Achieving the Triple Aim in Healthcare
Strategies for Rural Hospital Success

2012 National Conference of State Flex Programs

Strength in Numbers
July 10, 2012

Marriott Bethesda North
Bethesda, MD
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

- 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 Hospital Financial Value Equation

- Definitions
  - Patient Value

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.
Prioritizing Challenges

Introduction
Challenges
Priorities
- Payment systems
  - Quality
  - Cuts
Recommendation
Summary

- **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
• **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
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”
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
• 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
• 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
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% in 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

Introduction

Challenges

Priorities
• Payment systems
• Quality
• Cuts

Recommendation
Summary

- 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
• 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
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