Achieving the Triple Aim in Healthcare

Strategies for Rural Hospital Success

2012 National Conference of State Flex Programs

Strength in Numbers

July 10, 2012

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Bethesda, MD

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Overview/Introduction

- In the past 12-24 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 three years
      - Rural healthcare providers throughout the country are looking out to the future attempting to project what it means to them and how to position themselves for that future
  - State Medicaid programs are moving toward managed care models or reduced fee for service payments to balance State budgets
  - High deductible health plans are encouraging patients to engage in utilization management
- Thus, providers face new financial uncertainty and challenges and will be required to adapt to the changing market

Rural Challenges

- Market challenges affecting rural hospitals over the next five to ten years
  - Factors that will have, or continue to have, a significant impact on rural hospitals over the next 5-10 years
    - Payment systems transitioning from volume based to value based
      - FFS → Value Based Payment / Accountable Care
    - Increased emphasis of Quality as payment and market differentiator
      - Measurable and comparable
      - Must be meaningful
    - Reduced payments that are "Real this time"
      - Healthcare providers will have to do more with less
      - CCN – Medicaid underpayment
    - Increased burden of remaining current on onslaught of regulatory changes
      - Regulatory Friction / Overload
    - Continued difficulty with recruitment of providers to rural areas
    - Increasing competition from other hospitals and physician providers for limited revenue opportunities
    - Requirement that rural information technology is on par with urban hospitals
    - Rural hospital governance members without sophisticated understanding of rural hospital strategies, finances, and operations
    - Consumer perception that "bigger is better"
    - Severe limitations on access to capital of necessary investments in infrastructure and provider recruitment

New Environment Challenges

- New Environment Challenges
  - 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!!!

Future Healthcare Environment

- 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.

Prioritized Challenges

- Volume Based to Value Based Payment Systems
  - Important elements of Challenge
    - Hospital acquired condition penalties (beginning 2013)
    - 30-day Readmission Penalties (beginning 2013)
      - Readmissions – how does hospital manage behavior of patient population
        - Incentive to affect change now resides with providers
    - Value Based Purchasing
      - VBP – 2013 withhold for PPS Hospitals
    - Bundled payment initiative
    - Self funded health plans
      - Efficiencies around self funded benefit plan to drive savings to hospital bottom line
        - Incent employees to make better choices
          - Ex: Higher premiums for smoking, obesity, etc.
        - Align with Community Partners
          - Nursing Home
          - Home Health
          - Etc.
    - Medicare ACOs

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - Market Symptoms/Response
    - Generally agreed that fertile market for ACOs occur due to relatively low margins and need to transition from volume payment models due to reduced levels of fees
    - In 10 years likely that 90% of hospitals will be aligned (10% will be truly independent)
    - Shift at accelerated pace of independent physicians to employed physicians
      - Non-ACO accountable care initiatives will require increased integration between medical staff and rural hospitals
    - Concern of task force members is that transitioning of the delivery system functions must coincide with transitioning payment system or rural hospitals, without adequate reserves, will be a financial risk
      - "Stepping onto the shaky bridge" analogy

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - ACO Relationship to Rural Hospitals
    - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
      - ACO language: PCP can belong to one ACO. Hospitals and specialists can belong to several
        - Cost centers will become bricks and mortar, technology, and specialists
    - Rural hospital will not likely have the scale to form their own ACO and thus must consider their relationship with forming regional ACOs
      - Regional ACOs will look to increase number of covered patients to generate additional "revenue" and dilute fixed costs
    - Rural hospitals bring value / negotiating power to affiliation relationship as generally PCP based
      - Rural has 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
      - Rural hospital must better understand their value proposition to forming networks and **NOT** perceive themselves as approaching urban for a "hand out / bailout"

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - Provider Strategies
    - 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
      - Engage commercial payers in conversation about change in payment process
      - Engage all forming regional ACOs in discussions
      - Develop clinical integration strategies with medical staff that increase likelihood of successfully implementing "non-ACO" accountable care programs
      - Evaluate all opportunities to increase efficiency and improve quality
      - Engage employers in wellness programs
    - Hospital Affiliation Strategies
      - Understand that revenue streams of the future will be tied to primary care physicians, which often comprise a majority of the rural healthcare delivery network
        - ➢ Thus rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - Provider Strategies (continued)
    - Hospital Affiliation Strategies (continued)
      - 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"
        - Integration of services where it makes sense
      - Explore / Seek to establish interdependent relationships among rural hospitals understanding unique value of rural hospitals relative to future revenue streams
    - 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/Structure
      - Educate Board members about new market realities to both open eyes and influence decision makers in positive direction
        - Goal is to take local politics out of major strategic decisions including affiliation strategies, medical staff alignment, in increasing hospital efficiency

Prioritized Challenges

- Quality as Payment and Market Differentiator
  - Important elements of challenge
    - Value based payment program
      - Hospitals will be scored based on quality measures from three domains compared against peers (outcome score) and yourself (improvement scores)
        - Clinical Process
        - Patient Experience
        - Outcomes (beginning in 2014)
    - Educated Consumers / Transparency
      - Hospital quality data available publicly
        - Hospital Compare
        - Health Leaders
        - Hospital websites
    - Rural hospitals that lack sophisticated technology must combat negative market perceptions
    - Federal Office of Rural Health Policy initiatives MB-QIP program encouraging CAHs to report rural relevant quality measures

Prioritized Challenges

- Quality as Payment and Market Differentiator (continued)
  - Market Symptoms/Response
    - Rural hospitals have varying degree of acceptance as to rural relevant measures
      - Often unwilling to report (CAHs) as measures "not relevant to us"
      - Hospitals that have accepted measures are aggressively seeking to improve scores
    - Increasingly, patients have easy access through internet to hospital quality information (Healthgrades.com; Hospital Compare)
      - Hospital administration often not aware of their scores or do not believe their scores reflect the quality provided in their institutions
        - Unfortunately, perception often drives reality
    - Rural hospitals that have performed well on quality scores are beginning to promote quality and safety of their hospitals
    - Loss of market share due to perceived or real quality deficiencies is much more serious threat to rural hospitals that potential loss of 1-3% Medicare inpatient reimbursement
    - Increasingly, quality will be differentiator in future provider recruitment

Prioritized Challenges

- Quality as Payment and Market Differentiator (continued)
  - Provider Strategies
    - 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
      - Increase level of Board training, awareness, comprehension
    - 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 LA 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

Prioritized Challenges

- Quality as Payment and Market Differentiator (continued)
  - Provider Strategies (continued)
    - 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

Prioritized Challenges

- Payment Cuts "Real this time"
  - Important elements of challenge
    - Failure of Super Committee to reach agreement thus -2% sequestration impact beginning in 2013
    - Uncertainty related to future of state UPL and DSH programs
    - Value Based Payment Program with 1% maximum cuts beginning in 2013 and 2% in 2017 and after
    - Re-admission payment with max. reduction of 1% in 2013 and 3% 2015 and after
    - RACs, MICs, etc
    - High deductible commercial health plans (e.g., HSAs)
    - Commercial contract with insurers (not willing to cost share)
    - Healthcare Reform
      - Cuts in Update factors for PPS
      - ACOs – potential reduction in volume
      - DSH Dollars / UPL
      - Limitation on Provider assessments
      - 133% Federal Poverty Level eligible for Medicaid 2014
    - Potential physician pay cuts

Prioritized Challenges

- Payment Cuts "Real this time"
  - Market Symptoms/Response
    - Hospitals not operating at efficient levels are currently or will be struggling financially
      - Efficient being 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
    - Resources available for necessary investments in plant, technology, and recruitment are becoming increasingly scarce when required the most
    - Providers hospitals increasingly seeking affiliations primarily as a safety net strategy

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - 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
  - Review profitable / non-profitable service lines to determine fit with mission and financial contribution to viability of organization
    - Define who you are and be good at it
  - Continue to seek additional community funds to support hospital mission
    - Increase millage tax base where appropriate
    - Ensure ad valorem tax renewal
  - Evaluate 340B discount pharmacy program as an opportunity to both increase profit and reduce costs
    - Often 340B only looked upon as an opportunity to save costs not considering profit potential

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - Increase monitoring of staffing levels staffing to the "sweet spot"
    - Staffing education for DONs/Clinical managers
    - Salary Survey / Staffing Levels / Benchmarks that are relevant
  - 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
  - Develop physician practice expertise
    - Provider compensation
    - Clinic charge master
    - Revenue cycle functions
    - Practice throughput
    - Expense management

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - 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

Conclusions/Recommendations

- 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
  - Payment systems transitioning from volume based to value based
  - Increased emphasis on Quality as payment and market differentiator
  - Reduced payments that are "Real this time"
- 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
  - Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system