Evolving Rural Healthcare Environment
Crossing the Shaky Bridge

AWPHD & WSHA 13th Annual CEO Leadership Retreat
“Leading Wisely, Living Well”

Suncadia Lodge
Cle Elum, WA
September 25, 2014

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STROUDWATER
The Healthcare Environment Has Changed!

- In the past 24 months, the healthcare field has experienced considerable changes with an increased number of rural-urban affiliations, physicians transitioning to hospital employment models, flattening volumes, CEO turnover, etc.

- Federal healthcare reform passed in March 2010 with sweeping changes to healthcare systems, payment models, and insurance benefits/programs
  - Many of the more substantive changes will be implemented over the next two years
  - State Medicaid programs are moving toward managed care models or reduced fee for service payments to balance State budgets
  - Commercial insurers are steering patients to lower cost options

- Thus, providers face new financial uncertainty and challenges and will be required to adapt to the changing market
Market Overview

- State Budget Deficits
- Recovery Audit Contractors (RAC)
- High Deductible Health Plans
  - Non Healthcare CEO quote:
    - “We just renewed our High Deductible Plan going into our third year, and guess what.....5% reduction in premium!!! Needless to say everyone is thrilled. Not sure what the average HSA balance is, but I think it is high. Doing what it is supposed to do, turning health care patients into consumers.”
  - 3/18/2013 WSJ Article
Pressure on State and Local Budgets

Total state and local government health care spending as a share of own-source revenue, 1987-2012

- 15.8% in 1987
- 21.5% in 2000
- 31.5% in 2012

Note: Expenditure data from the National Health Expenditure Accounts were divided by revenue data from the National Income and Product Accounts. State and local revenues is state and local current receipts minus contributions for government social insurance and federal grants-in-aid.
Growth of High Deductible Plans

* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Trend of Lower Inpatient Use

Inpatient Days per 1,000 Persons, 1991 – 2011

Inpatient Days per Thousand

91 92 93 94 95 96 97 98 99 00 01 02 03 04 05 06 07 08 09 10 11

Market Overview – Results

- Declining Patient Volumes

**Washington Hospital Admissions per 1000 Population**

Source: Kaiser State Health Facts, kff.org
Market Overview – Healthcare Reform

• Coverage Expansion
  • By 1/1/14, expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes up to 133% FPL based on modified AGI
    • Currently, Medicaid covers only 45% of poor (≤ 100% FPL)
    • 16 million new Medicaid beneficiaries; mostly “traditional” patients
    • FMAP for newly eligible: 100% in 2014-16; 95% in 2017; 94% in 2018; 93% in 2019; 90% in 2020+
  • Establishment of State-based Health Insurance Exchanges
  • Subsidies for Health Insurance Coverage
  • Individual and Employer Mandate

• Provider Implications
  • Insurance coverage will be extended to 32 million additional Americans by 2019
    • Expansion of Medicaid is major vehicle for extending coverage
    • May release pent-up demand and strain system capacity
    • Traditionally underserved areas and populations will have increased provider competition
    • Have insurance, will travel!
Market Overview – Healthcare Reform

- Medicare and Medicaid Payment Policies
  - Medicare Update Factor Reductions
    - Annual updates will be reduced to reflect projected gains in productivity
  - Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
  - Medicare Hospital Wage Index
  - Independent Payment Advisory Board (IPAB)
    - Charged with figuring out how to reduce Medicare spending to targets with goal of $13B savings between 2014 and 2020
- Summary Impact

### ACA Payment Changes for Medicare and Medicaid

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<th>Potential Offsets</th>
<th>Reduction through 2022</th>
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<td>Medicare DSH Payments</td>
<td>$10.2 Billion</td>
<td>$7.3 Billion new uncompensated care pool</td>
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<td>Medicaid DSH payments</td>
<td>$500 Million reduction in FY 2014 rising to $4 Billion/year by 2019</td>
<td>Medicaid expansion</td>
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<td>EHR Meaningful Use Incentive Payments</td>
<td>$5.5 Billion in 2012 and 2013 to $0 in 2016</td>
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<td>PPS Payment Reductions</td>
<td>1.7%</td>
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<tr>
<td>Readmission Penalties</td>
<td>Increase from 1% to 2% in 2013</td>
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<td>Hospital Acquired Infections</td>
<td>1% penalty beginning in 2015</td>
<td></td>
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<tr>
<td>DRG Payments</td>
<td>1.25% reduction beginning in 2015 to fund value-based purchasing</td>
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Market Overview – Healthcare Reform

- Medicare and Medicaid Payment Policies (continued)

- Provider Implications
  - *Payment changes will increase pressure on hospital margins and increase competition for patient volume*
  - “*Do more with less and then less with less*”
  - Medicaid pays less than other insurers and will be forced to cut payments further

![Medicaid-to-Medicare Physician Fee Ratios, by State](image-url)
Market Overview – Healthcare Reform

• Medicare and Medicaid Delivery System Reforms
  • Expansion of Medicare and Medicaid Quality Reporting Programs
  • Medicare and Medicaid Healthcare-Acquired Conditions (HAC) Payment Policy
    • By Oct. 2014, the 25% of hospitals with the highest HAC rates will get a 1% overall payment penalty
  • Medicare Readmission Payment Policy
    • Hospitals with above expected risk-adjusted readmission rates will get reduced Medicare payments
  • Value based purchasing
    • Medicare will reduce DRG payments to create a pool of funds to pay for the VBPP
      • 1% reduction in FFY 2013, Grows to 2% by FFY 2017
  • Bundled Payment Initiative
  • Accountable Care Organizations
    • Each ACO assigned at least 5,000 Medicare beneficiaries
    • Providers continue to receive usual fee-for-service payments
    • Compare expected and actual spend for specified time period
    • If meet specified quality performance standards AND reduce costs, ACO receives portion of savings
Market Overview – Healthcare Reform

- Medicare and Medicaid Delivery System Reforms (continued)
  - Medicare Accountable Care Organizations (continued)
    - 154 ACOs effective August, 2012
    - 287 ACOs effective January, 2013
    - 401 ACOs effective January, 2014
  - More than half of the U.S. population now live in localities served by ACOs and almost 30 percent live in areas served by two or more
  - 5.3 million Medicare beneficiaries, or about 14 percent of total Medicare fee-for-service beneficiaries, now in Medicare ACOs

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html
New ACOS (Since the end of May 2013)

1. **Aetna Forms 5 New ACOs in Maine**
   Aetna announced accountable care agreements with five different healthcare organizations in Maine: Mercy Health System, InterMed, MaineHealth and Martin’s Point Health Care, all in Portland, and MaineGeneral Health in Augusta.

2. **Aetna, New Haven Community Medical Group Partner for Accountable Care**
   Aetna announced a new accountable care agreement with New Haven (Conn.) Community Medical Group, an integrated network of 591 providers.

3. **Aetna, Riverside Health System Ink ACO Deal**
   Aetna announced an accountable care organization collaboration with Riverside Health System, a five-hospital, 941-bed system based in Newport News, Va.

4. **St. Vincent's Health Partners, Anthem BCBS Sign Value-Based Agreement**
   St. Vincent's Health Partners, a Bridgeport, Conn.-based physician hospital organization developed between St. Vincent's Medical Center and regional physicians, announced a value-based reimbursement agreement with Anthem Blue Cross and Blue Shield.

5. **Providence Health & Services, Southern California Forms Commercial ACO**
   Blue Shield of California, Providence Health & Services, Southern California and its affiliates, Mission Hills, Calif.-based Facey Medical Foundation and Facey Medical Group, announced the formation of a three-year accountable care organization.

6. **Cigna Announces 2 New Accountable Care Partnerships**
   Cigna launched two new collaborative accountable care initiatives July 1: one with Baycare Health Partners, a physician hospital organization based in Springfield, Mass., and the other with Scottsdale Health Partners, a physician-led clinically integrated network created as a partnership between Scottsdale (Ariz.) Healthcare and Scottsdale Physician Organization.

Source: Becker’s Hospital Review
New ACOS (Since the end of May 2013)

7. **Cigna Launches 2 Accountable Care Initiatives in Arizona**
Cigna launched new collaborative accountable care initiatives, the payer's version of accountable care organizations, with physicians affiliated with two different organizations in Tucson: Arizona Community Physicians and Arizona Connected Care.

8. **CaroMont Medical Group, Cigna Partner for Accountable Care**
CaroMont Medical Group, a Gastonia, N.C.-based network of 44 physician practices in two states, partnered with Cigna for a collaborative accountable care initiative, Cigna's version of accountable care organizations.

9. **NYUPN Clinically Integrated Network, Cigna Link for Accountable Care Initiative**
Cigna is launching a collaborative accountable care initiative, its version of accountable care organizations, with NYUPN Clinically Integrated Network, an organization comprising all clinical faculty affiliated with NYU Langone Medical Center and the University Physicians Network in New York City.

10. **Valley Preferred, Cigna Partner for Accountable Care**
Valley Preferred, a provider-owned preferred provider organization aligned with Lehigh Valley Health Network in Allentown, Pa., and Cigna launched a collaborative accountable care initiative July 1.

11. **Hunterdon Healthcare Partners Launches ACOs With Cigna, Horizon BCBSNJ**
Hunterdon Healthcare Partners, a physician-hospital organization affiliated with Hunterdon Healthcare in Flemington, N.J., formed two commercial accountable care organizations with Cigna and Horizon Blue Cross Blue Shield of New Jersey.

12. **Beacon Health Partners, Empire BCBS Sign Value-Based Agreement**
Beacon Health Partners, a Medicare Shared Savings Program accountable care organization and independent physician association in Manhasset, N.Y., signed a patient-centered primary care agreement with Empire BlueCross BlueShield.

Source: Becker’s Hospital Review
New ACOS (Since the end of May 2013)

13. **Highmark Moves Toward Accountable Care With New Alliance**
Health insurer Highmark in Pittsburgh formed an accountable care alliance within its newly formed Allegheny Health Network, which will include physicians from Allegheny Health Network and the following six hospitals: Allegheny General Hospital in Pittsburgh, Allegheny Valley Hospital in Natrona Heights, Pa., Canonsburg (Pa.) General Hospital, Forbes Regional Hospital in Monroeville, Pa., Jefferson Regional Medical Center in Jefferson Hills, Pa., and The Western Pennsylvania Hospital in Pittsburgh.

14. **Barnabas, Horizon BCBS of New Jersey Partner for ACO**
West Orange, N.J.-based Barnabas Health linked with Horizon Blue Cross Blue Shield of New Jersey, the state's largest health insurer, for an accountable care organization.

15. **Adventist Health, Tuality Healthcare, Regence BCBS Form AC Network in Oregon**
Adventist Health-Portland (Ore.), Tuality Healthcare in Hillsboro, Ore., and Regence BlueCross BlueShield of Oregon announced they are forming an accountable care network.

16. **Regence BCBS, Willamette Valley Health Sol Announce Accountable Care Partnership**
Regence BlueCross BlueShield and McMinnville, Ore.-based Willamette Valley Medical Center's accountable care organization, Willamette Valley Health Solutions, formed an accountable care partnership.

17. **Mount Carmel Health Partners, UnitedHealthcare Link for ACO**
Mount Carmel Health Partners, a physician hospital organization jointly owned by Columbus, Ohio-based Mount Carmel Health System and 1,500 physicians, formed an accountable care organization with UnitedHealthcare, effective Oct. 1.

18. **Seton Health Alliance, UnitedHealthcare Form Central Texas' First Commercial ACO**
Austin, Texas-based Seton Health Alliance, a Pioneer accountable care organization that is a partnership between Seton Healthcare Family and other providers, partnered with UnitedHealthcare for the first-ever commercial ACO in central Texas.

Source: Becker’s Hospital Review
ACO Growth 2010-2013

Chart 1: Total Accountable Care Organizations; Source: Leavitt Partners Center for Accountable Care Intelligence
ACO Growth 2010-2013
Where Are ACOs Forming?

Figure 1. Medicare ACOs are expanding their reach with 23 Pioneer and 343 Shared Savings Program ACOs as of January 2014. Pioneer ACOs (Blue); Shared savings ACOs 2012 cohort (Red); Shared savings ACOs 2013 cohort (Purple); Shared savings ACOs 2014 cohort (Green).

Source: The Advisory Board Company
Where Are ACOs Forming?

ACOs by State

Source: healthaffairs.org
ACOs in Washington

There are 18 total ACOs in the state of Washington.

Washington ranks 16th out of the 50 states for total number of ACOs.

ACOs in Washington cover between 250,000 and 500,000 lives.

Source: Leavitt Partners Center for Accountable Care Intelligence
ACOs in Washington

- ACOs in Washington State include the following (Sources: aapmr.org, Becker’s Hospital Review, CMS)
  - Franciscan Northwest Physicians Health Network, LLC
  - Polyclinic Management Services Company
  - Health Connect Partners, LLC
  - Robert Bree Collaborative
  - Puget Sound Health Alliance

- In the **Washington State Health Care Innovation Plan**, the state “proposes to develop local ACOs around 50 hospitals with ~250 practices over 3 years and with a staggered implementation that may potentially affect ~91,200 deliveries over the first three years (WA has ~84,000 births per year).”
  - The state will pay for integrated services for births starting with a global budget negotiated with a set of professionals and their associated hospital(s), **with professionals and hospitals that achieve a lower target cost receiving a portion of the savings.**

Source: National Academy for State Health Policy
ACOs – Results and Projections

• 2012 Results from ACOs (Source: Levitt Partners Center for Accountable Care Intelligence as reported in 5/30/2014 Health Affairs Blog)

  - 54 MSSP ACOs kept costs below benchmark
  - 29 MSSP ACOs received $126M in shared savings and saved CMS $128M
  - 12 Pioneer ACOs generated $147M in total savings - $76M returned to the ACOs
    - “All Pioneers showed improved quality metrics”
ACOs – Results and Projections

• ACO participation expected to double by end of 2014 (source: Premier 2013 Annual Study)

• Growth of commercial ACOs (source: Becker’s Hospital Review)
  • 35 Commercial ACOs announced through 9/30/2013
  • Commercial insurers announce plans to dramatically increase their number of risk-based, accountable care contracts
Fee-For-Service Financial Model

Assumptions

• Utilization
  • Inpatient and Outpatient
    • Impact of ACA
    • Impact of Blue Cross steerage initiatives

• Revenue
  • Third party price increases
  • Cost based Medicare revenue
  • DSH payments (Zeroed out in 2014)
  • Bad debt % of patient service revenue (75% reduction in 2014)
    • Impact of ACA
  • Meaningful use incentive payments
  • Other operating revenue
  • Non-operating gains and

• Expenses
  • Salaries, wages and benefits
  • Productivity
  • Supplies and other
Age Normalized Use Rate Comparisons – Discharges/1,000

Current use rates based on Truven Healthcare Analytics population and discharge estimates by Dartmouth Hospital Service Area (HSA).

2021 use rates based on Milliman Governance Institute Presentation (2/2012).
## Use Rate Comparisons – Discharges/1,000

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<td>114</td>
<td>9.7%</td>
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<td>Littleton</td>
<td>93</td>
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<td>US Average</td>
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**MARKET OVERVIEW**
Fee-For-Service Financial Model – Results

When operating income becomes negative in 2016, cash reserves start to decline

- Operational improvement and shared service economies of scale are insufficient to combat declining utilization
- Can’t cut your way to sustainability
Market Overview – Healthcare Reform

- Medicare and Medicaid Delivery System Reforms (continued)

  - Provider Implications

    - Hospitals are taking the lead in forming Accountable Care Organizations with physician groups that will share in Medicare savings
    - Value based purchasing program will shift payments from low performing hospitals to high performing hospitals
    - Acute care hospitals with higher than expected risk-adjusted readmission rates and HAC will receive reduced Medicare payments for every discharge
    - Physician payments will be modified based on performance against quality and cost indicators
    - There are significant opportunities for demonstration project funding
Market Overview – Results

- Stability and US Healthcare Spending

Market Overview – Results

- Declining Healthcare Employment

***Healthcare employment drops for first time in decade***

By Melanie Evans
Posted: January 10, 2014 - 1:00 pm ET
Tags: Bureau of Labor Statistics, Hospitals, Labor, Physicians, Staffing

Healthcare, an engine of employment through the recession, shed 6,000 jobs in December with payroll declines in ambulatory care and hospitals.

The drop comes at the end of a year in which healthcare hiring flagged, adding a below average number of jobs, new figures from the U.S. Bureau of Labor Statistics show. Healthcare added 271,000 jobs last year to bring the industry's total to 14.57 million. Hiring fell about 2% below the annual average since 1990.

Source: modernhealthcare.com
Closed Hospitals Since the Beginning of 2013

Source: Reuters Graphics
In the first quarter of 2014,

• The economy contracted at a 2.9 percent annual rate
• Previous G.D.P. numbers showed that health care spending contributed 1 percentage point to economic growth. The new report now finds that health care spending actually subtracted 0.16 of a percentage point from the growth rate.

• “The BEA’s revised estimate says that healthcare spending decreased by 1.4%”

How Do Real and Projected Spending Compare?

Medicare cost projections and reality
Real and projected spending per Medicare recipient, in 2014 dollars

In 2006, the C.B.O. thought health care costs would grow very strongly through 2014.

Projected costs

Actual costs

Affordable Care Act passes

Sources: Congressional Budget Office, Office of Management and Budget, Medicare Trustees
These figures were calculated using estimates of Medicare outlays from the C.B.O.’s baseline reports, estimates of Medicare enrollment from the Medicare Trustees, historical G.D.P. price index rates from the Office of Management and Budget and G.D.P. price index projections from the C.B.O. The C.B.O. publishes more than one baseline report per year; this analysis uses the last report of each year, which is typically published in August.

Chart source: The New York Times
Data source: CBO
Challenges Affecting Rural Hospitals

- Factors that will have a significant impact on rural hospitals over the next 5-10 years
  - Difficulty with recruitment of providers and aging of current medical staff
    - Struggle to pay market rates
  - Increasing competition from other hospitals and physician providers for limited revenue opportunities
  - Small hospital governance members without sophisticated understanding of small hospital strategies, finances, and operations
  - Consumer perception that “bigger is better”
  - Severe limitations on access to capital for necessary investments in infrastructure and provider recruitment
    - Facilities historically built around IP model of care
  - Increased burden of remaining current on onslaught of regulatory changes
    - Regulatory Friction / Overload
  - Payment systems transitioning from volume based to value based
  - Increased emphasis of quality as payment and market differentiator
  - Reduced payments that are “Real this time”
    - 3rd party steerage (surgery, lab, and Imaging), RAC audits
We Have Moved into a New Environment!

• Subset of most recent challenges
  • Payment systems transitioning from volume based to value based
  • Increased emphasis as quality as payment and market differentiator
  • Reduced payments that are “Real this time”
• New environmental challenges are the TRIPLE AIM!!!
• Market Competition on economic driver of healthcare: PATIENT VALUE
Future Hospital Financial Value Equation

• Definitions
  • Patient Value

\[
\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}
\]

• Accountable Care:
  • A mechanism for providers to monetize the value derived from increasing quality and reducing costs
    • Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.
  • Different “this time”
    • Providers monetize value
    • New information systems to manage costs and quality
    • Agreed upon evidence-based protocols
    • Going back is not an option
Future Hospital Financial Value Equation

- ACO Relationship to Small and Rural Hospitals
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
  - Small and rural hospitals bring value / negotiating power to affiliation relationships as generally PCP based
    - Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
      - Functional alignment with PCPs in local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals
Future Hospital Financial Value Equation

• Economics

• As payment systems transition away from volume based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant

• New economic models based on patient value must be developed by hospitals but not before the payment systems have converted

• Economic Model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp
Future Hospital Financial Value Equation

- Value in Rural Hospitals
  - Lower Per Beneficiary Costs
  - Revenue centers of the future
    - PCP based delivery system
  - CAH cost-based reimbursement
    - Incremental volume drives down unit costs
    - Once commitment to community Emergency Room, system incentives to drive low acuity volume to CAH
    - MedPAC Confusion – Limited Incentives to manage costs???
The Challenge: Crossing the Shaky Bridge
The Challenge

• Shaky Bridge

  • Concern of task force members is that transitioning of the delivery system functions must coincide with transitioning payment system of rural hospitals, without adequate reserves, will be a financial risk
  • “Stepping onto the shaky bridge” analogy

  • Necessary for hospitals to survive the gap between pay-for-volume and pay-for-performance
    • Delivery system has to remain aligned with current payment system while seeking to implement programs/processes that will allow flexibility to new payment system
    • Delivery system must be ready to jump when new payment systems roll out
The Premise

Finance
Macro-economic Payment System
• Government Payers
  • Changing from F-F-S to PBPS
• Private Payers
  • Follow Government payers
  • Steerage to lower cost providers

Function
Provider Imperatives
• Transition from
  • Management of price, utilization, and costs (under F-F-S system) to
  • Management of care for defined population (under PBPS)
• Providers assume insurance risk

Form
Provider organization
• Evolution from
  • Independent organizations competing with each other for market share based on volume to
  • Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and care management organization
• New competencies required
  • Network development
  • Care management
  • Risk contracting
  • Risk management

MARKET OVERVIEW  TRANSITION  FRAMEWORK  STRATEGIES
## Changing Payment System Incentives

<table>
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<tr>
<th>Perspective</th>
<th>Current State</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Future State</th>
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<td><strong>Government</strong></td>
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<td>ACO pilot projects</td>
<td>Population based payments (PBP) for ACOs</td>
<td>Transition from ACOs to Medicare Advantage plans (budget to full capitation)</td>
<td>PBP with quality performance criteria</td>
</tr>
<tr>
<td></td>
<td>Cost based reimbursement for CAHs</td>
<td>FFS increasingly tied to patient value</td>
<td>ACOs with budget based payment predominates</td>
<td>Medicare Advantage plans with providers at full risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fee-For-Service (FFS) to PPS acute care hospitals</td>
<td>Cost based reimbursement for CAHs with impacts from sequestration and RAC audits</td>
<td>Interim payment models similar to Phase 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td>FFS</td>
<td>FFS with steerage based on network penalties and patient incentives</td>
<td>Pilot projects for risk sharing with providers</td>
<td>Providers and insurers functionally merging through acquisition or development of provider based health plans</td>
<td>PBP with quality performance criteria</td>
</tr>
<tr>
<td></td>
<td>Insurance provided to patients through employers</td>
<td>FFS with quality scores</td>
<td>Insurance exchanges become an option for individuals and small groups to obtain insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary employer relationships with insurers</td>
<td>High deductible health plans negatively impacting patient volume</td>
<td></td>
<td>Provider based health plans</td>
<td></td>
</tr>
</tbody>
</table>

**Macro-economic Environment – Payment System**

### Phase 1
- ACO pilot projects
- FFS increasingly tied to patient value
- Cost based reimbursement for CAHs with impacts from sequestration and RAC audits
- Interim payment models similar to Phase 1

### Phase 2
- Population based payments (PBP) for ACOs
- ACOs with budget based payment predominates
- Transition from ACOs to Medicare Advantage plans (budget to full capitation)

### Phase 3
- PBP with quality performance criteria
- Medicare Advantage plans with providers at full risk
## Physician Perspectives

### Micro-economic Environment – Physicians

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Current State</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCPs</strong></td>
<td>• Loss leaders</td>
<td>• System aligned (employed and independent)</td>
<td>• Increasing compensation</td>
<td>• Revenue centers</td>
<td>• System employed and integrated</td>
</tr>
<tr>
<td></td>
<td>• Employed to maintain primary care base in their communities</td>
<td></td>
<td></td>
<td>• Relatively high compensation</td>
<td>• Relatively high compensation</td>
</tr>
<tr>
<td></td>
<td>• Independent PCPs</td>
<td></td>
<td></td>
<td></td>
<td>• Emphasis on care management and chronic disease management</td>
</tr>
<tr>
<td></td>
<td>• Relatively low compensation</td>
<td></td>
<td></td>
<td></td>
<td>• Operating at top of license, leveraging non-physician practitioners and team members</td>
</tr>
<tr>
<td></td>
<td>• Emphasis on high volume episodic care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialists</strong></td>
<td>• Profit centers</td>
<td>• Caught between volume emphasis and system cost emphasis</td>
<td>• Declining compensation</td>
<td>• Cost centers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emphasis on high volume of high dollar procedures</td>
<td>• Regional consolidation with lower volumes</td>
<td>• Increasing employment by systems</td>
<td>• Increase value through care management models that drive down costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increasing employment by systems</td>
<td></td>
<td>• Quality must be demonstrated</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Make (employ) or buy (purchase externally) decision based on cost</td>
<td></td>
</tr>
</tbody>
</table>
## Hospital Perspectives

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Current State</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Future State</th>
</tr>
</thead>
</table>
| Rural       | • Profit by increasing volume and reducing unit costs  
              • Generally primary care based delivery systems | • Demonstrate quality  
              • Imperative to increase efficiencies  
              • Seek economies of scale through collaboration | • Full alignment with primary care providers within service area  
              • Developing sub-regional system | • Rationalize specialty services across sub-region | • Maintaining appropriate primary care, ancillary and urgent care services  
              • Access point into the delivery system  
              • Accounting systems to recognize contributed value at system or sub-system level  
              • Balance sheet linkage to larger system |
## Hospital Perspectives

### Micro-economic Environment – Hospitals

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Current State</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Future State</th>
</tr>
</thead>
</table>
| **Community** | • Profit by increasing volume and reducing unit costs  
• Blend of primary care and specialty care | • Demonstrate quality  
• Imperative to increase efficiencies  
• Seek economies of scale through collaboration | • Decision point for entering regional system as an individual hospital or as a member of a sub-regional system | • Rationalize specialty services between rural, community and tertiary care hospitals | • Access point into delivery system  
• Sub-regional specialty hospital with shared primary care focus and linkage to tertiary providers |
| **Tertiary** | • Profit by increasing volume and reducing unit costs  
• High dependence on technology and specialists to generate profit | • Demonstrate quality  
• Imperative to increase efficiencies  
• Seek economies of scale through collaboration | • Leader in conversion of system from volume payment to risk based payment  
• Aggregate patient lives with outreach to rural communities | | • Regional aggregator of lives to reduce insurance risk  
• Provider / facilitator of infrastructure to manage care across the system  
• Provider of high tech tertiary and sub-specialty services |
Implementation Framework – What Is It?

• A strategic framework for assisting organizations transition from a payment system dominated by the FFS payment model to one dominated by population based payment models
  • Delivery system side addresses strategic imperatives for providers
  • Provider side addresses strategies for providers to influence the evolution of the payment system in their market
  • Requires creation of an integrating vehicle so that providers can contract for covered lives, create value through active care management and monetize the creation of that value
• Strategic imperatives drive the initiatives that must be designed and timely implemented to successfully make the transition
  • Each initiative is developed in phases that correspond to the evolution of the payment models
  • Work on each initiative needs to begin now so they will be ready to implement when required
• Delivery system must respond to at a similar pace to changing payment models in order to maintain financial viability
  • Getting too far ahead or lagging behind will be hazardous to their health
Initiative I – Operating Efficiencies, Patient Safety and Quality

- Hospitals not operating at efficient levels are currently, or will be, struggling financially

- “Efficient” is defined as
  - Appropriate patient volumes meeting needs of their service area
  - Revenue cycle practices operating with best practice processes
  - Expenses managed aggressively
  - Physician practices managed effectively
  - Effective organizational design

Graphic: National Patient Safety Foundation
Initiative I – Operating Efficiencies, Patient Safety and Quality

- Grow FFS patient volume to meet community needs
  - “Catching to pitching”
  - Opportunities often include swing bed, imaging, lab, ER, etc.
- Increase efficiency of revenue cycle function
  - Adopt revenue cycle best practices
    - Effective measurement system
    - “Super charging” front end processes including online insurance verification, point of service collections
    - Education on necessity for upfront collections
    - Ensure chargemaster is up to date and reflects market reality
- CAHs to ensure accuracy of the Medicare cost reports
  - Improving accuracy of Medicare cost reports often results in incremental Medicare and Medicaid revenue to CAHs
- Continue to seek additional community funds to support hospital mission
  - Increase millage tax base where appropriate
  - Ensure ad valorem tax renewal
• Increase monitoring of staffing levels staffing to the “sweet spot”
  • Staffing education for DONs/Clinical managers
  • Salary Survey / Staffing Levels / Benchmarks that are relevant

### Sample of Selected Departments

<table>
<thead>
<tr>
<th>Department</th>
<th>Performance Indicator</th>
<th>FY 2012 Volume</th>
<th>Hourly Standard</th>
<th>Standard FTEs</th>
<th>Actual FTEs</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing - Med Surg</td>
<td>Per Patient Day</td>
<td>3,263</td>
<td>12.00</td>
<td>18.82</td>
<td>36.82</td>
<td>18.00</td>
</tr>
<tr>
<td>Nursing - Endoscopy/GI Lab</td>
<td>Per Case</td>
<td>120</td>
<td>3.60</td>
<td>0.21</td>
<td>-</td>
<td>(0.21)</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Per Case</td>
<td>2,672</td>
<td>2.40</td>
<td>3.08</td>
<td>-</td>
<td>(3.08)</td>
</tr>
<tr>
<td>UR/Case Mgr/Soc Ser</td>
<td>Patient Days</td>
<td>3,263</td>
<td>0.75</td>
<td>1.18</td>
<td>-</td>
<td>(1.18)</td>
</tr>
<tr>
<td>Nursing Administration</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>1.75</td>
<td>1.54</td>
<td>-</td>
<td>(1.54)</td>
</tr>
<tr>
<td>Subtotal Nursing</td>
<td></td>
<td></td>
<td></td>
<td>24.83</td>
<td>36.82</td>
<td>11.99</td>
</tr>
<tr>
<td>Radiology</td>
<td>Per Procedure</td>
<td>6,368</td>
<td>1.42</td>
<td>4.34</td>
<td>6.99</td>
<td>2.65</td>
</tr>
<tr>
<td>Lab/Blood Bank</td>
<td>Per Test</td>
<td>36,551</td>
<td>0.30</td>
<td>5.27</td>
<td>8.70</td>
<td>3.43</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Per Treatment</td>
<td>11,014</td>
<td>0.50</td>
<td>2.65</td>
<td>3.08</td>
<td>0.43</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Per Procedure</td>
<td>531</td>
<td>1.31</td>
<td>0.33</td>
<td>0.51</td>
<td>0.18</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Per Treatment</td>
<td>333</td>
<td>1.00</td>
<td>0.16</td>
<td>-</td>
<td>(0.16)</td>
</tr>
<tr>
<td>Cardio/Pulmonary</td>
<td>Per Procedure</td>
<td>6,381</td>
<td>0.55</td>
<td>1.68</td>
<td>3.63</td>
<td>1.95</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Per Adjusted Day</td>
<td>9,969</td>
<td>0.60</td>
<td>2.88</td>
<td>2.00</td>
<td>(0.88)</td>
</tr>
<tr>
<td>Subtotal Ancillary</td>
<td></td>
<td></td>
<td></td>
<td>17.31</td>
<td>24.91</td>
<td>7.60</td>
</tr>
<tr>
<td>Subtotal - Clinical</td>
<td></td>
<td></td>
<td></td>
<td>42.14</td>
<td>61.73</td>
<td>19.59</td>
</tr>
<tr>
<td>Hospital Administration</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>1.65</td>
<td>1.46</td>
<td>3.18</td>
<td>1.72</td>
</tr>
<tr>
<td>Information Systems</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>1.00</td>
<td>0.88</td>
<td>2.00</td>
<td>1.12</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>1.10</td>
<td>0.97</td>
<td>1.00</td>
<td>0.03</td>
</tr>
<tr>
<td>Marketing/Planning/Public Re</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>0.28</td>
<td>0.25</td>
<td>1.94</td>
<td>1.69</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>0.75</td>
<td>0.66</td>
<td>-</td>
<td>(0.66)</td>
</tr>
<tr>
<td>Telecommunications</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>0.36</td>
<td>0.32</td>
<td>-</td>
<td>(0.02)</td>
</tr>
<tr>
<td>General Accounting (5)</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>1.23</td>
<td>1.09</td>
<td>3.00</td>
<td>1.91</td>
</tr>
<tr>
<td>Security</td>
<td>Gross Square Feet</td>
<td>-</td>
<td>0.02</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patient Accounting</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>3.00</td>
<td>2.65</td>
<td>5.03</td>
<td>2.38</td>
</tr>
<tr>
<td>Admitting/Patient Registration</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>4.25</td>
<td>3.75</td>
<td>2.00</td>
<td>(1.75)</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>3.50</td>
<td>3.09</td>
<td>7.09</td>
<td>4.62</td>
</tr>
<tr>
<td>Cent Supply/Mt Mgmt/Sterile</td>
<td>Per Adjusted Day</td>
<td>9,969</td>
<td>0.30</td>
<td>1.44</td>
<td>2.67</td>
<td>1.23</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>Net Square Feet</td>
<td>43,795</td>
<td>0.31</td>
<td>6.57</td>
<td>6.99</td>
<td>0.42</td>
</tr>
<tr>
<td>Dietary</td>
<td>Meals Served</td>
<td>40,801</td>
<td>0.25</td>
<td>4.90</td>
<td>8.99</td>
<td>4.09</td>
</tr>
<tr>
<td>Plant Ops/ Maintenance</td>
<td>Gross Square Feet</td>
<td>-</td>
<td>0.12</td>
<td>-</td>
<td>1.58</td>
<td>1.58</td>
</tr>
<tr>
<td>Laundry and Linen</td>
<td>Lbs of Laundry</td>
<td>349,015</td>
<td>0.02</td>
<td>3.36</td>
<td>-</td>
<td>(3.36)</td>
</tr>
<tr>
<td>Subtotal Support</td>
<td></td>
<td></td>
<td></td>
<td>31.37</td>
<td>46.09</td>
<td>14.72</td>
</tr>
</tbody>
</table>

1 Hourly Standards based on Stroudwater sample of hospitals
2 FY 2012 information provided by hospital administration (average of last three payrolls ending 2/4/2012)
Initiative I – Operating Efficiencies, Patient Safety and Quality

• Develop LEAN production practices that consider the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful
  • Preserving value / quality with less processes
  • Workflow redesign
  • Inventory Levels / Standardization
  • Response Times
  • Replicating Successes among all hospitals
  • C-Suite training on LEAN / Six Sigma

• Evaluate self funded health insurance plans for optimal plan design
  • Self funded health insurance plans offer often overlooked opportunity to develop accountable care strategies for a defined patient base through aligning employee incentives through improved benefits design and more effective care management processes

• Evaluate 340B discount pharmacy program as an opportunity to both increase profit and reduce costs
  • Often 340B is only looked upon as an opportunity to save costs not considering profit potential
Initiative I – Operating Efficiencies, Patient Safety and Quality

• Develop physician practice expertise

Financial Performance

Organizational Structure

Revenue

Price

Visits

RVU Benchmarks

Visit Benchmarks

New Patients

Throughput

Collections

Fee Schedules

Payer Mix

Coding

Expenses

Non-Provider

Staff Ratios

Overhead Expenses

Provider

Compensation

Physician Ratio
Initiative I – Operating Efficiencies, Patient Safety and Quality

• Have an effective organizational design that drives accountability into the organization
  • Decision Rights
    • Drive decision rights down to clinical/operation level
    • Education to department managers on business of healthcare
      • Avoid separation of clinical and financial functions
  • Performance Measurement
    • Department managers to be involved in developing annual budgets
    • Budget to actual reports to be sent to department managers monthly
      • Variance analysis to be performed through regularly scheduled meetings between CFO/CEO and department managers
  • Compensation
    • Recognize performance in line with organizational goals
Focus on Quality and Patient Safety

As a strategic imperative

As a competitive advantage

<table>
<thead>
<tr>
<th>U.S. HHS Hospital Compare Measures</th>
<th>National Avg.</th>
<th>New York Avg.</th>
<th>Lewis County General</th>
<th>Carthage Area Hospital</th>
<th>Samaritan Medical Center</th>
<th>Rome Memorial Hospital</th>
<th>E.J. Noble Hospital</th>
<th>Clifton-Fine Hospital</th>
<th>The River Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Acquired Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls and Injuries</td>
<td>0.53</td>
<td>N/A</td>
<td>0.81</td>
<td>0.80</td>
<td>0.71</td>
<td>1.09</td>
<td>0.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Infection from a Urinary Catheter</td>
<td>0.36</td>
<td>N/A</td>
<td>1.62</td>
<td>0.00</td>
<td>0.00</td>
<td>0.82</td>
<td>0.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Satisfaction (HCAHPS)</td>
<td>71%</td>
<td>66%</td>
<td>74%</td>
<td>69%</td>
<td>69%</td>
<td>66%</td>
<td>57%</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Nurses &quot;Always&quot; communicated well</td>
<td>78%</td>
<td>73%</td>
<td>76%</td>
<td>72%</td>
<td>76%</td>
<td>76%</td>
<td>63%</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Doctors &quot;Always&quot; communicated well</td>
<td>81%</td>
<td>77%</td>
<td>87%</td>
<td>77%</td>
<td>80%</td>
<td>77%</td>
<td>76%</td>
<td>97%</td>
<td>91%</td>
</tr>
<tr>
<td>&quot;Always&quot; received help when wanted</td>
<td>66%</td>
<td>59%</td>
<td>70%</td>
<td>61%</td>
<td>64%</td>
<td>62%</td>
<td>53%</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Pain &quot;Always&quot; well controlled</td>
<td>70%</td>
<td>66%</td>
<td>70%</td>
<td>66%</td>
<td>68%</td>
<td>68%</td>
<td>53%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Staff &quot;Always&quot; explained med's before administering</td>
<td>63%</td>
<td>58%</td>
<td>67%</td>
<td>61%</td>
<td>61%</td>
<td>58%</td>
<td>49%</td>
<td>72%</td>
<td>78%</td>
</tr>
<tr>
<td>Room and bathroom &quot;Always&quot; clean</td>
<td>73%</td>
<td>68%</td>
<td>76%</td>
<td>78%</td>
<td>82%</td>
<td>72%</td>
<td>66%</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>Area around room &quot;Always&quot; quiet at night</td>
<td>60%</td>
<td>49%</td>
<td>60%</td>
<td>55%</td>
<td>54%</td>
<td>49%</td>
<td>42%</td>
<td>55%</td>
<td>78%</td>
</tr>
<tr>
<td>YES, given at home recovery information</td>
<td>84%</td>
<td>81%</td>
<td>84%</td>
<td>87%</td>
<td>84%</td>
<td>84%</td>
<td>83%</td>
<td>81%</td>
<td>83%</td>
</tr>
<tr>
<td>Gave hospital rating of 9 or 10 (0-10 scale)</td>
<td>69%</td>
<td>61%</td>
<td>72%</td>
<td>64%</td>
<td>62%</td>
<td>61%</td>
<td>47%</td>
<td>86%</td>
<td>78%</td>
</tr>
<tr>
<td>YES, definitely recommend the hospital</td>
<td>70%</td>
<td>64%</td>
<td>75%</td>
<td>66%</td>
<td>61%</td>
<td>57%</td>
<td>41%</td>
<td>87%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Note: footnotes [detailed below] may not apply to all data points within the selected hospital compare measure (data source: www.hospitalcompare.hhs.gov)

1 The number of cases is too small to reliably tell how well a hospital is performing.
2 The hospital indicated that the data submitted for this measure were based on a sample of cases.
3 No data are available from the hospital for this measure.
4 Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
Initiative I – Operating Efficiencies, Patient Safety and Quality

- Publicly report quality measures
  - All CAHs to begin reporting to Medicare Beneficiary Quality Improvement Program (MBQIP)
  - Increase internal awareness of internet based, publicly available, quality scores
  - Develop internal monitor systems to “move the needle”
  - Monitor data submissions to ensure reflect true operations
  - Consider reporting quality information on hospital website or direct patient to Hospital Compare
  - Staying current with industry trends and future measures
  - Educate staff on impact of how actual or perceived quality affects the hospital image
  - Must develop paradigm shift from quality being something in an office down the hall to something all hospital staff responsible for
    - Shift from being busy work to being integrated in business plan
Initiative I – Operating Efficiencies, Patient Safety and Quality

- Partner with Medical Staff to improve quality
  - Restructure physician compensation agreements to build quality measures into incentive based contracts
  - Modify Medical Staff bylaws tying incentives around quality and outcomes into them
- Ensure most appropriate methods are used to capture HCAHPS survey data
  - Consider transitioning from paper survey to phone call survey to ensure that method has increased statistical validity
- Electronic Health Record (EHR) to be used as backbone of quality improvement initiative
  - Meaningful Use – Should not be the end rather the means to improving performance
- Increase Board members understanding of quality as a market differentiator
  - Move from reporting to Board to engaging them (i.e. placing board member on Hospital Based Quality Council)
  - Quality = Performance Excellence
Initiative II – Primary Care Alignment

• Understand that revenue streams of the future will be tied to primary care physicians, which often comprise a majority of the rural and small hospital healthcare delivery network

• Thus small and rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs

• Physician Relationships
  • Hospital align with employed and independent providers to enable interdependence with medical staff and support clinical integration efforts
    • Contract (e.g., employ, management agreements)
    • Functional (share medical records, joint development of evidence based protocols)
    • Governance (Board, executive leadership, planning committees, etc.)
Initiative III – Rationalize Service Network

• Develop system integration strategy
  • Evaluate wide range of affiliation options ranging from network relationships, to interdependence models, to full asset ownership models
    • Interdependence models through alignment on contractual, functional, and governance levels, may be option for rural hospitals that want to remain “independent”
    • Explore / Seek to establish interdependent relationships among small and rural hospitals understanding their unique value relative to future revenue streams
  • Identify the number of providers needed in the service area based on population and the impact of an integrated regional healthcare system
  • Conduct focused analysis of procedures leaving the market
    • Understand real value to hospitals
      • Under F-F-S
      • Under PBPS (Cost of out of network claims)
• Providers have opportunities to “shorten” and “stabilize” the shaky bridge by:
  • Working with payers to create transitional payment models
  • Initiating development with payers of full-capitation payment models
Payment System Initiatives

Initiative I: Develop self-funded employer health plan

- Hospital is already 100% at risk for medical claims
- Change benefits to encourage greater “consumerism”
- Begin creation of care management infrastructure
- Begin to move up the learning curve
- Cost reduction opportunity for the delivery system

Initiative II: Begin implementation planning for transitional payment models

- Transitional payment models include:
  - FFS against capitation benchmark w/ shared savings
  - Shared savings model Medicare ACOs
  - Shared savings models with other governmental and commercial insurers
  - Partial capitation and sub-capitation options with shared savings
- Prioritize insurance market opportunities
- Take the initiative with insurers to gauge interest and opportunities for collaborating on transitional payment models
- Explore direct contracting opportunities with self-funded employers

Initiative III: Develop strategy for full risk capitated plans
Initiative IV – Population Based Payment System

- A narrow rural/urban provider network focused on patient value
  - Aggregates multiple rural/CAH populations for critical mass
  - Restricted to payers willing to commit to population health and payment
    - On CCO’s terms
    - NOT for existing fee-for-service or cost contracts
- Legal entity with corporate powers
  - Governance structure for setting strategy, policy, accountability
- Actively secures and manages risk/reward-based payer contracts
- Supports PCP-focused quality & care coordination across the network
- Retains local hospital independence, but with contractual accountability
- Houses care management infrastructure
Community Care Organizations (CCO) Initiatives – Phase I and II

Phase I: Develop care management building blocks

• Goal: Infrastructure to manage self insured lives

• Initiatives:
  • PCMH
  • Develop claims analysis capabilities/infrastructure
  • Develop evidenced based protocols

Phase II: Develop Strategy for full population health management

• Goal: Infrastructure to manage transitional payment models

• Initiatives:
  • Develop capability to contract with third party payers including actuarial expertise
  • Acquire and analyze third party payer claims targeting high cost users
  • Develop payment/measurement system to attribute value and distribute shared savings
  • PCMHs are provided tools to better manage patient care to improve outcomes and patient health
CCO Initiatives – Phase III and IV

Phase III: Implementation plan for full risk-based population contracts

• Goal: Infrastructure to manage care for a defined population within a budget

• Initiatives:
  • Risk management capability (e.g., re-insurance)
  • Enhanced third-party payer “partnerships” (e.g., plan design, joint marketing, etc.)
  • Capability to support value-based credentialing

Phase IV: Implementation of Integrated delivery and payment system

• Goal: Implement full provider-based health plan
Implementation Framework – In review

MARKET OVERVIEW

TRANSITION

FRAMEWORK

STRATEGIES
For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.

- The current environment driven by healthcare reform and market realities now offers a new set of challenges. Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes.

- Core set of new challenges represents the Triple Aim being played on in the market.

- Locally delivered healthcare (including rural and small community hospitals) has high value in the emerging delivery system.

- “Shaky Bridge” crossing will required planned, proactive approach.
  - Finance will lead function and form.
  - Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system.
Conclusions / Recommendations (continued)

• Important strategies for providers to consider include:
  • Increase leadership awareness of new environment realities
  • Improve operational efficiency of provider organizations
  • Adapt effective quality measurement and improvement systems as a strategic priority
  • Align/partner with medical staff members contractually, functionally, and through governance where appropriate
  • Seek interdependent relationships with developing regional systems
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