Partnerships: Positioning Hospitals for the Future

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Brian Haapala, Director

Triple Aim: Then and Now

The IHI Triple Aim

- Efficiency
- Safety
- Accessibility

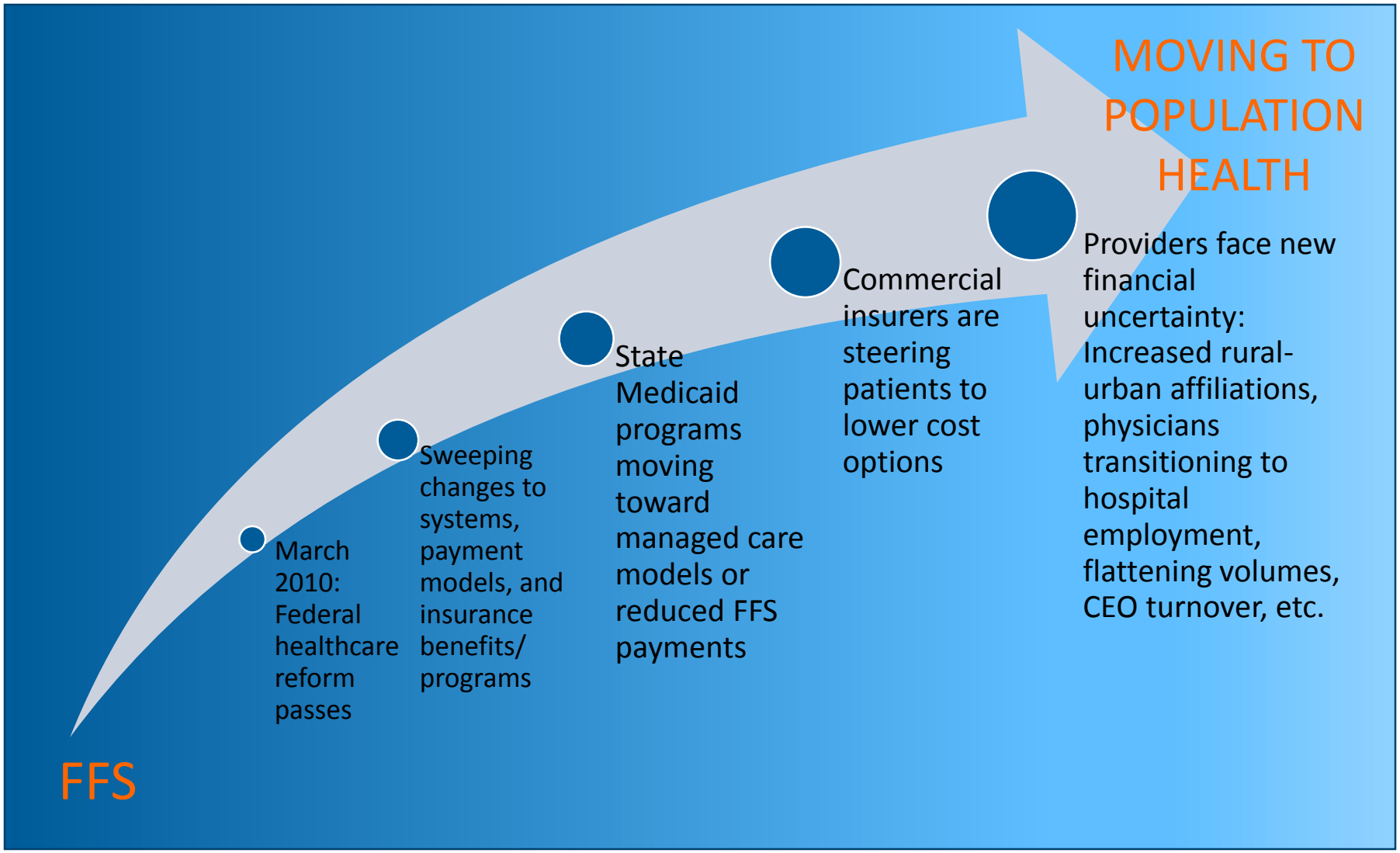
- Costs
- Quality
- Population Health

Today's Presentation

- Affiliation trends resulting from the industry's transition
- Understanding value of rural

Stroudwater's Qualifications
Advisors to CEOs and Boards of Directors on affiliations, joint ventures, and transactions
Strategic planning, financial and operational improvement
Facilities planning, volume forecasting, space needs and financial sustainability
Rural focus with over 17 years of experience
Multi-disciplinary expertise and perspectives
Active projects in all regions

The Healthcare Environment Is Changing Rapidly!



Putting the Challenge in Context

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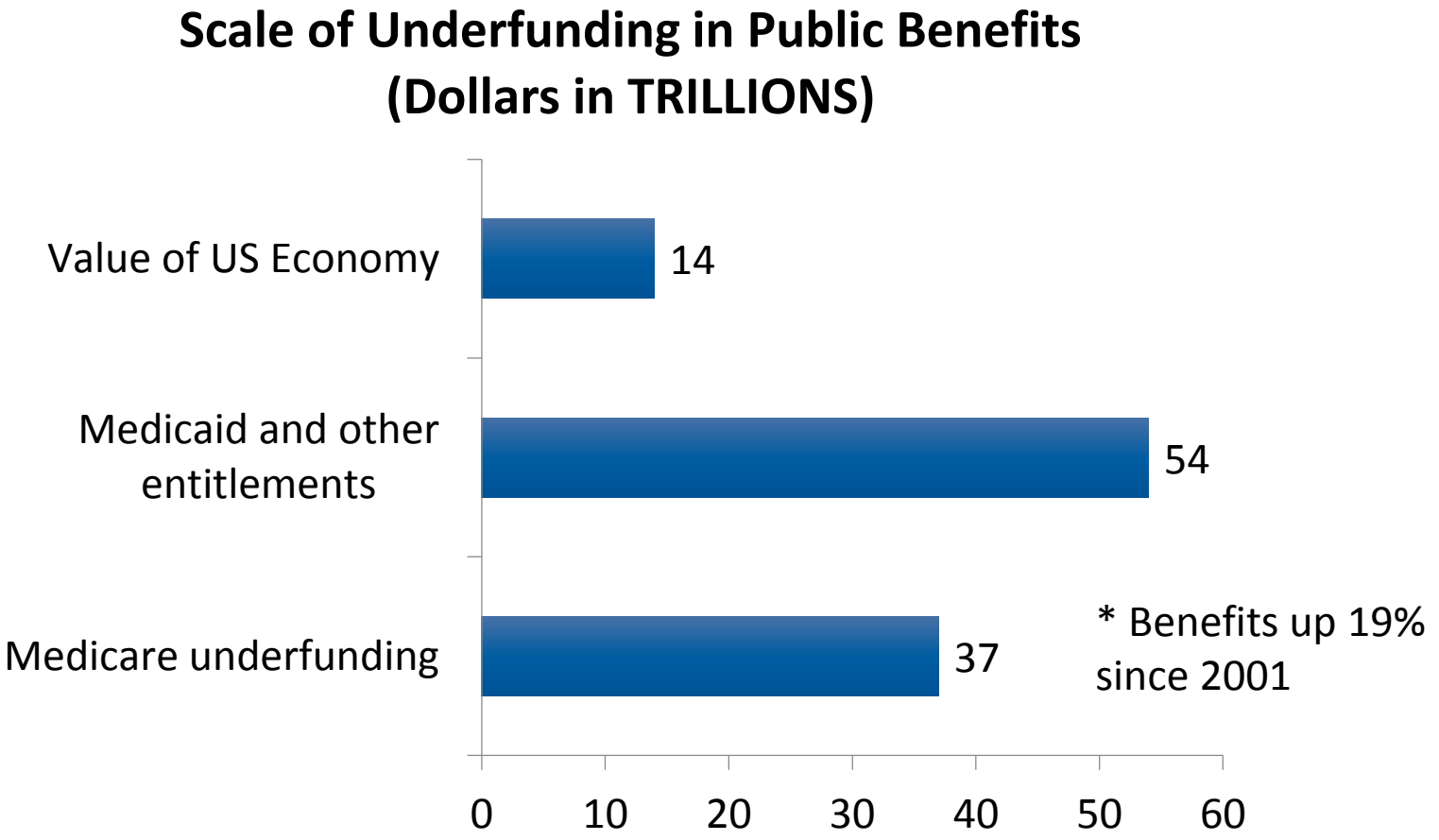

Dependent on Public Funding Sources

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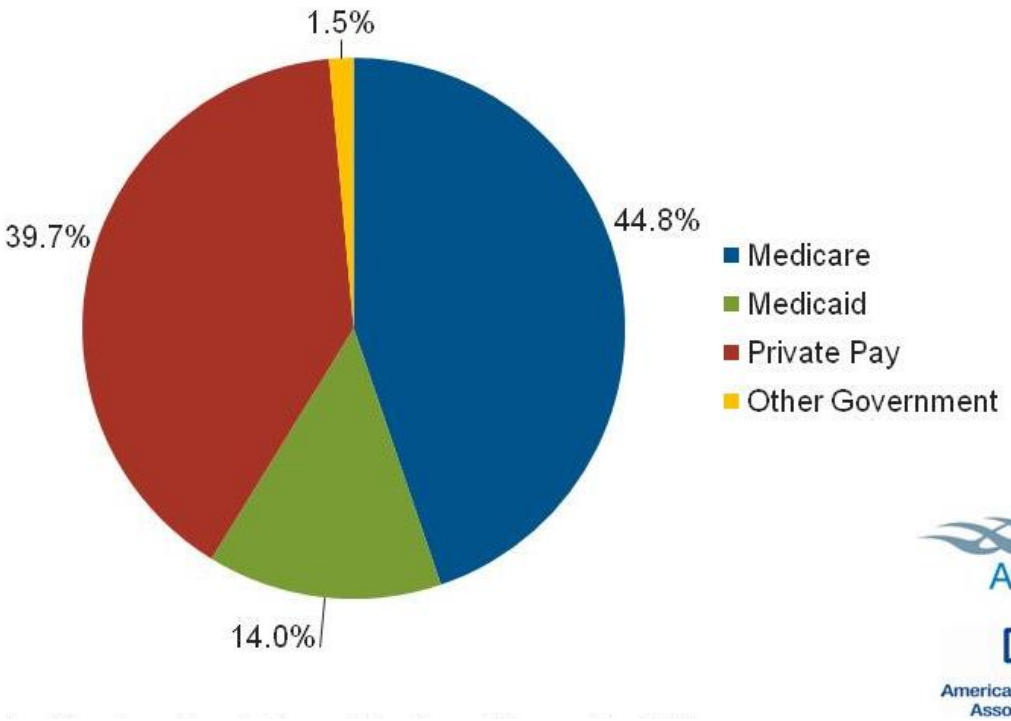
Federal / State

1. Lower payment rates and lower adjustments (e.g., DSH)

2. Pay for quality results in "Winners and losers"

3. Incentives for reducing costs through ACOs, for example

4. Medicaid expansion
   - 23 states opting out, waivers for their own approaches
   - Medicaid managed care for transitioning to global payments



Avalere

American Hospital Association

Less Demand from Consumers

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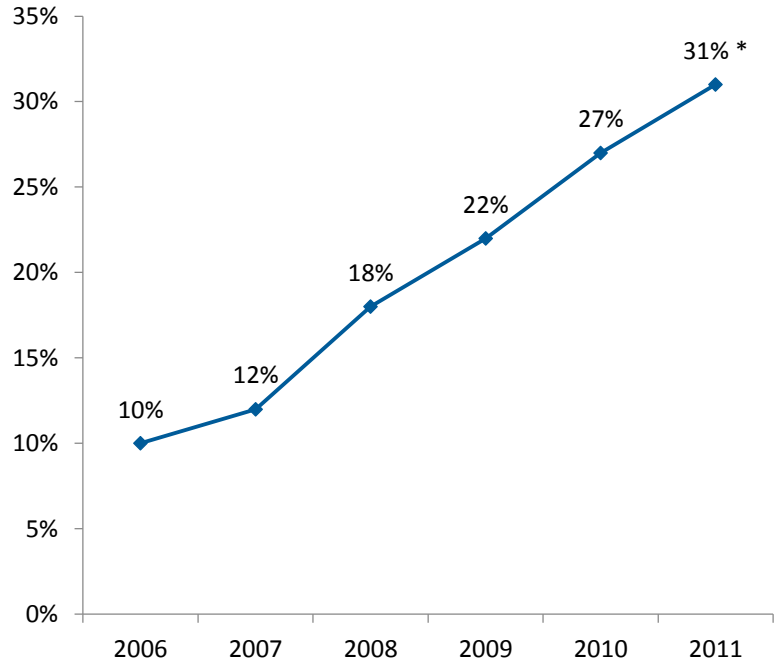
Consumerism and retail shopping mindset of patients

- High deductible health plans
- Emerging transparency re: quality and pricing
- More competition among providers

Percentage of Workers With Deductible of $1,000 or More



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2010.; Single Coverage; and The Wall Street Journal.

Employers Contracting Directly

- **Increased move toward direct contracting arrangements** between employers seeking to contain healthcare costs and increase quality

Cleveland Clinic

Walmart

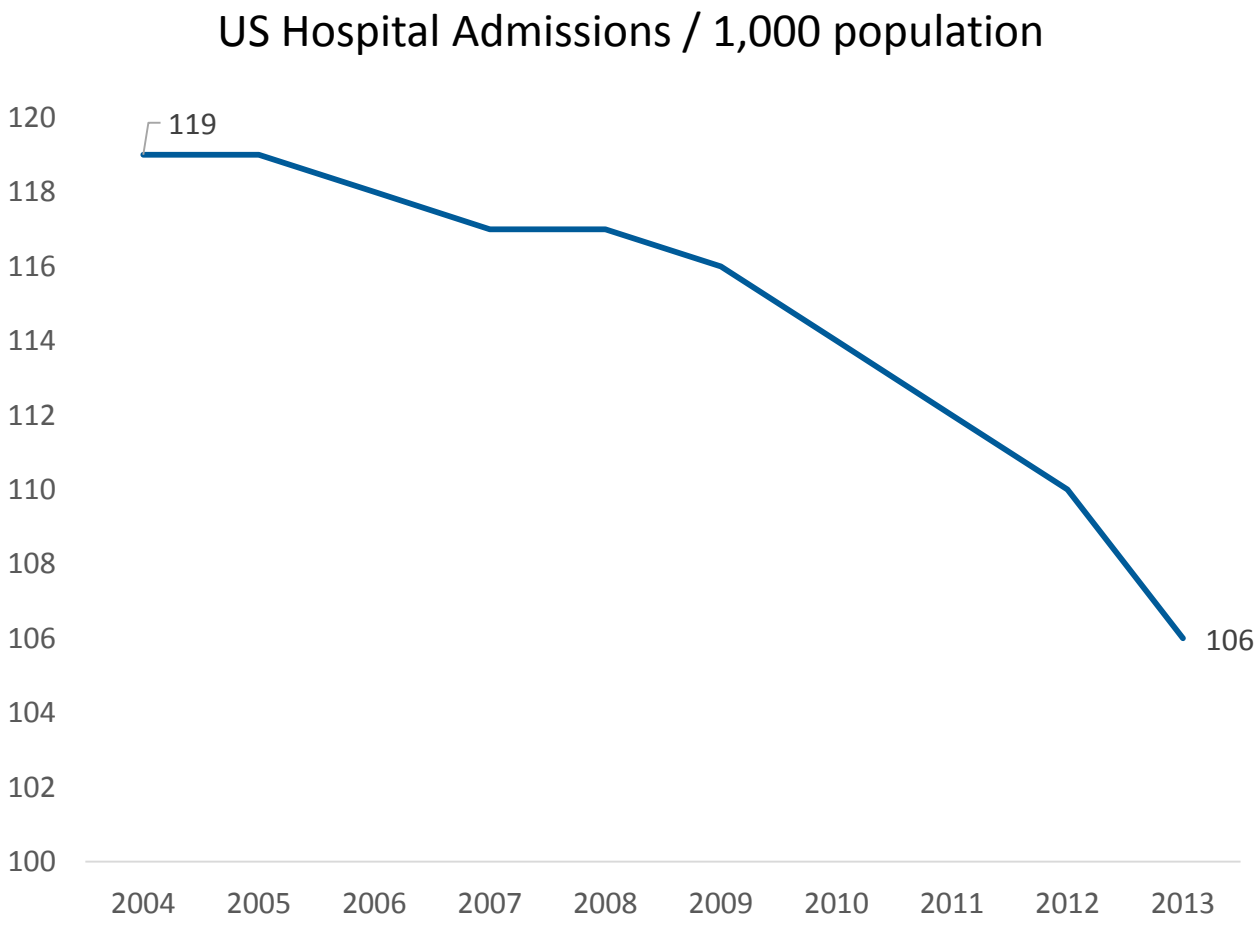
LOWE'S

PROVIDENCE-SWEDISH
Health Alliance
PROVIDENCE Health & Services
SWEDISH

BOEING

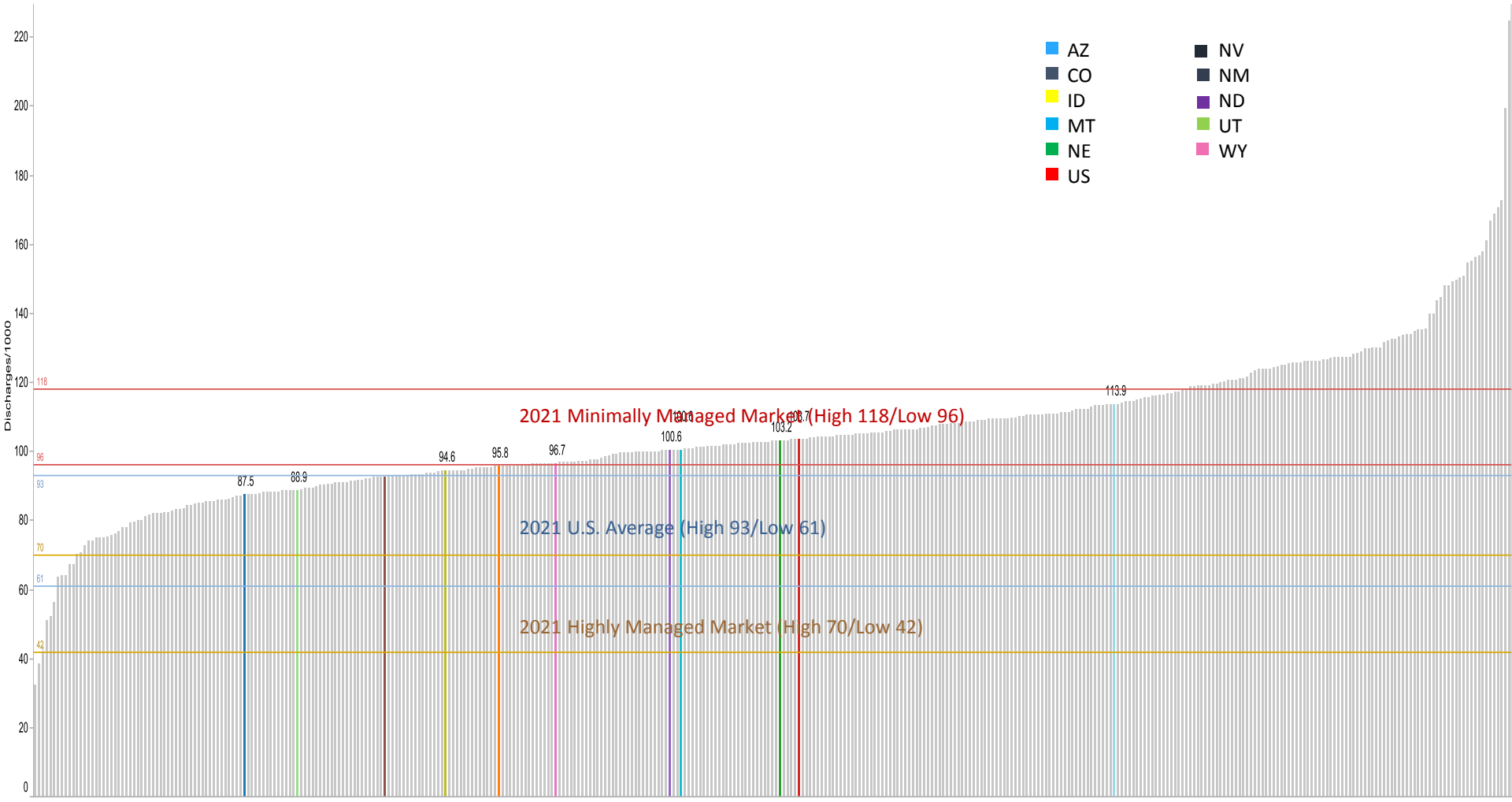
Source: Becker's Hospital Review

11% Inpatient Decline in Use



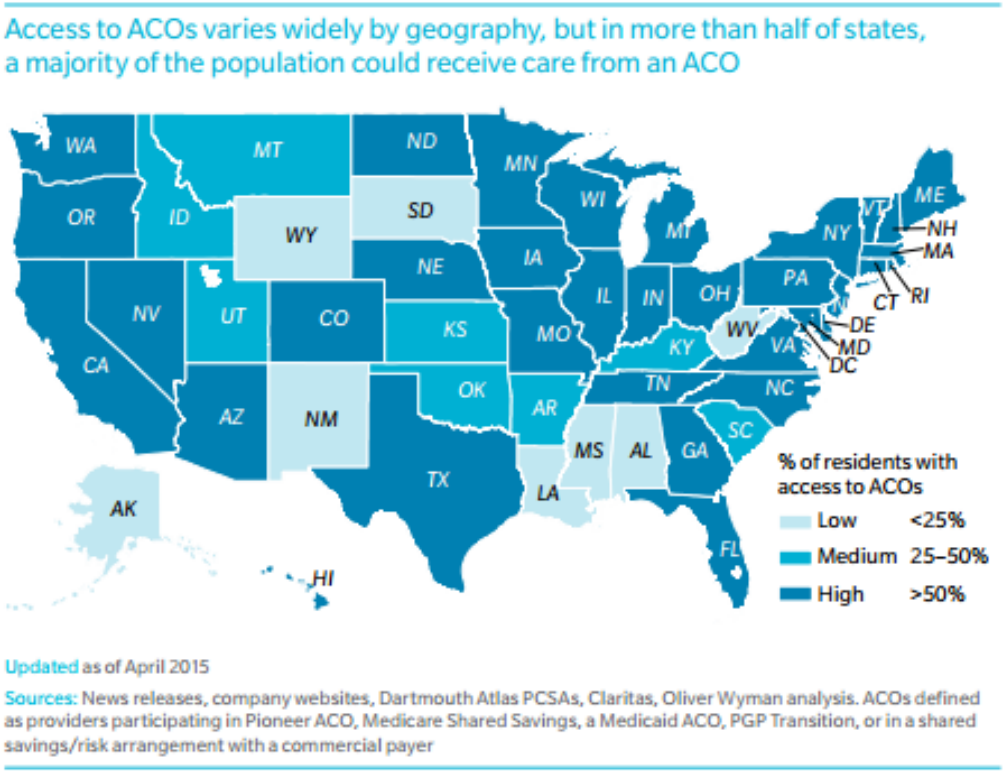
Source: Kaiser State Health Facts, kff.org

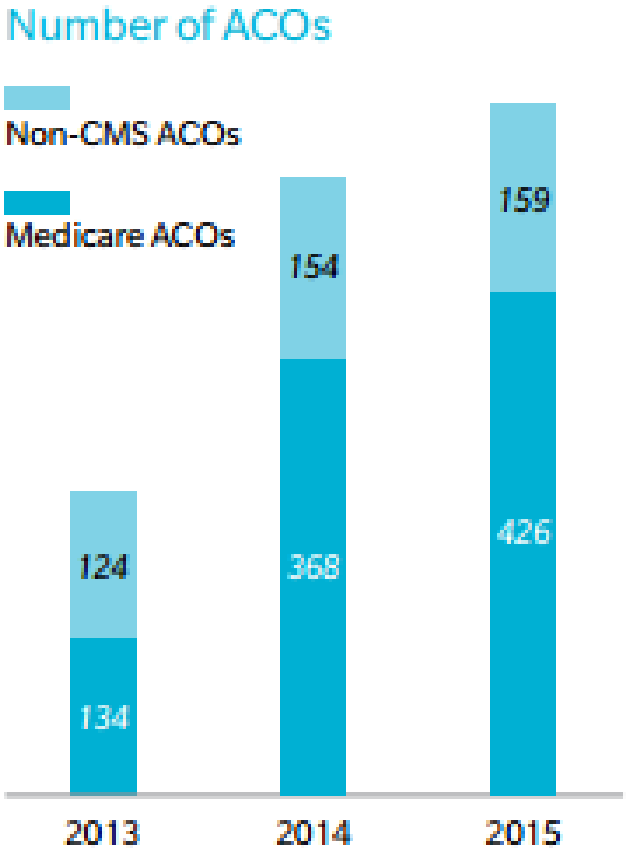
Variation in Utilization



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)

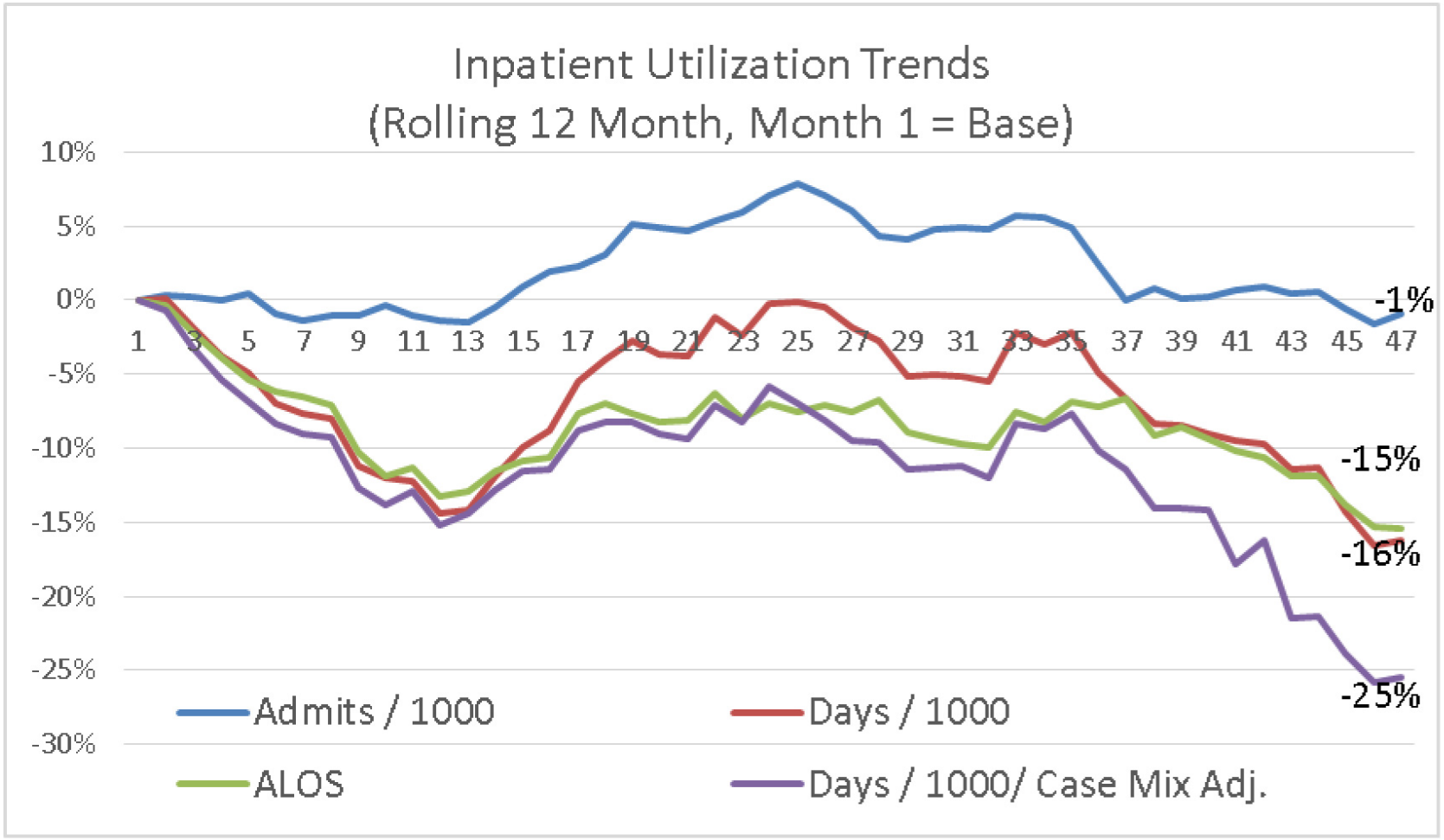
Number and Location of ACOs





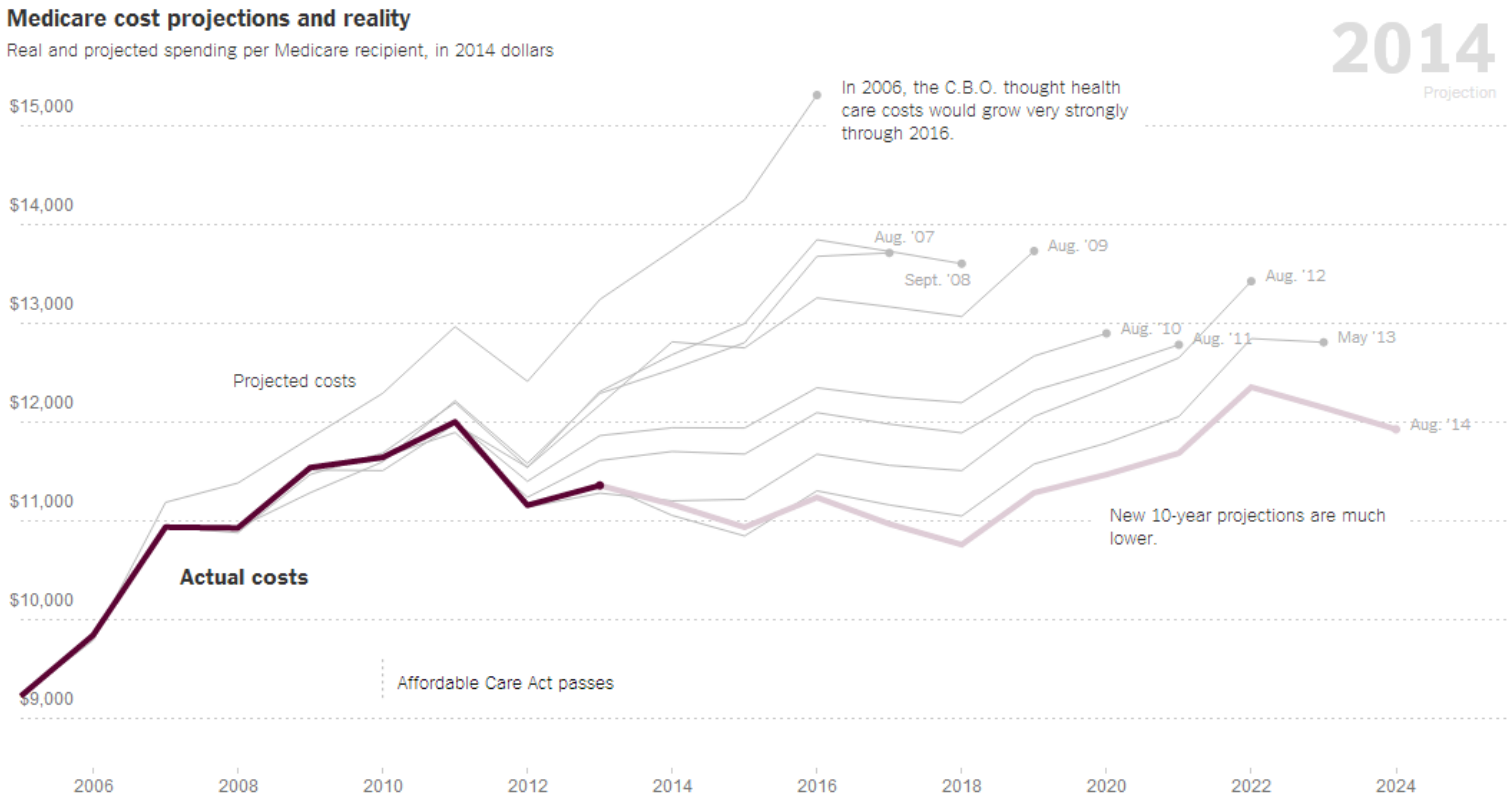
Source: Oliver Wyman, *ACO Update: A Slower Pace of Growth in 2014*

California ACO Experience



Four Years Into A Commercial ACO For CalPERS: Substantial Savings And Lessons Learned. Health Affairs, April 2014

How Do Real and Projected Spending Compare?



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

Hospital Implications

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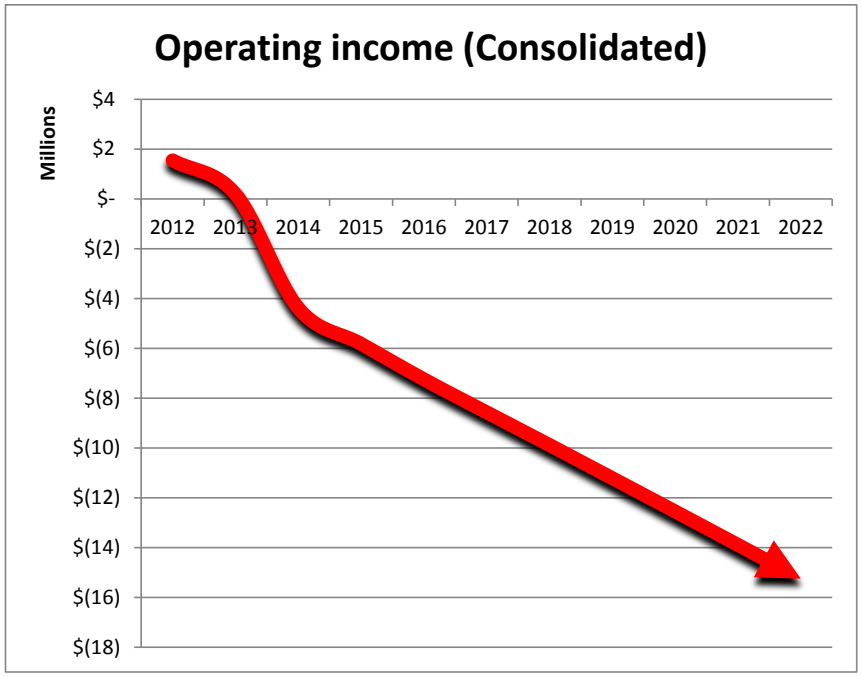
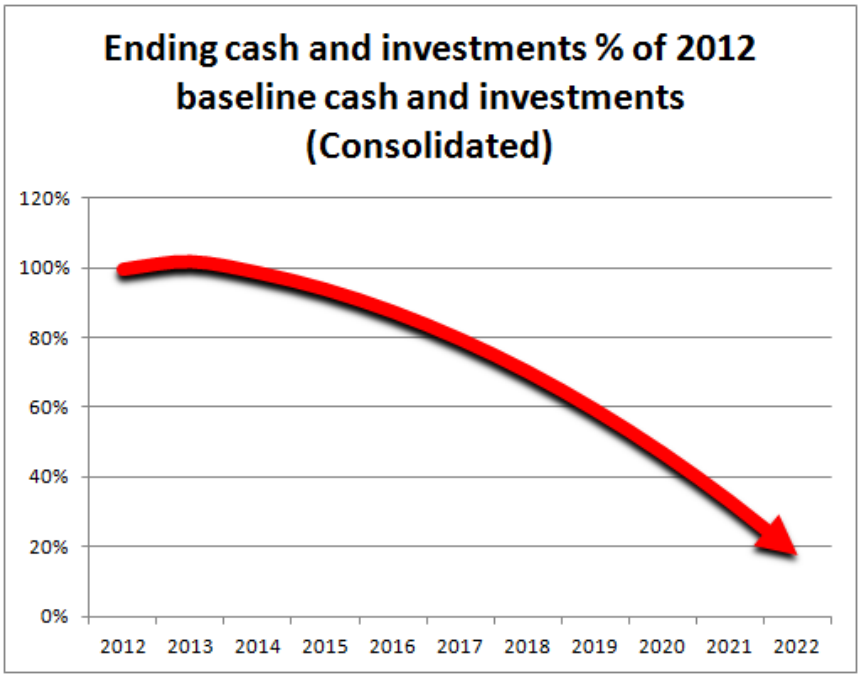
- Changing environment
  - Payment systems changing from volume-based to value-based
  - More competition on quality and payment
  - Reduced payments that are "real this time"
- New environmental challenges are the **TRIPLE AIM!!!**
- Market competition on economic driver of healthcare: **PATIENT VALUE**

Financial Implications

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

Closed Hospitals Since the Beginning of 2013

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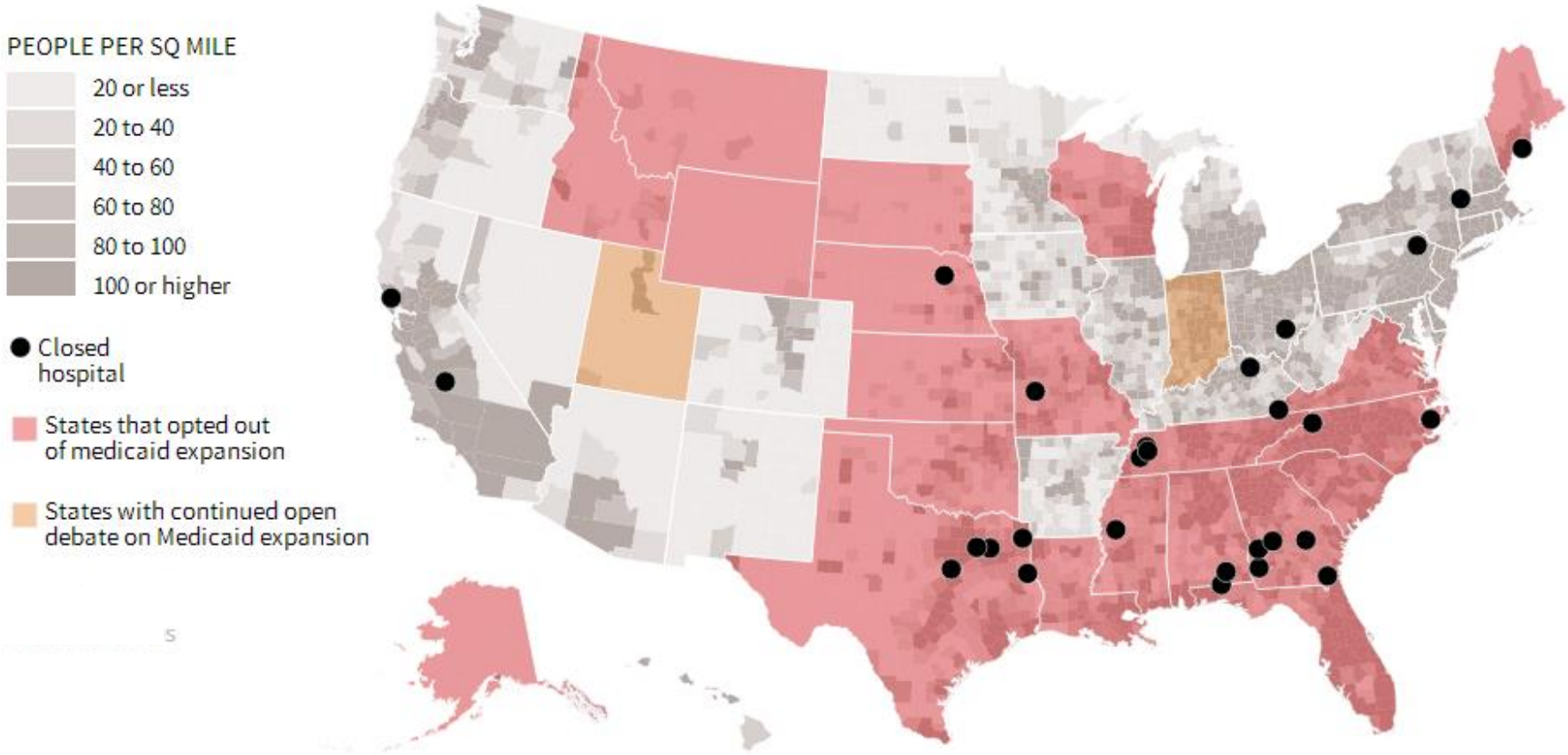

Source: Reuters Graphics

Increasing System Membership

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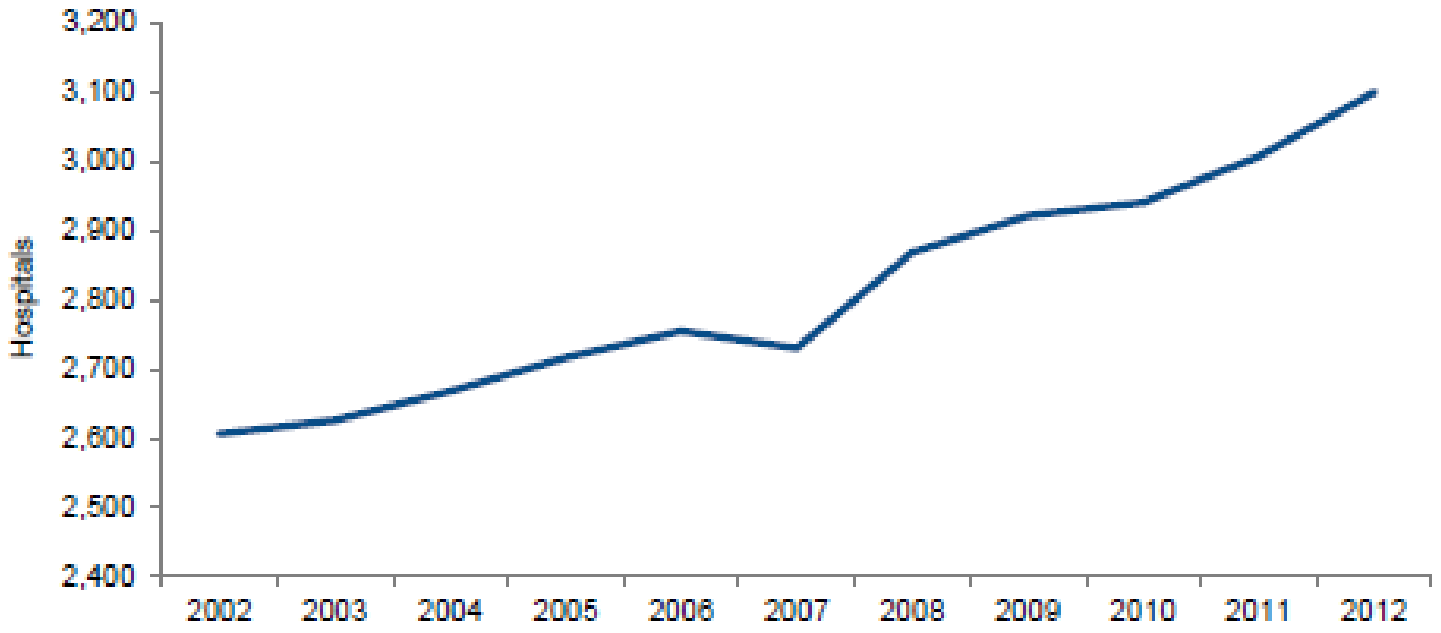
Chart 2.4: Number of Hospitals in Health Systems,[1] 2002 – 2012



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2012, for community hospitals.

(1) Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries, as well as non-health-related facilities including freestanding and/or subsidiary corporations.

Affiliation is not a goal; it is a strategy to achieve an organization's objectives.

Transition Framework

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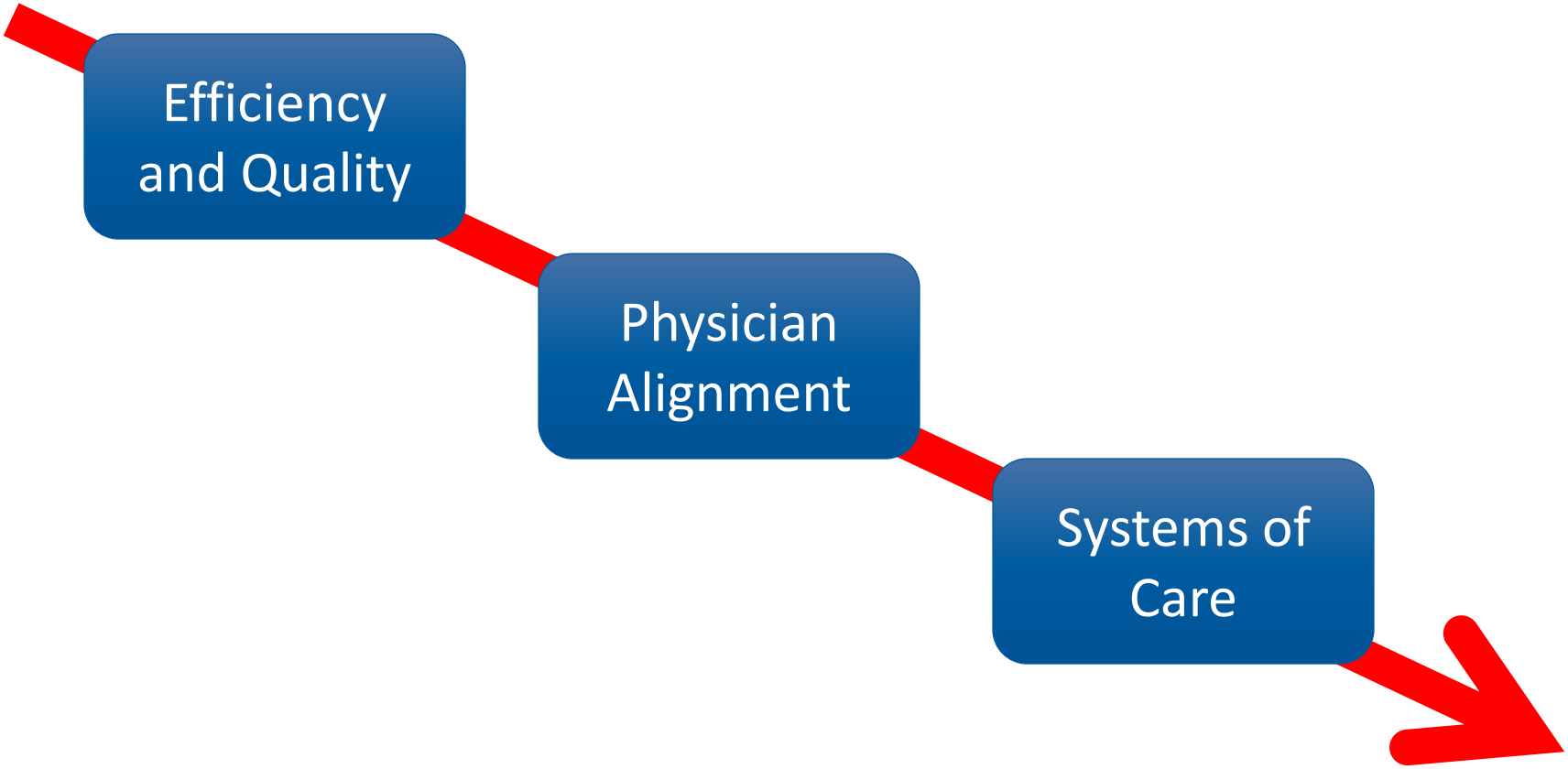


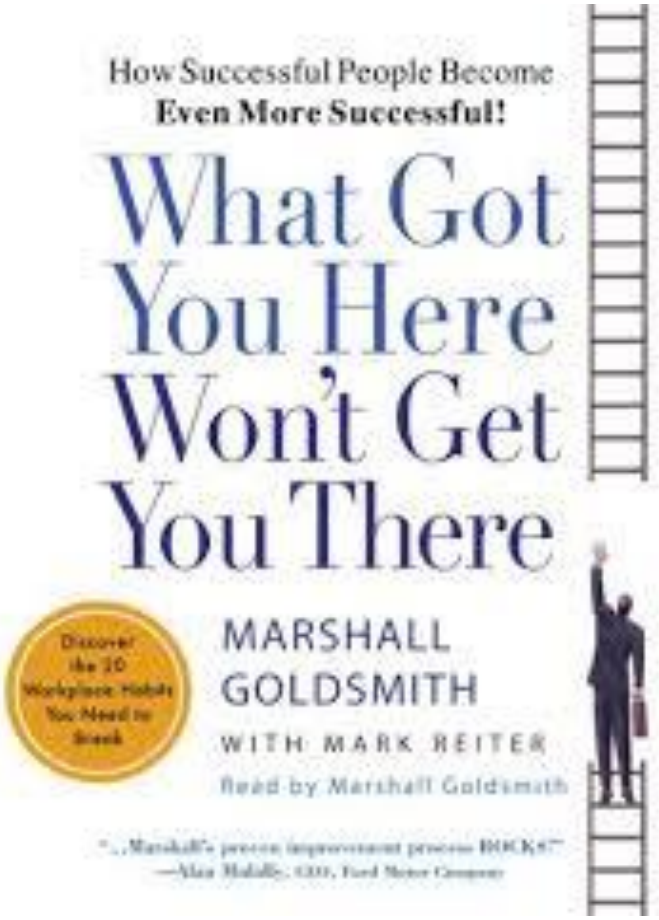
Volume	Value	Population
Market Approach to Payments		

Three Elements of Financial Contribution

X- Regional Health System – T-Hospital Contribution Margin Analysis			
YTD as of June 30, 2010			**T-Hospital**
Net Income (Loss):			
Total Operating Revenue		$	18,209,000
Total Operating Expense			18,420,000
Operating Income (Loss)			**(211,000)**
Depreciation Expense			546,000
Non Operating Income			485,000
Net Income (Loss) Less Depreciation Expense		**$**	**820,000**
Indirect Cost Allocations to CAH Affiliates:			
Estimated Administrative and General Costs (Source: Below Analysis)		$	1,638,537
Medicare Cost-Based Payer Mix (Source: Below Analysis)			29.50%
Net Increase in CAH Cost Based Reimbursement			**483,320**
Net Income Less Depreciation Expense Plus Fixed Allocated Costs		**$**	**1,303,320**
Transfer Benefits			
Total 2014 Est. Discharges for CAH Service Area (Source: Thomson Reuters)			3,134
Current Partner Medicare Market Share (Source: 2009 CMS Med Par Data)	**(I)**		56%
Estimated X-RHS Discharges from CAH Service Area			1,755
Estimated Net Revenue Per Discharge (Source: AHD.com; 2009 Data)	**$ 8,930**	$	8,930
Estimated X-RHS Net Inpatient Revenue from CAH Service Area			15,672,507
Est Net OP Rev From CAH Service Area (source: AHD OP % of IP Charges)	**102%**	$	16,010,228
Total Net Transfer / Referral Dollars to System from CAH Affiliates		$	31,682,735
Estimated Contribution Margin % (Source: Estimated)	**60%**		60%
Estimated Contribution Margin on Net Revenue from CAH Service Area	**(II)**	$	19,009,641
Contribution Margin Per 1% of Inpatient Market Share	**(II)/(I)**	$	339,458
Estimated Change in Market Share % with Competitive Entry into CAH			**5%**
CM from Loss of existing or potential gain of CAH Service Area Market Share		**$**	**1,697,289**
Total Benefit / Cost to X-RHS from T-Hospital		**$**	**3,000,609**

1. Cash flow
2. Cost allocation
3. Transfers

Fee-for-Service vs. Population Health



Sustainability of projects in a *fee-for-service* world is based on

Volume

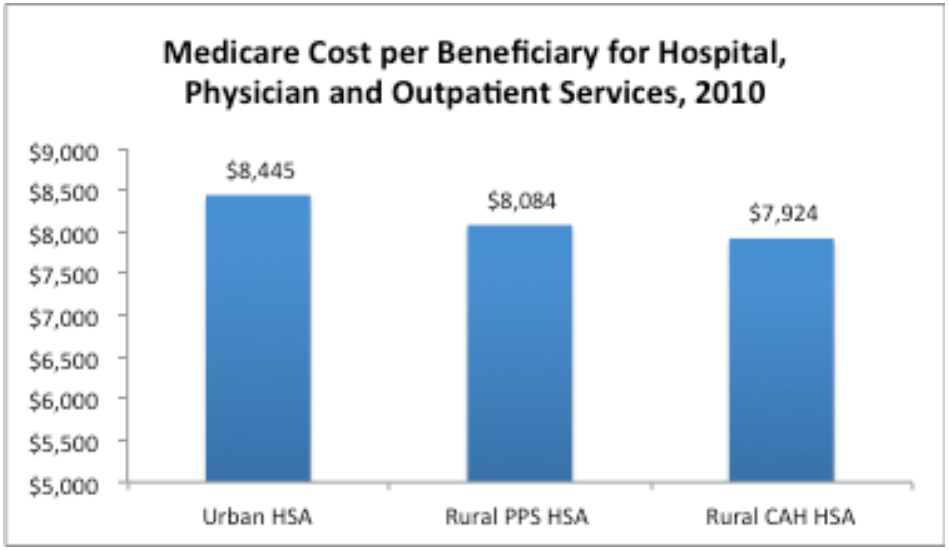
Sustainability of projects in a *population health* world is based on

Value

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

Lower Rural Costs Result in Medicare Savings

- $903M of cost savings from Rural CAH for hospital, physician, and outpatient services
  - Urban cost per beneficiary is $8,445 compared to $8,084 for Rural PPS and $7,924 for Rural CAH service areas
  - $903M of cost savings from Rural CAH ($7,924-$8,455) *1.7M beneficiaries in Rural CAH areas
- Rural PPS and CAH areas are 4.3% and 6.2% lower in cost per Medicare beneficiary
  - Analysis based on location of primary residence and includes total costs of hospital, physician and outpatient care

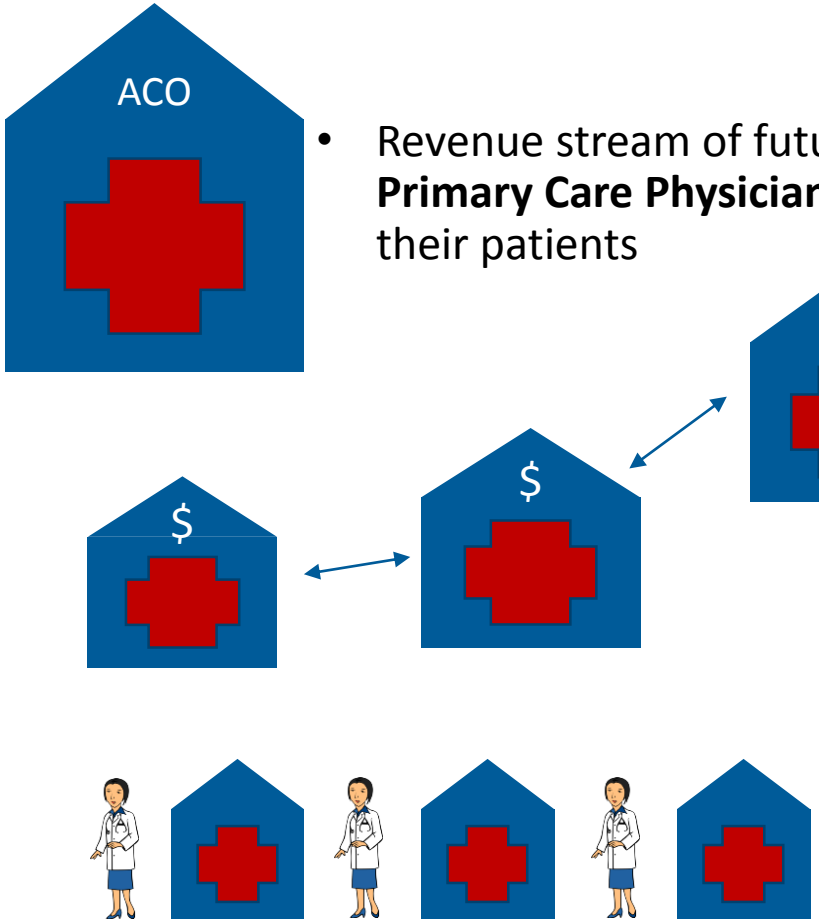


Beneficiaries (millions)	
Urban HSA	20.02
Rural PPS HSA	3.72
Rural CAH HSA	1.71

Source: Dartmouth Atlas of Healthcare, 2010 Medicare reimbursements per enrollee (Parts A and B) for hospital, physician, and outpatient services Price, age, sex & race-adjusted. Hospital service areas (HSA) divided into urban and rural based on 2010 Census data. Areas with a Prospective Payment System (PPS) general acute or a Critical Access Hospital (CAH) were assigned accordingly.

Future Hospital Financial Value Equation

- ACO Relationship to Small and Rural Hospitals



- Revenue stream of future tied to **Primary Care Physicians (PCPs)** and their patients

- **PCP-based small and rural hospitals** bring value/negotiating power to affiliation relationships

- **Smaller rural & community hospitals have value through alignment with PCPs** but must position themselves for new market:
  - Align with local PCPs
  - Develop a position of strength by becoming highly efficient
  - Demonstrate high quality through monitoring and actively pursuing quality goals

Rural Provides Tremendous Value to a Partner

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To understand the potential of the financial power of primary care physicians, consider the following:

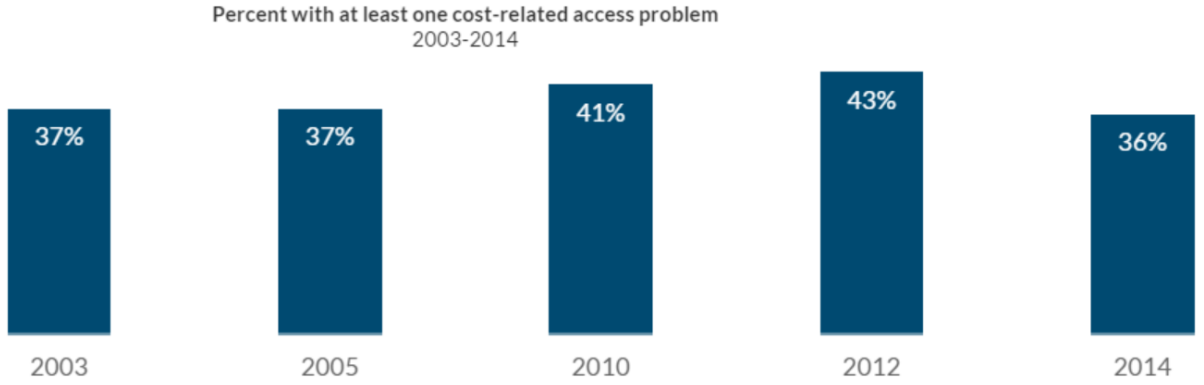
PCP Value Worksheet	
PCP Panel Size	2,300
Annual Medical Cost Per Patient	$7,097
Total PCP Panel Healthcare Expenditure	$16,300,100
Annual value of 5% savings from enhanced patient management	$815,005

- This surplus would be available to increase PCP compensation, to reward their employers, and even to reduce insurance prices.
- ***Under capitation-based revenue models, the PCP becomes the critical generator of medical savings.***

Sources: *Journal of General Internal Medicine*; MedPAC, and Patient Centered Primary Care Collaborative.

Value of Access to Care

Percent with at least one cost-related access problem



American adults 19-64 with at least one cost-related access problem

Source: The Commonwealth Fund Biennial Health Insurance survey 2014

Opportunity with Hospital Employees

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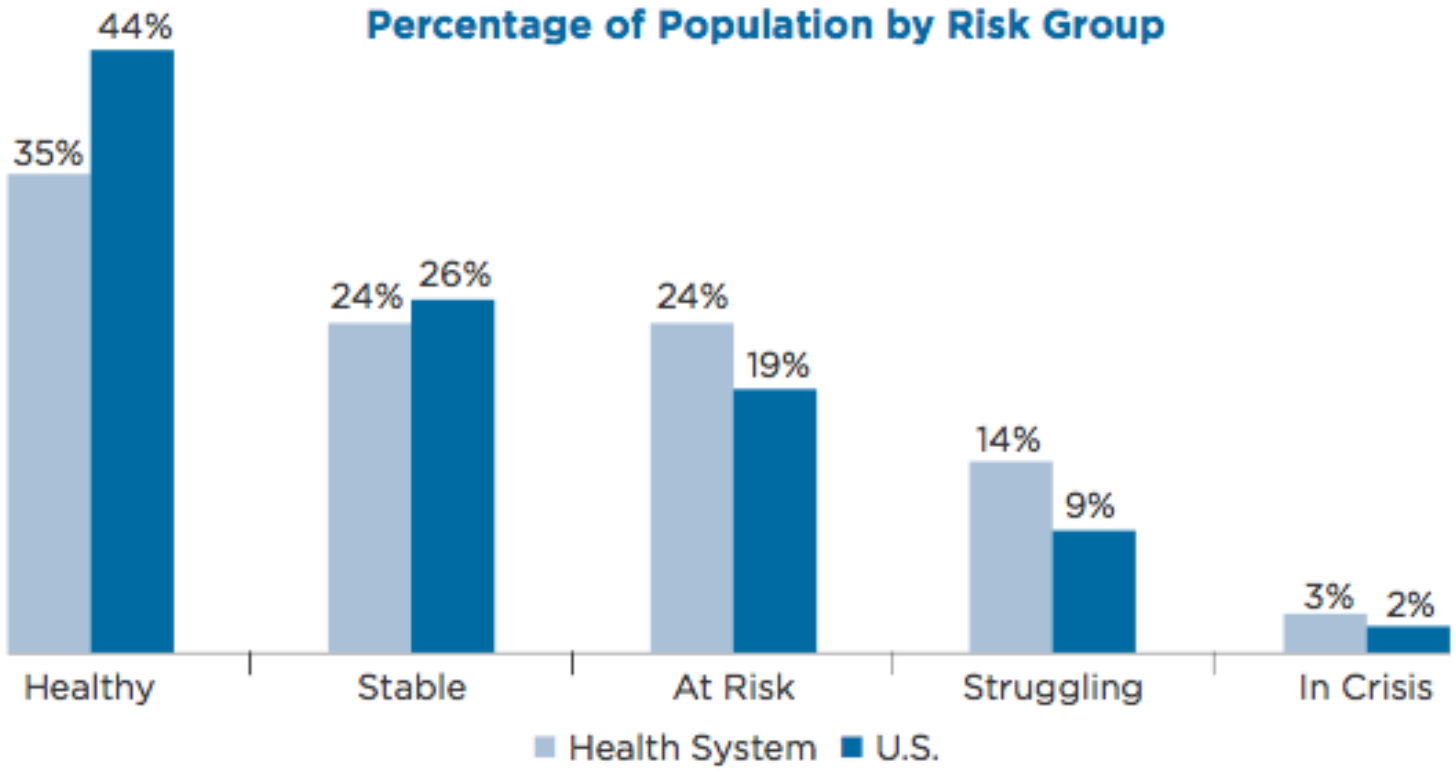
Figure 1: Burden of Illness for Hospital Employees Compared to the U.S. Workforce



Source: Truven Health MarketScan data, 2012.

The Good News & Bad News About Improving Value

Higher quality generates lower per-capita patient costs...

… which, under FFS, can kill your hospital.

The Challenge: Crossing the Shaky Bridge

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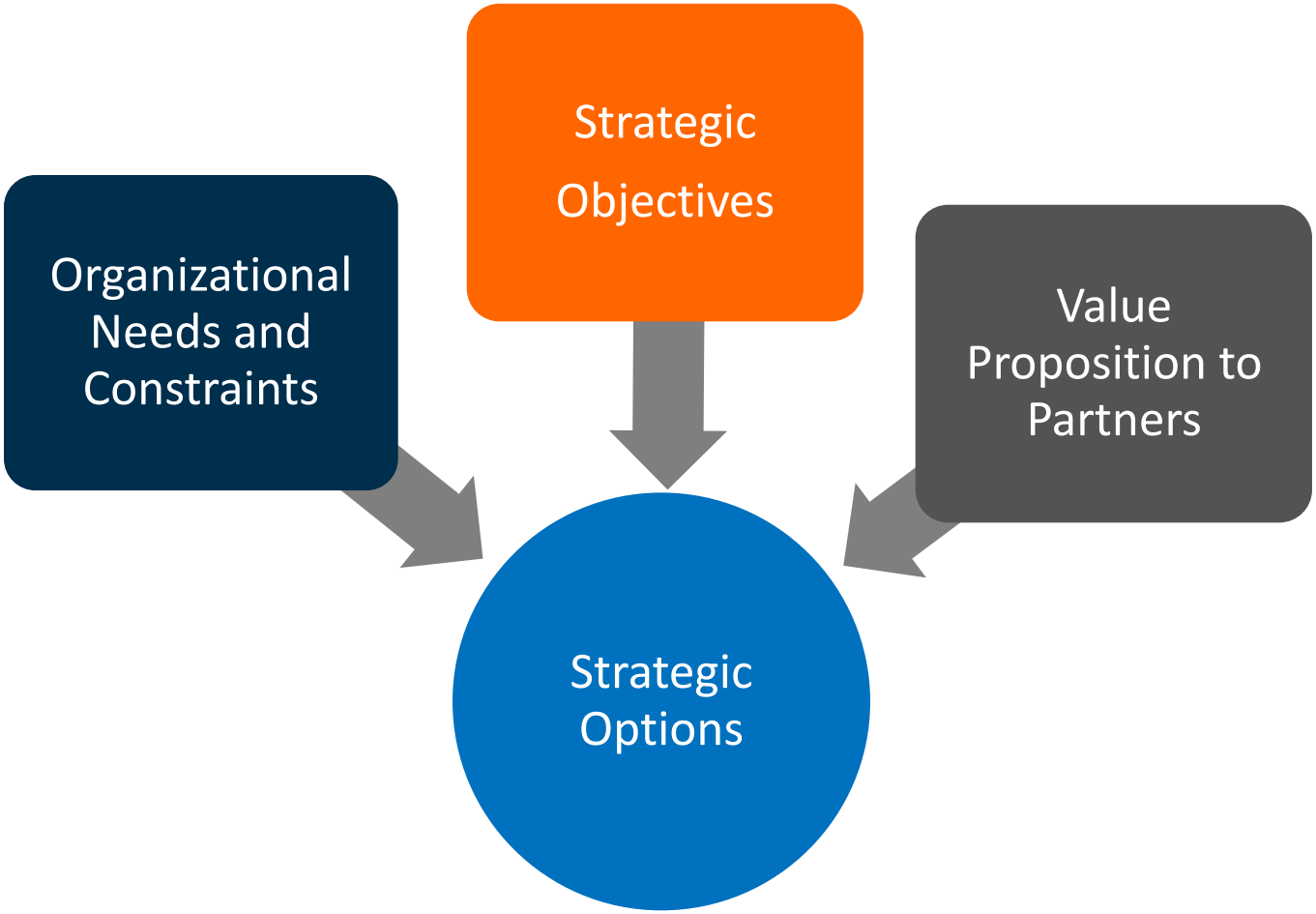
Fee for Service Payment System

Population Based Payment System


Strategic Objectives
Organizational Needs and Constraints
Value Proposition to Partners
Strategic Options

Thank you.

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