Strategies to **THRIVE**, not just Survive, in these uncertain times

Rural Health Care Leadership Conference

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Value

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A Foot on the Dock, A Foot in the Boat
The Uncertain Future of Healthcare

Russ Johnson
A FOOT ON THE DOCK, A FOOT IN THE BOAT
The Voyage Ahead

- The challenges
- The responsibility
- The excitement
- The privilege
I’m optimistic
I like people
47% Medicaid/self pay
77% government payer
95% providers employed
I’m not a “hospital” guy

Disclaimer: I am biased…
Back to Docks and Boats

- **The Dock**: Current delivery & payment systems
- **The Boat**: New model of what a hospital is
- **The Water**: Future delivery & payment systems
Stuff I think is in the water
(and why I’m committed to drinking it)

- Convergence of economics & clinical medicine
- Risk taking for providers
- Higher expectations from consumers
- Less reimbursement (no matter what model)
- Changing benefits and individual engagement
- The dock, the hospital
- Building boats from our dock
- There'll be lots of different boats
- There will be options for new kinds of boats
- People we don’t know will build boats

The Analogy: One foot on the dock, one foot in the boat
The Scary Part

Being in That Precarious Situation:

- Uncertainty emerging
- Timing is unclear
- Being proficient
- Leaving behind
- The role
THE DOCK IS **BURNING!**

Sense of urgency

Timing unclear

Hard to be courageous...
There is Good News…

…it’s less scary being IN the boat!
Not all Boats Will Be the Same...
The Way I Envision our Boat
The waters will be **choppy**!

- Technology
- Emerging boat-builders
- Policy and regulations
- Self perception
- Future of hospitals
Not all boats will float...
Return to Principle
HAPPY SAILING
Health System of the Future
Hospital Financial Sustainability in the New World

Eric Shell
The industry 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

- 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

  - Thus, providers face new financial uncertainty and challenges and will be required to adapt to the changing market
Market overview - coverage

• 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 - payment

- 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 – delivery system

- 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 – delivery system

- Medicare and Medicaid Delivery System Reforms (continued)
  - Accountable Care Organizations (continued)
    - 153 ACOs effective July 1, 2012
Market overview – delivery system

- 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
Market overview – other

• State Budget Deficits

• 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.”
Challenges affecting smaller hospitals

- Factors that will have, or continue to have, a significant impact on small 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”*
Moved to 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!!!
Future hospital value equation

- Definitions
  - Patient Value

\[ \text{Patient Value} = \frac{\text{Quality}}{\text{Cost}} \]

- Accountable Care:
  - A mechanism for \textit{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 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 value equation

- Value in Small and 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

• 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

• ACO Relationship to Small and Rural Hospitals
  • 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
    – Smaller hospitals must better understand their value proposition to forming networks and NOT perceive themselves as approaching systems for a “hand out / bailout”
  • Smaller hospitals 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
Prioritized challenges – payment

• 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
  
• 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”
Prioritized challenges – payment

• 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 – quality

• 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

• 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)
    – 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
    – Must develop paradigm shift from quality being something in an office down the hall to something all hospital staff responsible for
  • Partner with Medical Staff to improve quality
    – Restructure physician compensation agreements to build quality measures into incentive based contracts
  • Electronic Health Record (EHR) to be used as backbone of quality improvement initiative
Prioritized challenges – cuts are real!

• 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!

- Provider Strategies
  - 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
  - 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
  - Increase monitoring of staffing levels staffing to the “sweet spot”
    - Staffing education for DONs/Clinical managers
    - Salary Survey / Staffing Levels / Benchmarks that are relevant
Prioritized challenges – cuts are real!

• Provider Strategies (continued)
  • 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
  • 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
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.

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
Reinventing Systems of Care

Bob Gomes & Brian Haapala
Triple Aim: Then and Now

- Efficiency
- Safety
- Accessibility
- Costs
- Quality
- Population Health
Cooperative Health Networks

- Loose form of affiliation
  - Dominant approach historically
- Programming
  - Education
  - Shared programs
- “Good neighbor” system participation
- High participation – low value
Increasing System Membership

Number of Hospitals in Health Systems,\(^{(1)}\) 2000 – 2010

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2010, for community hospitals.

\(^{(1)}\) Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.
Rural is least affiliated

Percentage of Hospitals in Systems

- Small Hospitals: 29% (2007), 42% (2010)
- Community Hospitals: 59% (2007), 63% (2010)
- Total: 50% (2007), 56% (2010)

Source: ahd.com based on public cost reports
Different Types of Risk

Partnership strategies affect your chances of your success (or failure) as follows:

Independence leads to **execution** risk

Affiliation leads to **partner** risk
Affiliation is not a goal, it is a strategy to achieve a set of strategic objectives.
Systems are Seeking Growth

- Populations to spread risk
- A full continuum of care
- Distributed access points
- Convenient, least costly environment
- Opportunity to spread the reach of its “Brand”
Central Oregon’s Healthcare Provider

- St. Charles Health System
  - Bend – main campus
  - Redmond – owned, Sole Community
  - Madras - managed
- Pioneer Memorial Hospital
  - 25 bed Critical Access Hospital
  - SCHS owns operations, leases facility
    - Built in 1950
    - Attached clinic
A three-way connection

- Prineville’s Needs
  - January 2008 - Financial distress
  - Access to capital for new facility

- SCHS Needs
  - System of care
  - Annual capital investment

- Community needs
  - Board leases facility
  - Earns a 30% of EBIDA in excess of 2% operating margin
Highlight of System Benefits

- Support functions became part of system
  - Finance, information systems, human resources
  - Focus on health & wellness

- Improved physician recruitment
  - St. Charles Medical Group – January 2012
  - 2 Family Practice, 1 General Surgeon, 2 Physicians Assistants
  - Rural Health Clinic

- Electronic Medical Record integration
  - Patient registration and billing – 2008
  - All scripts in clinic - 2012
  - HLAB – 2012
  - Paragon - 2013
Keeping score on quality

- Infrastructure of resources for improving:
  - Core measures
  - National patient safety goals
  - Patient satisfaction
  - Other quality goals
SCHS direction reflects industry

- Historical drivers:
  - Financial distress
  - Access to capital
  - Market share

- New drivers:
  - Quality
  - Infrastructure
  - Scale for new payment systems
Successful partnerships require alignment

Affiliate

System

Level of Commitment

Value

Clinical Integration

Physician Integration

Technology Integration

Capital Integration

Regional Investment

Financial & Clinical Transparency

Broad Physician Deployment

Integrated System Capacity

Gap

Gap

Franchise Support Services
Focused Service Linkage
Distributed Overhead

Management Support
Service Coordination
Purchased Services
Image

Successful partnerships require alignment.
Operational Value

Affiliate Examples

- Eliminate “bigger is better”
- Cost savings
- Management expertise

System Examples

- Increased footprint
- Regional case finding
- Cost allocations
Affiliate Examples

- Reinvented facilities
- Shared technology platform
- Levels of care

System Examples

- Primary care network
- Contracting scale
- Clinical best practices
Prineville Case Study

- Facility Feasibility Study
  - Recommending new campus
  - Focus on Health & Wellness

- Community Focus Groups
  - Health & Wellness
  - See it as a health system function

- Public and Private Entities Requesting Health & Wellness
  - City
  - County
  - School District
  - Local Businesses
Campus Concept
Facility Development

- St. Charles to own and operate
- $30 million from SCHS
- $3 million from community/PMH-R
- $9 million for Health & Wellness from private investor
Systems of Care

- Building a system of care requires partnership
  - Timing
  - Partner options
  - Structures
- Partnership success requires:
  - Common definition of value
  - Vision, goals, objectives
  - Shared accountabilities
  - An exit strategy
Bridge the gap between concept and concrete
Through Strategic Facility Investments

Michael Curtis & Randy Heitmann
Bridge the Gap
The Alliance Bridges the Gap
Took a Catastrophe to Inspire
Became Relevant
UNIQUE ATTRIBUTES
NOW ATTRACTIVE
Medical home, health and wellness
The Gap
Columbus, MT
The Gap Widens
A Helping Hand

System Affiliation

Strategic Partner
Align Stakeholders

- The Billings Clinic
  - Brand
  - Physicians
  - Service line management

- Stillwater
  - Acquired the land and the financing

- Community
  - fear loss of control
Tangible Results

- Strong brand
- PCMH
- Visiting specialists
- Emergency care
- Lab & imaging
- Surgery
- 10 inpatient beds
- CEO becomes a hero
When to Jump?

- OPPORTUNITY
- CONCERN
- CRISIS
- CATASTROPHE
Integrated Rural Health Delivery
Unique Rural Setting
FOUND HELPING HAND
CROSSED THE BRIDGE
RESULTS
Community Education & Events
Behavioral Shift
Redefining Health Delivery in a Rural Setting
Not your typical facility replacement project

Andleeb Dawood & Cole White
Where’s the money
What you need to know about financing your future vision
Where’s the money?

- Where are the investors?
- How do you reach them?
- What **must you** prepare for?
- What do they want to know?
Who’s out there?
How do you reach them?
Have you done your homework?
Investor speak

- Collateral
- Rate of Return
- Risk protection
- Term
- Exit strategy
Why is it so complicated?

- Market conditions
- Rating agencies
- Lending limits
- Exit strategies
Keys to success

- Position yourself
- Gather your resources
- Build your bridge
Move from Sick Care to Well Care

- Value
- Investment
- System
- Capital