Financial Sustainability in the New Healthcare Environment
Strategies for Rural Hospital Success

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STROUDWATER ASSOCIATES
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 three years

  - State Medicaid programs are moving toward managed care models or reduced fee for service payments to balance State budgets

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

- 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

![On the Exchange](source)
Market Overview – Market Forces
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 which will produce $895B over 10 years
      – 0.25% in 2010-2011; 0.35% in 2012-2013; 0.45% in 2014; 0.35% in 2015-2016; 1.0% in 2017-2019
  • Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
  • Medicare Hospital Wage Index
    – Likely redefinition of wage areas – projected savings $2.3B over 10 years
  • 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

• 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
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)

  • Accountable Care Organizations (continued)
    • 154 ACOs effective August, 2012
    • 259 ACOs effective January, 2013
      • 40% increase
    • 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.
    • 4 million Medicare beneficiaries, or about 11 percent of total Medicare fee-for-service beneficiaries, will now receive their healthcare from ACOs.
      • The corresponding figures in September were 2.4 million and 6 percent.
    • Total number of Medicare and non-Medicare patients served by Medicare-approved ACOs: 29 million

http://www.heraldonline.com/2013/02/19/4630015/accountable-care-organizations.html
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
Challenges affecting rural hospitals

• Factors that will have, or continue to have, a significant impact on rural hospitals over the next 5-10 years
  • Continued difficulty with recruitment of providers
  • Increasing competition from other hospitals and physician providers for limited revenue opportunities
  • Requirement that information technology is on par with large hospital systems
  • 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 of necessary investments in infrastructure and provider recruitment
  • 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”
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

Harvard Business Review

Redefining Competition in Health Care

by Michael E. Porter and Elizabeth Olmsted Teisberg

www.hbr.org
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.
• 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
Prioritized Challenges – Payment Systems

• Important elements of Volume Based to Value Based Payment 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.
  • Medicare ACOs
Prioritized Challenges – Payment Systems

• Market Symptoms/Response

  • Generally agreed that fertile market for ACOs to 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

  • 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
Prioritized Challenges – Payment Systems

• ACO Relationship to Small and 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

  • Small and rural hospitals bring value / negotiating power to affiliation relationship 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
Prioritized Challenges – Payment Systems

• ACO Relationship to Small and Rural Hospitals (continued)

  • Smaller hospitals will not likely have the scale to form their own ACO and should consider their relationship with forming regional ACOs (rural or urban based)
    – Regional ACOs will look to increase number of covered patients to generate additional “revenue” and dilute fixed costs
Prioritized Challenges – Payment Systems

• 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
Prioritized Challenges – Payment Systems

• Provider Strategies (continued)

  • 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
    ➢ [https://secure.ruralcenter.org/help-registration/playbacks](https://secure.ruralcenter.org/help-registration/playbacks); or
Prioritized Challenges – Payment Systems

• Provider Strategies (continued)

• 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 and small hospital healthcare delivery network
  ➢ Thus small and rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs
  – 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
Prioritized Challenges – Quality as 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)
  
  • Educated Consumers / Transparency
    – Hospital quality data available publicly
      ➢ Hospital Compare
      ➢ Health Leaders
      ➢ Hospital websites
  
  • Small 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 Differentiator

• 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
  • 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
Prioritized Challenges – Quality as Differentiator

- Provider Strategies (continued)

- 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 Differentiator

• 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
  
  • 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
Prioritized Challenges – Cuts Are Real This Time!

• Important elements of challenge

  • Failure of Super Committee to reach agreement thus possible -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
  • Potential physician pay cuts
Prioritized Challenges – Cuts Are 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
Prioritized Challenges – Cuts Are Real This Time!

- 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
Prioritized Challenges – Provider Strategies

- 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 FTEs @ Standard</th>
<th>Actual FTEs</th>
<th>Variance</th>
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</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>
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<tr>
<td>Nursing - Endoscopy/GI Lab</td>
<td>Per Case</td>
<td>120</td>
<td>3.60</td>
<td>0.21</td>
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<tr>
<td>Emergency Room</td>
<td>Per Case</td>
<td>2,672</td>
<td>2.40</td>
<td>3.08</td>
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<tr>
<td>UR/Case Mgr/Soc Ser</td>
<td>Patient Days</td>
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<td>0.75</td>
<td>1.18</td>
<td>-</td>
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<tr>
<td>Nursing Administration</td>
<td>Per Adj. Admissions</td>
<td>1,835</td>
<td>1.75</td>
<td>1.54</td>
<td>-</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>
</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>
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<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>
</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>
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<tr>
<td>Speech Therapy</td>
<td>Per Treatment</td>
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<td>Cardio/Pulmonary</td>
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<td>0.55</td>
<td>1.68</td>
<td>3.63</td>
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<tr>
<td>Pharmacy</td>
<td>Per Adjusted Day</td>
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<td>2.00</td>
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<tr>
<td>Radiology</td>
<td>Per Procedure</td>
<td>6,368</td>
<td>1.42</td>
<td>4.34</td>
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<td>Human Resources</td>
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<td>1.10</td>
<td>0.97</td>
<td>1.00</td>
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<td>Marketing/Planning/Public Re</td>
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<td>Volunteers</td>
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<td>0.75</td>
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<td>Telecommunications</td>
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<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>
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<tr>
<td>Security</td>
<td>Gross Square Feet</td>
<td>-</td>
<td>0.02</td>
<td>-</td>
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<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>
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<tr>
<td>Admitting/Patient Registration</td>
<td>Per Adj. Admissions</td>
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<td>4.25</td>
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<td>2.00</td>
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<td>Medical Records</td>
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<td>3.09</td>
<td>7.71</td>
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<td>Cent Supply/Mt Mgmt/Sterile</td>
<td>Per Adjusted Day</td>
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<td>Laundry and Linen</td>
<td>Lbs of Laundry</td>
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<td>0.02</td>
<td>3.36</td>
<td>-</td>
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<tr>
<td>Subtotal Support</td>
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<td></td>
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<td></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)
Prioritized Challenges – Provider Strategies

• 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 only looked upon as an opportunity to save costs not considering profit potential
Prioritized Challenges – Provider Strategies

- Develop physician practice expertise
Prioritized Challenges – Provider Strategies

• 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 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
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
  – Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system
The Challenge: Crossing the Shaky Bridge

Fee for Service Payment System

Population Based Payment System

# Changing Payment System Incentives

## Macro-economic Environment – Payment System

<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>
| Government  | • Cost based reimbursement for CAHs  
• Fee-For-Service (FFS) to PPS acute care hospitals | • ACO pilot projects  
• FFS increasingly tied to patient value  
• Cost based reimbursement for CAHs with impacts from sequestration and RAC audits | • Population based payments (PBP) for ACOs  
• ACOs with budget based payment predominates  
• Interim payment models similar to Phase 1 | • Transition from ACOs to Medicare Advantage plans (budget to full capitation) | • PBP with quality performance criteria  
• Medicare Advantage plans with providers at full risk |
| Private     | • FFS  
• Insurance provided to patients through employers  
• Primary employer relationships with insurers | • FFS with steerage based on network penalties and patient incentives  
• FFS with quality scores  
• High deductible health plans negatively impacting patient volume | • Pilot projects for risk sharing with providers  
• Insurance exchanges become an option for individuals and small groups to obtain insurance | • Providers and insurers functionally merging through acquisition or development of provider based health plans | • PBP with quality performance criteria  
• Provider based health plans |
When operating income becomes negative in 2016, cash reserves start to decline
3 Phase Transition Model from FFS to PBPS

Implementation phases linked to evolution of payment system incentives over time

Current State

Phase I
- Aggressively Pursue Operating Efficiencies, Patient Safety and Quality Improvement

Phase II
- Consolidate Primary Care Network

Phase III
- Rationalize Service Network

Phase IV
- Population Based Payment System

Fee for Service Payment System

Years:
- 2012
- 2013
- 2014
- 2015
- 2016
Implementation Framework

Implementation phases linked to evolution of payment system incentives over time

Current State | Phase I | Phase II | Phase III | Future State
---|---|---|---|---
Initiative I | **Operating Efficiencies and Quality Implementation** | **Primary Care Network Alignment Implementation** | **Service Network Rationalization Implementation** | **Population Based Payment System Implementation**
Initiative II | **Primary Care Network Alignment Planning** | **Service Network Rationalization Strategy** | **Population Based Payment System Conceptual Plan** | **Population Based Payment System Conceptual Plan**
Initiative III | | **Service Network Rationalization Implementation Planning** | **Population Based Payment System Strategy** | **Population Based Payment System Strategy**
Initiative IV | | | **Population Based Payment System Implementation Planning** | **Population Based Payment System Implementation Planning**

Year
