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

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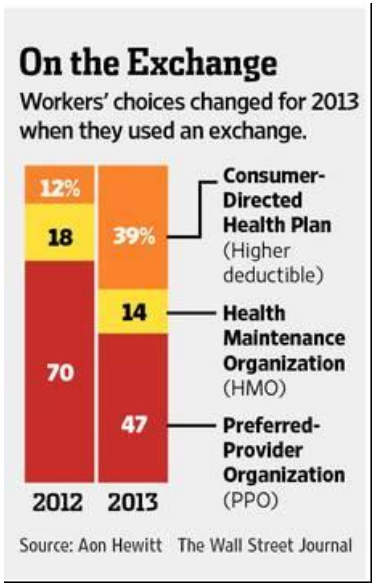
The healthcare environment has changed!

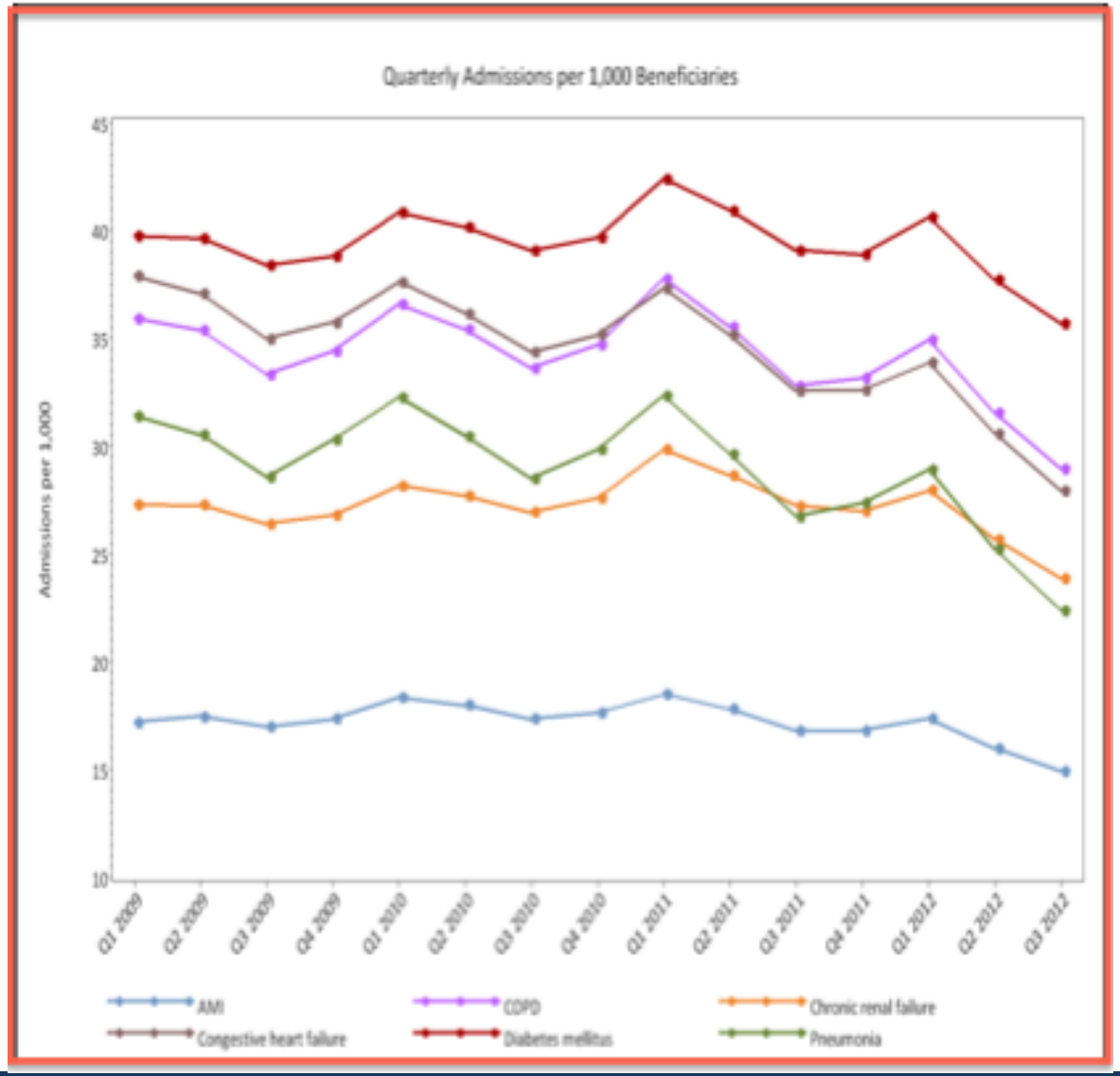
- In the past 24 months, the healthcare field has experienced considerable changes with an increased number of rural-urban affiliations, physicians transitioning to hospital employment models, flattening volumes, CEO turnover, etc.
  - Federal healthcare reform passed in March 2010 with sweeping changes 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 out 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



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

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- 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

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- 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
http://www.hhs.gov/news/press/2013pres/01/20130110a.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

Future Hospital Financial Value Equation

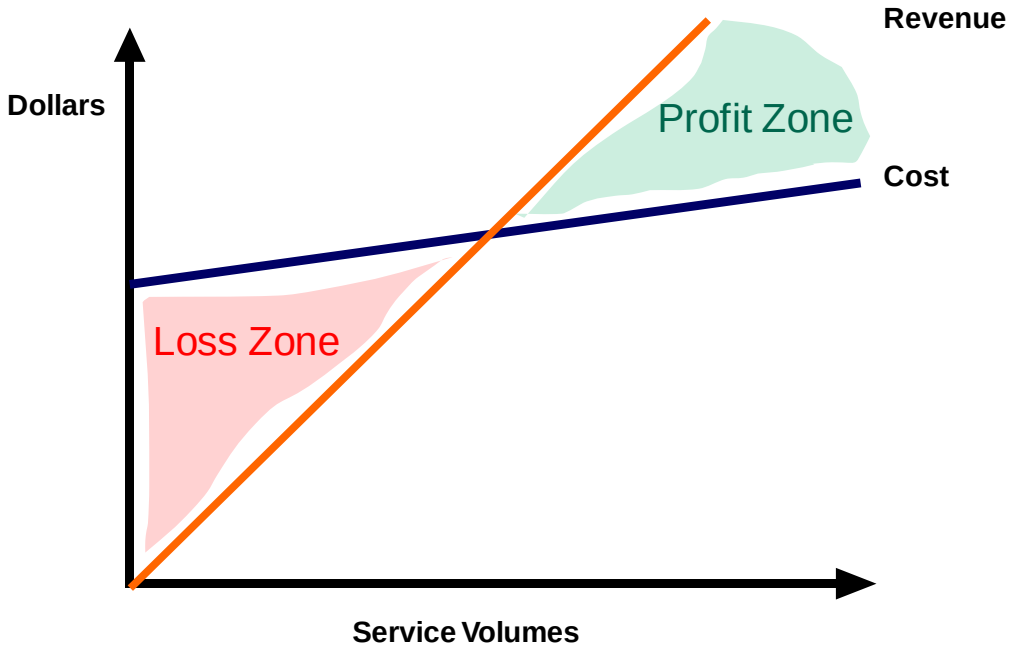
- Definitions
  - Patient Value

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

  - 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.

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

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- 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

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- 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

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- 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

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- 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; or
      - https://secure.ruralcenter.org/help-registration/pmg/playback/79

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

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- 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

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- 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

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- 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!

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- 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!

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- 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

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- 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

Department	Performance Indicator	FY 2012 Volume	Hourly Standard[1]	FTEs @ Standard	Actual FTEs[2]	Variance
Nursing - Med Surg	Per Patient Day	3,263	12.00	18.82	36.82	18.00
Nursing - Endoscopy/GI Lab	Per Case	120	3.60	0.21	-	(0.21)
Emergency Room	Per Case	2,672	2.40	3.08	-	(3.08)
UR/Case Mgr/Soc Ser	Patient Days	3,263	0.75	1.18	-	(1.18)
Nursing Administration	Per Adj. Admissions	1,835	1.75	1.54	-	(1.54)
Subtotal Nursing				24.83	36.82	11.99
Radiology	Per Procedure	6,368	1.42	4.34	6.99	2.65
Lab/Blood Bank	Per Test	36,551	0.30	5.27	8.70	3.43
Physical Therapy	Per Treatment	11,014	0.50	2.65	3.08	0.43
Cardiac Rehab	Per Procedure	531	1.31	0.33	0.51	0.18
Speech Therapy	Per Treatment	333	1.00	0.16	-	(0.16)
Cardio/Pulmonary	Per Procedure	6,381	0.55	1.68	3.63	1.95
Pharmacy	Per Adjusted Day	9,969	0.60	2.88	2.00	(0.88)
Subtotal Ancillary				17.31	24.91	7.60
Subtotal - Clinical				42.14	61.73	19.59
Hospital Administration	Per Adj. Admissions	1,835	1.65	1.46	3.18	1.72
Information Systems	Per Adj. Admissions	1,835	1.00	0.88	2.00	1.12
Human Resources	Per Adj. Admissions	1,835	1.10	0.97	1.00	0.03
Marketing/Planning/Public Re	Per Adj. Admissions	1,835	0.28	0.25	1.94	1.69
Volunteers	Per Adj. Admissions	1,835	0.75	0.66	-	(0.66)
Telecommunications	Per Adj. Admissions	1,835	0.36	0.32	-	(0.32)
General Accounting (5)	Per Adj. Admissions	1,835	1.23	1.09	3.00	1.91
Security	Gross Square Feet	-	0.02	-	-	-
Patient Accounting	Per Adj. Admissions	1,835	3.00	2.65	5.03	2.38
Admitting/Patient Registratio	Per Adj. Admissions	1,835	4.25	3.75	2.00	(1.75)
Medical Records	Per Adj. Admissions	1,835	3.50	3.09	7.71	4.62
Cent Supply/Mtl Mgmt/Steril	Per Adjusted Day	9,969	0.30	1.44	2.67	1.23
Housekeeping	Net Square Feet	43,795	0.31	6.57	6.99	0.42
Dietary	Meals Served	40,801	0.25	4.90	8.99	4.09
Plant Ops/ Maintenance	Gross Square Feet	-	0.12	-	1.58	1.58
Laundry and Linen	Lbs of Laundry	349,015	0.02	3.36	-	(3.36)
Subtotal Support				31.37	46.09	14.72
				73.52	107.82	34.30

[1] Hourly Standards based on Stroudwater sample of hospitals

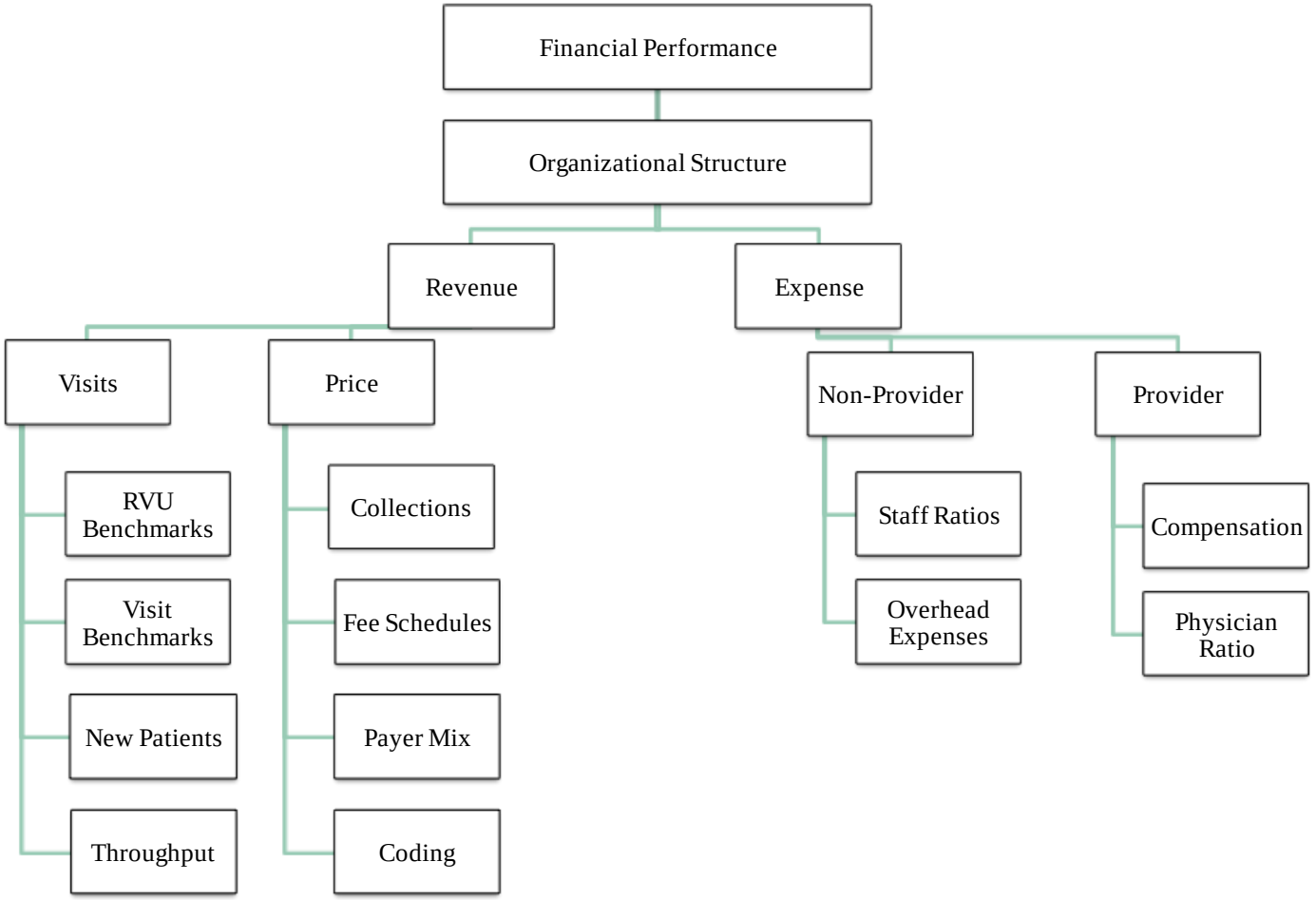
[2] FY 2012 information provided by hospital administration (average of last three payrolls ending 2/4/2012)

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

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- 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

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Fee for Service Payment System

Population Based Payment System

2012 2013 2014 2015 2016

Changing Payment System Incentives

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Macro-economic Environment – Payment System					
Perspective	**Current State**	**Phase 1**	**Phase 2**	**Phase 3**	**Future State**
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

Fee-For-Service Financial Model – Results

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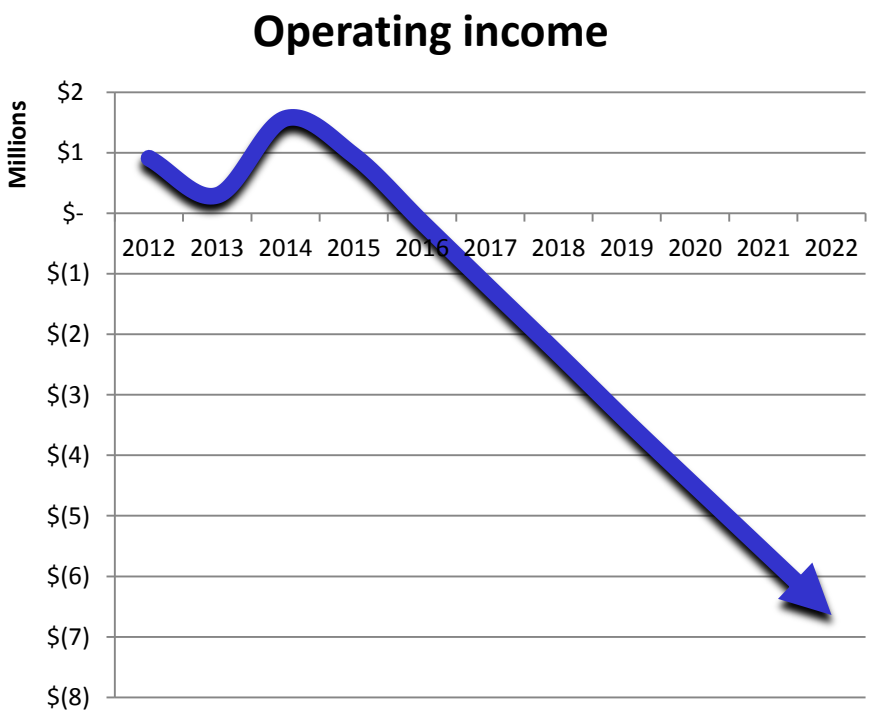
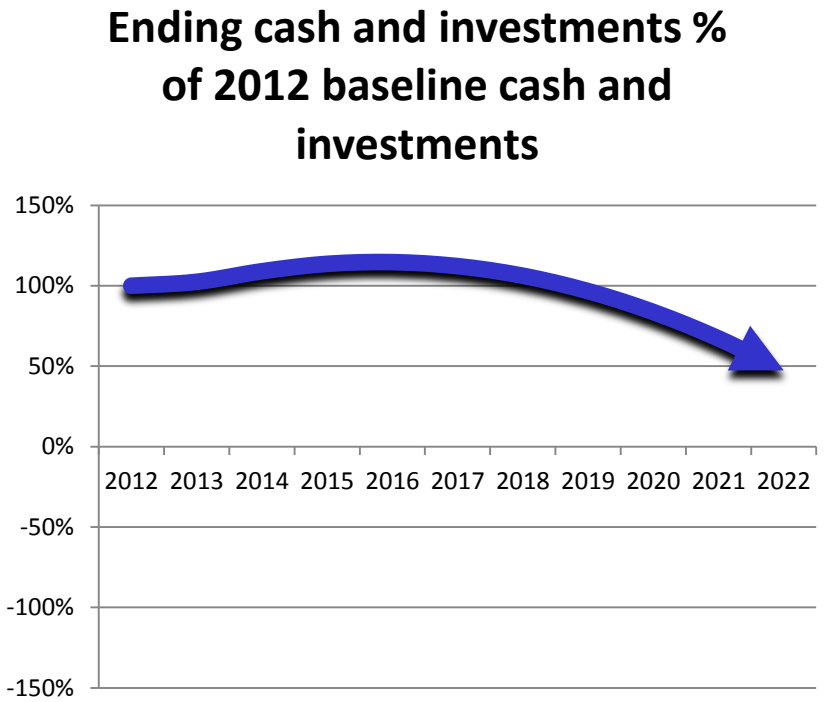
When operating income becomes negative in 2016, cash reserves start to decline





3 Phase Transition Model from FFS to PBPS

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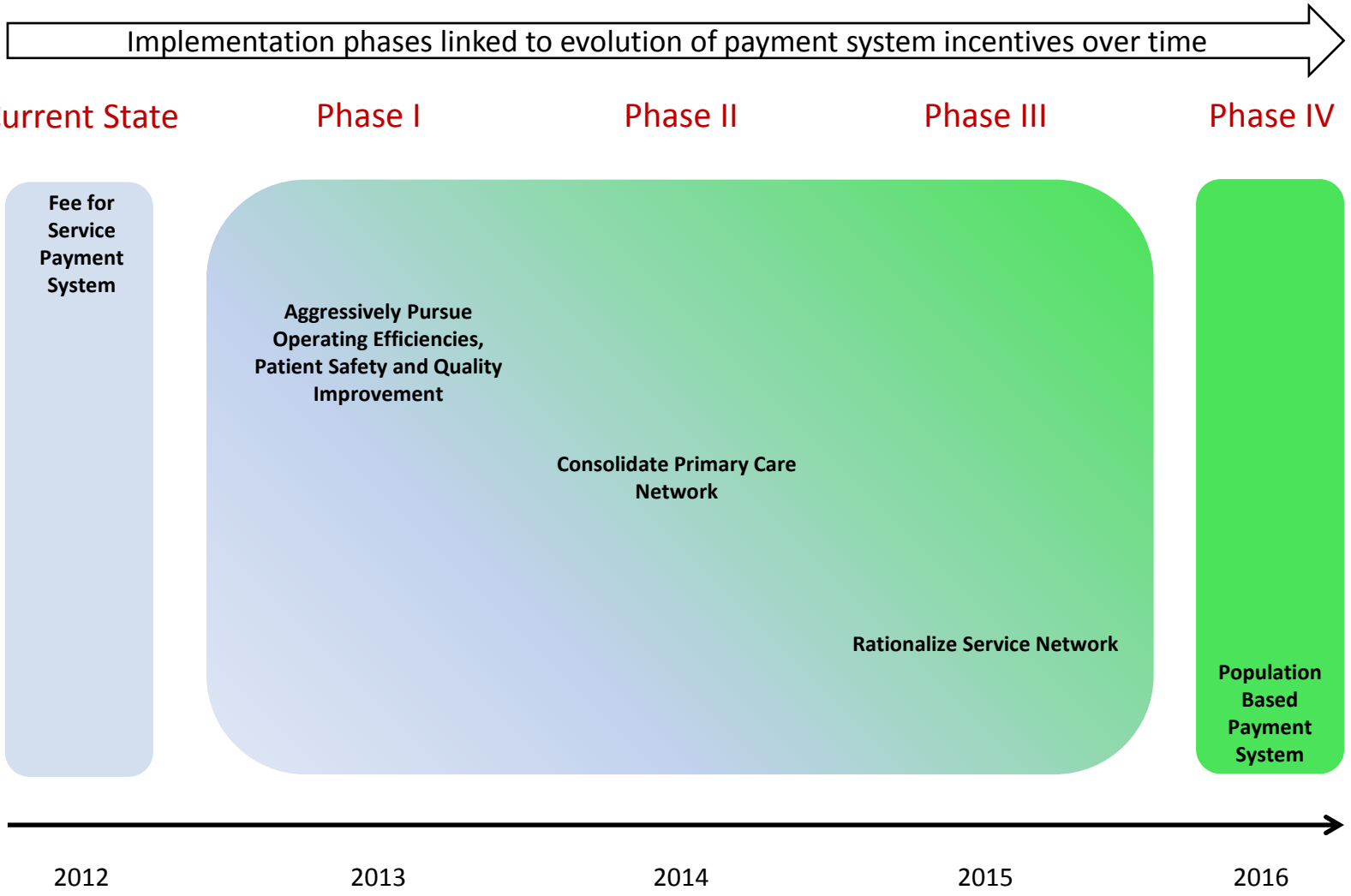

Implementation Framework

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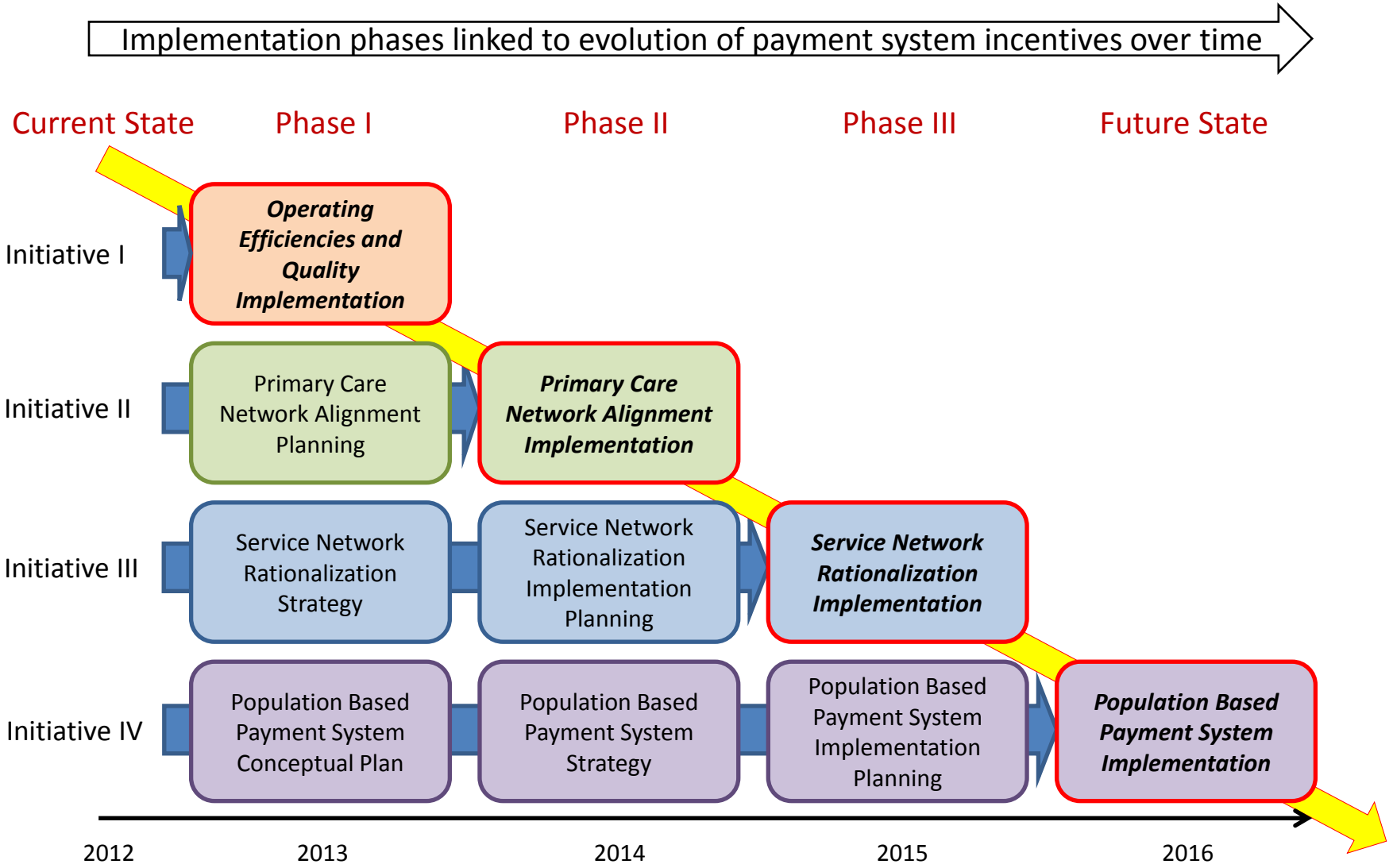

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