TORCH Conference
Spring 2022

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Topics

• Updates and Current Events
  • Directed Payment Programs and Medicaid Financing
  • RHC Modernization
  • PRF
  • DSH/UC
  • Pricing Transparency

• Preparing for the Future
  • Community Engagement
  • Under Arrangements
  • Medicare Advantage
  • Observations of Trends
Directed Payment Programs (DPP)

- District Court ordered CMS to issue a final approval or denial decision on the SFY2022 DPP programs by March 25, 2022.
- On March 25, 2022, CMS approved CHIRP, RAPPS, and TIPPS for 2022
  - QIPP was already approved for SFY 2022 on November 15, 2021
- HHSC and CMS have not agreed to an acceptable method of funding
  - Per CMS, all LPPFs will be subject to OIG Audits
- 2023 (Year 2) CHIRP applications were due on March 22\textsuperscript{nd} to HHSC
  - Private Hospital are required to pay a $8,500 application fee. Those fees were due on April 15\textsuperscript{th}
- IGT for CHIRP / RAPPS / TIPPS-DPP is due by May 6\textsuperscript{th}
- CMS has not approved the various DPP for 2023
Trial Status

• Trial is set for September 2022 on the 10 year extension.

• Primary issue is the revocation of the Trump Administration waiver extension by the Biden Administration
  • The injunction hearing had to prove that Texas would probably prevail, and the judge agreed.
  • If Texas prevails, the 10 year extension of the waiver would stand.
    • CMS will likely still be difficult to deal with on year by year approvals.

• In the March ruling, the judge also hinted that he would agree that the LPPF private payments are permissible, but that such issue was not plead by Texas
  • Did offer that he would rule if Texas amended his petition.
Directed Payment Programs

- **CHIRP (Comprehensive Hospital Increased Reimbursement Program)**
  - Replaces UHRIP program as of Sept 1, 2021 – **Now retro to this date**
  - Continues to provide a uniform rate enhancement similar to UHRIP
  - Uses average commercial incentive award payments to allow providers to earn higher reimbursement rates
  - Hospitals providing healthcare services to adults and children enrolled in STAR and Star + Plus. Eligible hospitals include children’s, rural, mental health, state owned and urban
  - All participating hospitals are required to report on all program measures in the components for which they are eligible

- **QIPP (Quality Improvement Payment Program)**
  - Incentive payment program for Texas nursing facilities for residents enrolled in STAR + PLUS
  - Providers earn payments for meeting participation and performance requirements
  - Non-state government owned facilities are eligible

Directed Payment Programs

• **RAPPS (Rural Access to Primary and Preventive Services Program)**
  - Directed payments program for rural health clinics that provide primary care and long-term care services to STAR, STAR +PLUS and STAR Kids members
  - Focus on management of chronic conditions
  - 2 types of RHC’s Eligible:
    - Hospital-Based (including non-state gov’t owned & private RHCs)
    - Free-Standing
  - 2 payment components:
    1. Monthly prospective uniform dollar increase
    2. Uniform % increase for certain services

• **TIPPS (Texas Incentives for Physicians and Professional Services)**
  - Value-based directed program for certain physician groups providing health care services to children and adults enrolled in STAR, STAR + PLUS and STAR Kids Medicaid programs.
  - Eligible groups include health related institutions, IME physician groups affiliated with hospitals and other physician groups
  - 3 payment components:
    1. Monthly performance incentive pmt
    2. Semi-annual performance incentive pmt
    3. Uniform rate increase on paid claims for certain services based on metrics achieved

• Source & More Info: https://www.hhs.texas.gov/doing-business-hhs/provider-portals/medicaid-supplemental-payment-directed-payment-programs/directed-payment-programs-
ALL DPP’s

- HHSC is going to cram through these programs as fast as possible
- Accelerating IGT payments
  - Various payment dates. We will send emails of deadlines to all on our list
  - The dates change very often
  - Cash flow concerns, especially for QIPP providers, may be critical
- The rules, processes, and payments will also be changing very quickly
- Data on the HHSC web site is not always up to date. It is changing too quickly.
Comprehensive Hospital Increase Reimbursement Program (CHIRP)

- Payments are to be made shortly (no promise of a date) for a retro on the first 6 months.
- Quality Measure Reporting for CHIRP Year 1 is due between April 29 to May 26th
  - HHSC is hosting a webinar on April 26th
- Comprised of two components:
  - UHRIP -
    - SDA Region calculation - AVERAGE
    - Offsets for NAIP
  - Average Commercial Incentive Award (ACIA). Average Commercial Rate (ACR)
    - Not average - Specific
- Open to six classes of hospitals: children’s, rural, state-owned that are not IMDs, urban, non-state owned IMDs, and state owned IMDs.
- IGT is accumulated and based on each SDA
Quality Metrics for the CHIRP ACIA
Rural Hospital Component

• For rural, this is comprised of two components:
  1. Tobacco Use: Screening & Cessation Intervention
     • Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user
  2. Influenza Immunization
     • Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

• Reporting periods for both:
  • October 2021 – measurement period of 1/1/21 to 6/30/21
  • April 2022 – measurement period of 1/1/21 to 12/31/21

• Payer types: Medicaid, uninsured, and other
• Must have at least one encounter for each component during the measurement period
Rural Access to Primary and Preventive Services (RAPPS)

- For RHC’s – hospital-based or free standing
- Application was due April 13th
- Quality Measure Reporting for RAPPS year 1 is due by May 26th
  - HHSC is hosting a webinar on April 26th
- Each SDA with at least one sponsoring governmental entity for the IGT
- Minimum volume of 30 Medicaid MCO unique encounters in the prior fiscal year
- Payment methodology:
  - Component 1 - Uniform dollar – 75% of total program value. Performance based
  - Component 2 - Percent rate increase for certain services. Providers must report quality metrics – 25% of total program value
RAPPS Metrics

- Component 1 –
  - Reporting on electronic health record (E.H.R) use
  - Telemedicine/telehealth capabilities
  - Care coordination
- Component 2 –
  - Providers must report quality metrics
  - Have not released codes
- Not very well defined, especially for the pay IGT and chase methodology
Texas Incentives for Physician and Professional Services (TIPPS)

- Application was due April 5th and is filed by hospital Physician NPI
  - Not for RHCs—RHCs are eligible for RAPPS
    - Physician can bill non-RHC services in a group and potentially qualify for TIPPS
    - This is primarily an URBAN and State & Large system program
DSRIP DY11 Schedule
April Reporting

• April 30, 2022  - Deadline for reporting to HHSC

• May 18, 2022  - HHSC will post estimated IGT for providers

• June 1, 2022  - IGT change forms due to HHSC

• June 15, 2022  - HHSC to send out IGT notifications

• July 6, 2022  - IGT settlement date

• July 29, 2022  - Payment to all providers
Medicaid Financing

• CMS is trying to limit these programs by attacking the source of the State match
• MFAR was the proposed rule, that was withdrawn
  • CMS is still trying to implement through approval process many of the MFAR principles. CMS admitted in the previous hearing.
• Community benefit programs – These were eliminated with the DAB trial. Still in District court December 2022
• LPPF’s – The local agreements between private hospitals are being attacked.
• Loans – If loans for IGT are made, then the source of repayment is an issue. If this is from program funds, this is an issue. This is recycling of federal funds.
Loans

• Very complicated issues
  • Is an MCO dollar still a Federal dollar?
  • Can State dollars be reused?
  • How long does it take for a dollar to lose this identity?
    • Permanent?

• Real issue – CMS wants “real” public funds - tax dollars
RHC Modernization Act

RHC Certified after 12/31/2020?
→ Cap of $113 per visit in 2022 (increasing by $13/year through 2028)

RHC Certified before 12/31/2020?
→ Cap of your 2020 per visit rate plus an adjustment for MEI (Medicare Economic Index) each year OR your actual cost per visit for the year (whichever is lower)
New Rules regarding Telemedicine visits in the RHC (during health emergency)

- Telemedicine is **NOT** an RHC encounter and should **NOT** be included in the visits on the cost report

- Payment for telemedicine visits are approx. $92.03/visit
  
  ➢ *Will increase each year with inflation*
PRF Phase 4 Payments

• 92% of all applications have now been processed as of April 13th
  • The remaining 8% will be processed before June of 2022
  • You have until June of 2023 to spend these funds
### PRF Phase 4 Payments (to date)

<table>
<thead>
<tr>
<th>Funding Distribution</th>
<th>Number of Providers</th>
<th>Payment Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Batch 1 - December 2021</strong></td>
<td>68,954</td>
<td>$8,703,783,581</td>
</tr>
<tr>
<td><strong>Batch 2 - January 2022</strong></td>
<td>7,658</td>
<td>$2,028,577,215</td>
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<tr>
<td><strong>Batch 3 - February 2022</strong></td>
<td>4,171</td>
<td>$560,111,674</td>
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<tr>
<td><strong>Batch 4 - March 2022</strong></td>
<td>3,651</td>
<td>$413,776,448</td>
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<tr>
<td><strong>Batch 5 - April 2022</strong></td>
<td>3,680</td>
<td>$1,754,244,019</td>
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</table>
# PRF Important Dates

<table>
<thead>
<tr>
<th>Period</th>
<th>Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)</th>
<th>Period of Availability</th>
<th>Reporting Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period 1</td>
<td>From April 10, 2020 to June 30, 2020</td>
<td>January 1, 2020 to June 30, 2021</td>
<td>July 1, 2021 to September 30, 2021*</td>
</tr>
<tr>
<td>Period 2</td>
<td>From July 1, 2020 to December 31, 2020</td>
<td>January 1, 2020 to December 31, 2021</td>
<td>January 1, 2022 to March 31, 2022</td>
</tr>
<tr>
<td>Period 3</td>
<td>From January 1, 2021 to June 30, 2021</td>
<td>January 1, 2020 to June 30, 2022</td>
<td>July 1, 2022 to September 30, 2022</td>
</tr>
<tr>
<td>Period 4</td>
<td>From July 1, 2021 to December 31, 2021</td>
<td>January 1, 2020 to December 31, 2022</td>
<td>January 1, 2023 to March 31, 2023</td>
</tr>
<tr>
<td>Period 5</td>
<td>From January 1, 2022 to June 30, 2022</td>
<td>January 1, 2020 to June 30, 2023</td>
<td>July 1, 2023 to September 30, 2023</td>
</tr>
</tbody>
</table>

*Grace period ended on November 30, 2021.*
Missed Period 1 and Period 2 Reporting?

Make a request with HRSA before April 22nd at:

https://www.hrsa.gov/provider-relief/reporting-auditing
PRF Uses Strategy

• One and Done – Using funds for current operations
• Lasting Future Benefits – Investing funds for longer term benefits. (Just like DSRIP)
  • Recruiting & Retaining Personnel
  • Facility Improvements
  • Allied Health & Nursing School
  • Community Outreach / Education – Strengthen market presence
  • Develop New Service Lines
    • Under Arrangement
  • Technology
    • EHR upgrades
    • Community Engagement

• Regardless of strategy, who have to report and justify the funds
HRSA Programs Cancelled

• HRSA Uninsured Claims Reimbursement for Testing, Treatment, and Vaccine Administration *ended March 22nd*
• HRSA Coverage Assistance Fund *ended April 5th*

*Important to write these off to charity where qualified and claim under UC*
Current Developments Update

DSH/UC

2018/2019 DSH audits completed: many hospitals are in recoup status due to change in CHAT rule

DY 8 UC reconciliations are in process and due May 6th, but expect CHAT rule audit exposure on these

2022 DSH/UC Applications were filed in early December 2021

2022 and probable 2023 recoupments for UC CHAT impact may be as much as $200,000-$800,000 per facility
**2018/2019 DSH Audits & CHAT**

\[(\text{Medicaid Shortfall} + \text{Uninsured Shortfall}) \times \text{DSH inflator} = HSL\]

**Example:** $1,000 in Costs, $300 Medicaid pmts, $200 Medicare pmts, $100 Other Ins pmts

| CHAT rule during DSH/UC App timeframe: | EXCLUDED Medicare and Other Insurance pmts | CHAT rule during DSH Audit timeframe: INCLUDED Medicare and Other Insurance payments |
|-----------------------------------------|-------------------------------------------|———————————————————————————————————|
| **Medicaid + Medicare + Other Costs**   | **$1,000**                                 | **$1,000**                                                   |
| - Medicaid pmts                         | ($300)                                    | ($300)                                                       |
| - Medicare pmts                         | 0                                         | ($200)                                                       |
| - Other ins pmts                        | 0                                         | ($100)                                                       |
| **= Medicaid Shortfall**                | **$700**                                  | **$400**                                                     |
Ways to improve DSH/UC:

**DSH**
- Preservation of Trauma Designation
- Maintenance of 2 physician rule

**UC**
- Charity claims must be written off in FY to claim
- Is your charity policy written to maximize this program? Do you have the actual data?
- Time Studies by physicians are crucial for Sch 1

**DATA**
- The key to all of these programs is DATA
- We have developed a software application to overcome EHR system inadequacies
- **EHR system conversions can be catastrophic**
# Data
(The Lifeblood of Your Business)

<table>
<thead>
<tr>
<th></th>
<th>Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge Records</td>
<td>76,690,128</td>
</tr>
<tr>
<td>Encounter Records</td>
<td>20,845,556</td>
</tr>
<tr>
<td>Transaction Records</td>
<td>81,603,246</td>
</tr>
</tbody>
</table>

Total Records: 170,415,643

![Graph showing records by year](image)
Advantages of Data Warehouse

• Allows us to have more timely reporting and results
• Allows for data to be used in multiple ways
  • Price Transparency
  • DSH / UC / CHIRP
  • Charity and other cost report modeling
  • New State rules – Whatever they come up with next
  • Impact of possible rule changes
  • Community Engagement
  • Managed Care
• HIPAA compliant, redundancy and secure – Much better than email and other methods.
• Not shared or otherwise used.
Price Transparency
Where are we now?

• Many are not compliant - Do your due diligence and verify that you are
  • CMS has proposed an increase in penalty of up to $2 Million a year.
  • Basic requirements are posted on CMS website:
    • Machine-Readable File
    • Shoppable File
• Published Data/Machine readable files are being consumed
  • Beware of chargemaster reviews that don’t consider the implications to your Medicare reimbursement!
Examples of Non-Compliance

• Pricing Estimators do not constitute as a machine-readable file
• Historic data is not compliant- *based on claim data*
• All contracted payors must be listed
• Incomplete excel files could be problematic
• Most do not include EMPLOYED physician’s & mid-level’s charges
Pricing Transparency
(Data (or lack of) becomes fodder for Activism)

Campaigns

https://twitter.com/EvanMcMullin

Community Organizers

https://chieforganizer.org/2022/04/06/hospital-pricing-transparency-not/
Pricing Transparency
(Texas is being Examined)

We found that price comparison tools were only truly accessible at 33% of Arkansas hospitals, 42% of Louisiana’s, and 30% of Texas’s. Of that minority whose tools were accessible, unfortunately, the estimates were often useless.

• ACORN stands ready to help researchers and patients in these three states get better understandings of the costs of care.

Pricing Transparency
(Texas is being Examined)

References: https://acorninternational.org/index.php/hospital-price-transparency-arkansas-louisiana-texas/
From Burden to Benefit
(Pricing Transparency benefits?)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Competitor 1</th>
<th>Competitor 2</th>
<th>Competitor 3</th>
<th>Competitor 4</th>
<th>Competitor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA, SUBFASCIAL</td>
<td>$13,388.00</td>
<td>$9,499.02</td>
<td>$5,712.51</td>
<td>$3,923.46</td>
<td>$1,183.11</td>
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<td>EXCISION, TUMOR, SOFT TISSUE, OR VASCULAR MALFORMATION, OF HAND OR ARM</td>
<td>$10,830.00</td>
<td>$10,121.70</td>
<td>$7,008.73</td>
<td>$1,492.39</td>
<td>$613.81</td>
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<tr>
<td>EXCISION NOT FOLLOWED BY SURGICAL REPAIR, ARTERY, UPPER EXTREMITY</td>
<td>$10,830.00</td>
<td>$5,281.29</td>
<td>$537.64</td>
<td>$515.81</td>
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<tr>
<td>EXCISION NOT FOLLOWED BY SURGICAL REPAIR, VEIN, UPPER EXTREMITY</td>
<td>$44,532.00</td>
<td>$22,290.95</td>
<td>$11,216.47</td>
<td>$1,665.06</td>
<td>$1,426.00</td>
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<tr>
<td>EXTERNAL CEPHALIC VERSION, WITH OR WITHOUT TOCOLOYSIS</td>
<td>$6,427.00</td>
<td>$812.43</td>
<td>$778.37</td>
<td>$70.21</td>
<td>$39.70</td>
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<tr>
<td>EXTERNAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR</td>
<td>$47,962.00</td>
<td>$26,654.67</td>
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<tr>
<td>FASCICUTOMY, PLANTAR FASCIA, PARTIAL (SEPARATE PROCEDURE)</td>
<td>$13,119.00</td>
<td>$5,770.55</td>
<td>$1,104.48</td>
<td>$159.55</td>
<td>$118.21</td>
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<td>FASCICUTOMY, PLANTAR FASCIA, RADICAL (SEPARATE PROCEDURE)</td>
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<td>$3,873.10</td>
<td>$3,713.25</td>
<td>$3,302.51</td>
<td>$624.23</td>
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<td>FASCICUTOMY, FOOT AND/OR TOE</td>
<td>$6,880.00</td>
<td>$760.78</td>
<td>$449.44</td>
<td>$7.65</td>
<td>$5.11</td>
</tr>
</tbody>
</table>

Gross Charge Distribution

[Graph showing distribution of charges with categories and competitor data]
Changing Role of the “Patient”

Historical Healthcare
(Links between stakeholders often bypassed the patient)

Future Healthcare
(“Patients” have a consumer mindset and direct connection to stakeholders)
Provider’s Role has Changed

Medical Influencer: Institution
Need: Advertising

Ultimate Reference

Advisor

Medical Influencer: Doctors
Need: Word of Mouth

One of many Influencers

Medical Influencer: ?
Need: Influence
Re-Establishing the Core Team

**Observations:**
- The forces influencing healthcare decisions HAVE totally changed.
- People still need trustworthy, knowledgeable, medical professionals to make good healthcare choices.
- Nobody is more knowledgeable about your community member’s needs than YOU.
- We need to re-establish the local, trusted, knowledgeable, medical professionals as THE healthcare **Core Team**.
- It will require deeper Engagement with Community Members than the Extended healthcare team.
Community Engagement Capabilities

Community Engagement Platform

- Forms
- Preference Center
- Contact Management
- Personalized Journeys

Engagement

- Print
- Email
- Social
- Web
- Text

Community Members

EHR
Targeted Actionable Content

Target -> Likely Moms (Female age 18 - 45)

Target -> (Age > 50)

Form Fill
Assessment
Appointment Request

Print
Digital Signs
Articles

Email
Social Posts
Web Text

Your Logo
Personalized Journeys

- Targeted Audience
- Content with a Call to Action
- AI-based Send Time Optimization
- Follow-up Call to Action
- Alternative Engagement Channel

Journey Split based on Action
Objectives

• Community perception
  • Larger health systems have apps built into their EMR or already fully integrated
    • Epic – MyChart is the largest
    • Constant Contact – Common simple solution
  • Goal - to present a technical platform to enhance credibility

• Utilize better technology
  • Email & even social programs are falling out of favor
  • The phone is the connection of choice for most American
  • Constant contact is one way communication
  • Goal – to have two-way automated communication
    • Provide an economical and efficient marketing platform
  • Ultimate Goal – Own your market!
Opportunities are Endless

- New Staff/Services
- Under utilized Services
- Follow-up Appointments
- Preventative Care
- Building your Foundation
- Personalized Diagnosis Education
Summary on Community Engagement

• Increased engagement = Improved Healthcare

• Better integration/data = Smarter Journeys and Improved Engagement

• Partnerships will be critical
Physician / Hospital Arrangements

- Primary care physicians have moved to an employment model
- Specialist are still more of private practice model
  - All physicians are looking for opportunities for ancillary income
  - More Phys Ancillary income = less hospital revenue
- Options
  - In urban areas JV’s are no longer permitted
    - Momentum to restoring the physician ownership
    - CMS lifted the cap on expansion of physician owned hospitals
  - Rural options are still available
    - Regular JV’s
    - Under Arrangement
Under Arrangements – What is it?

• Hospital can joint venture with physicians (third-party entity) to provide services to hospital patients.

• Help in recruitment/retention of physicians.
  • Especially Specialist

• Has been done in other states.
  • Imaging Center
  • Cancer Center

• Currently working on a surgical center in Texas. Set to start 5/1/2022.
Entity that Would Provide the “Under Arrangements” Services

1. LLC that could be jointly owned by a Hospital and Physicians (51%/49%).
2. Physicians’ Interests must be at Fair Market Value.
3. Physicians would need to be actively involved with LLC and management.
Under Arrangements with a Joint Ventured Services Provider

- **Payers**
- **Hospital**
- **JV/Service Provider**
- **Physicians**

**Key Points:****
- **Claims for Services**
- **Payment**
- **FMV Service Agreement**

- **Own minimum of 51%**
- **Own maximum of 49%**
Possibilities

- Surgery
- Imaging
- Physical Therapy
- Radiology
- Infusion Therapy
- Cancer programs (Medical and Radiation)
Guardrails

• MUST BE IN A RURAL AREA (NON-METROPOLITAN) PER THE OMB.

• HOSPITAL EXERCISES PROFESSIONAL RESPONSIBILITY OVER ARRANGED SERVICES.
  • Accept patient for treatment in accordance with admission policies
  • Maintain complete and timely clinical record on patient
  • Maintain liaison with attending physician regarding patient’s progress
  • Hospital’s utilization review and quality assurance programs apply to the service
Considerations of Medicare Advantage Growth

Total Medicare Advantage Enrollment, 1999-2020 (in millions)
Trends in Rural Healthcare
Transition to Managed Care

- Continued transition in payments to managed care

- Medicaid has already transitioned – mostly

- Growing trend of Medicare patients are transitioning to Advantage Plans (MA)

- Consistency in payment / aggregate reimbursement
Trends in Rural Healthcare Transition to Managed Care

- Current Transitional trends – Texas

- Medicaid MCO accounts for 95% of the aggregate claims volume

- Medicare enrollment in Texas is approximately 36% of the Medicare population

- Medicare Advantage enrollment has doubled in the past decade and increased, on average, 8-10% per year

- CBO projects Medicare Advantage to at 50% or greater of the aggregate Medicare population by 2029.
Trends in Rural Healthcare Transition to Managed Care

- **Medicare Advantage continues to grow**
  - (39% of Medicare population in TX)

- Topics of Consideration with Medicare Advantage Plans
  - Contract language
  - Using CAH / SCH Reimbursement
  - Periodic Internal Claims Review –
    - Do you have the data?
Considerations of Medicare Advantage Growth

- Lack of peripheral or non-claim payments (i.e. bad debt, charity)

- Contract often has “Lesser of Medicare or Charge” based wording or limitations on charge adjustments.
  - This can create line item anomalies, where the provider always gets shorted

- No settlement on Under / Over payment

- Standard review of claims for medical review

- Peer to Peer review of claims is not generally successful
Future of Healthcare

- Patient Demographics

- Medicare Beneficiaries
  - Expectation - 54M to 80M by 2030
  - Baby Boomer growth. (birth mid 1946 - late 1964)
  - Age Gap - Rapid Growth in Longevity of Life (est. 85 years old - 2030)

- Characteristics of Culture
  - Fewer smokers than previous generations of Medicare patients
  - Higher rates of Obesity and Diabetes
  - Higher rates of certain other chronic conditions - (i.e. Kidney disease)
  - Higher Prescription drug needs / availability
Future of Healthcare

- Patient Treatment - Continued Transition from IP to OP
- Technology is playing more roles, and care management.
- Physician / Hospitalist Practice
- Electronic Health Records (Patient Record-keeping Systems)
  - Integration capabilities
- Payor Systems Internal Evaluations (increased Internal Medical Review)
- Community and Patient Involvement - Better Consumers
Questions?

--- Dallas ---
Phone: 972-312-9102
Fax: 469-277-2797
Location: 101 W Renner, Suite 475, Richardson, TX 75082

--- Lubbock ---
Phone: 806-791-1591
Fax: 806-791-3974
Location: 1500 Broadway, Suite 1000 Lubbock, TX 79401

--- Waco ---
Phone: 254-757-2448
Fax: 254-255-4474
Location: 400 Austin, Suite 1001, Waco, TX 76701