Limited Indemnity Insurance

The limited indemnity insurance plan, underwritten by Symetra Insurance, started in 2010 that covers hospital admissions, outpatient surgery, ER visits and inpatient physician payment. It has been in existence for the last 3 years and the program costs $99 a month paid by the patients. A 3 year average

of 154 out of 1100 patients purchased the insurance plan and we have not had a rate increase in 3 years.

(Figure 5) Payment from the insurance to Altoona regional, along with recaptured Medicaid payments			
Plan Years	**2010**	**2011**	**2012***
Revenue Received	$38,349	$90,498	$ 31,956

*Medicaid payments still pending

Total reimbursements from the insurance company back to providers in the community for all covered services have been approximately $250,000 from inception to date of this study. This is a considerable contribution from a population that previously provided zero revenue.

Hospital Admission Avoidance Cost

The hospital avoidance cost was derived from a study done at Altoona Regional that compared admissions from Partnering for Health Services with the two largest family practice groups, Blair Medical Associates (BMA) and Mainline Medical Associates (MLM), which consist of a total of 34 providers. BMA, MLM, PHS, all use the hospitalist service for admissions and we measured admission per year per provider per 1000 patients for the years 2009-2012 ages 18-64. We also took into account the health of each group by calculating the percentage of patients with HTN, DM, CVA, COPD, and CAD. We found the clinic patient to have a slightly higher percentage of all these (which we then can assume PHS is a sicker group) and found that PHS averaged 27 admissions per year per provider per 1000 patients over the 3 year period. MLM averaged 48.6. BMA averaged 50.7.

(Figure 6) Comparison of inpatient admission rates per thousand patients per year. Statistical data 2009 -2012			
Practice Model	**Blair Medical Associates**	**Mainline Medical**	**Partnering for Health**
Admissions Per Provider	50.7	48.6	27.0

The average admission cost to the hospital for an average length of stay of 4 days was $8,200. So, if PHS admitted 22.65 patients less than both groups the total cost savings was $185,730.

(Figure 7) Inpatient cost avoidance using Partnering For Health care model.			
Avg. Admission Cost Per Day	Avg. Length of Stay in Days	PHS reduced admissions vs. standard practice model per year	Actual cost savings to ARHS in avoided inpatient admissions
$ 2,050	4	22.65	$ 185,730

Total Cost Savings

(Figure 8) Total Return On Investment for ARHS with Partnering For Health Outpatient Charity Care Model								
Year	Clinic Budget	In-Kind Costs	Total Cost of Clinic	Avg. Avoided Cost of ER	Avg. Avoided Cost of Admissions	Avg. Total Costs Avoided	Symetra Payments/ Medicaid/Grants	Annual Net Difference to ARHS
2009	$ 212,950	$ 845,740	$ 1,058,690	$ 1,308,708	$ 185,730	$ 1,491,978	N/A	+$ 433,288
2010	$ 330,938	$ 859,584	$ 1,190,708	$ 1,308,708	$ 185,730	$ 1,491,978	$ 38,349	+$ 339,805
2011	$ 413,937	$ 1,021,419	$ 1,435,356	$ 1,308,708	$ 185,730	$ 1,491,978	$ 90,498	+$ 147,120
2012	$ 413,937	$ 1,334,251	$ 1,748,188	$ 1,308,708	$ 185,730	$ 1,491,978	$ 141,656	-$ 114,554
Totals	$1,371,762	$ 4,060,994	$ 5,432,942	$ 5,234,832	$ 742,920	$ 5,967,912	$ 270 503	+$ 805,659

Insurance Component

In September 2010, we launched a limited indemnity insurance product that would wrap around the existing clinic model. With the population of the clinic consisting of a 100% problem-seeking population for care purposes, the challenge was to see if the insurance-less office concept in Altoona could effectively manage and stabilize premiums rates. Adverse selection possibilities in a group of this type would be considered extremely high and normally force the insurance element to be unsustainable.

The reasons to add the insurance element were the following:

1. Provide peace of mind to the low income, working uninsured that is typically afforded to the higher income worker.
2. Instead of the hospital absorbing the patients' care as a complete loss, voluntary affordable premiums would now generate revenue back to the medical providers.
3. Provide predictability to the patient who would normally avoid medical care due to the unknown cost of treatment. This avoidance behavior has been proven by many studies to only exacerbate the cost of care to the providers and deteriorate the quality of life for the individual.

As of June 2013, the program has averaged a participation rate of approximately 154 members per month. The insurance was rolled out to clinic patients on a voluntary basis conditioned to already receiving all their medical care for free. The fact that this number of patients decided to purchase the expanded coverage for themselves was encouraging and proved that not everyone is looking "to get something for free". They had simply been priced out of the market by spiraling health insurance costs. The current trend projections in commercial health insurance offerings will only force more employees and individuals out the insurance market which will then trigger the accelerating "death spiral" for the insurance market. This occurs when pricing becomes such an obstacle to participation in the insurance marketplace that only the sick and elderly stay. This group then makes up the largest segment of the risk management pool. Our program to date has proven that insurance protection is still viable at the correct price point if packaged together with the community provider that previously was obligated to provide care with zero revenue in return.

After two full years of premium collections and paid claims data to draw from, our insurance company partner has been able to maintain plan premiums as originally quoted with ***zero increases*** to the subscriber/patient population. In an insurance market with trend increases alone accounting for a steady 10%-12% increase in group premiums, this is a truly notable accomplishment. Latest premium to claims data reflects a pattern of decreasing per claim costs as of June 2013. Loss ratios to the carrier appear to be widening, lessening the risk to them. Since this project is a unique collaboration between the hospital and the insurance company, communication between the two entities should allow a reasonable increase in reimbursements to providers while maintaining stable and affordable premiums.

Conclusion

The overall benefit to ARHS from Partnering for Health Services from the years 2009-2012 comes to $805,669. We believe that this is a conservative number because we cannot access the cost savings from inserting a chronically sick population and placing them into a practice that aggressively manages them. We see our patients on average 5 times per year. BMA and MLM see their patients on average 2.55 times per year. We also have an aggressive risk reduction program that involves diabetic educators, dieticians and soon a pharmacist. We believe this is the reason behind the lower admission rates and better outcomes. This was proven to be true in a large group of breast cancer patients in a study done Sept. 2012 in Annals of Family Medicine and for a population of diabetic patients in a study done by The Agency for Healthcare research and quality in 2012. We also believe we underestimate how many visits

to the ER were avoided in the routine preventative offices visits (example: A diabetic patient comes in for a routine checkup and also has bronchitis or cellulitis).

We have shown that it much more cost effective and beneficial for hospitals to perform charity care on an outpatient basis, rather than an inpatient environment. If ARHS didn't have PHS, they would have incurred 1.3 million dollars in cost from the ER visits that were avoided by those patients being seen in the office. Even the $ 114,445 loss they incurred in 2012 is far less the loss they would have incurred without the clinic. Also Senate Bill 5, which passed 2 months ago, will infuse $250,000-$500,000 into the hospital systems to help support a hospital-based clinic. The combination of all of these factors supports the establishment of these types of clinics in all hospitals systems across the commonwealth. The CBO estimates the best possible scenario for coverage under the Affordable Care Act is 20 million of the 50 million uninsured. If you subtract 11 million for illegal immigrants, that will still leave 19 million people without coverage. And with Medicaid expansion on hold in Pennsylvania and 21 other states, the number of people who flood the emergency room and are admitted will continue to rise. A study done in 2009 by The Agency for Healthcare Research and Quality, showed admissions from the uninsured rose by 34% from 1997-2009, which is double the rise of the insured admission rates. The need for this kind of clinic is imperative for hospitals across the commonwealth even if the ACA is executed perfectly. And most importantly, the working poor would finally get the care they need and deserve in a setting that preserves and respects their dignity as equally valuable members of the community.

Sources:

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