Protecting and Preserving the Community Hospital – Immediate Action for Future Success

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CHC
Community Hospital Consulting

Healthcare Environment

These factors are unsustainable…

- The size of the federal budget deficit
- The annual increase in the Medicare budget
- The percentage of healthcare spending to GDP
- State Medicaid programs
- The continued shifting of costs to employers and consumers

The business model is changing… this is our opportunity!

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Forces Driving Reform

Uninsured Rate Soars,
50+ Million Americans Without Coverage

- Uninsured Americans increased to 17.1% in 2011from 14.8% in 2008
- Most demographic groups posted an increase except ages 18 to 26 who are benefiting from the healthcare law
- People covered by employer-sponsored coverage dropped to 55.8% in 2009 from 58.5% in 2008
- Since 2001 family premiums have increased 113% compared with 34% increase in worker wages and 27% for inflation

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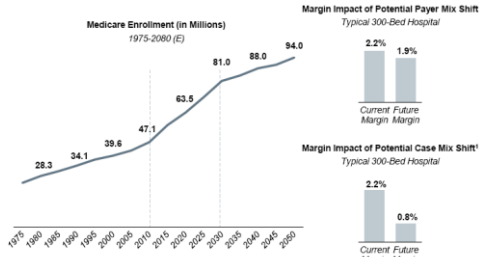
Gallup-Healthways Well-Being Index, 12/11; Kaiser Family Foundation, 2011

Health Care System Entering a Brave New World

First Wave of the "Silver Tsunami" Hit Medicare in 2011



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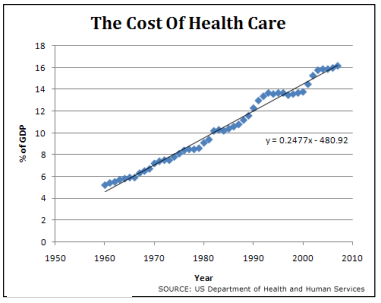
Source: Advisory Board 2011;
Based on five percentage point reduction in surgical share of inpatient volume

Cost of Care Continues Upward



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More Fuel to the Fire

"The healthcare sector is far and away the most inefficient economic driver in the U.S." – Peter Orszag, Director, OMB

- 30% of what we spend adds no clinical value (5% of GDP) – Institute of Medicine
- Nearly 4.4 million hospital admissions totaling $30.8 billion in hospital costs could have been prevented – AHRQ
- Geographic disparities – End of Life Care: UCLA/Hopkins $90K vs. Cleveland Clinic/Mayo $55K – Dartmouth (Wennberg and Fisher)

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Source: James E. Orlifkoff, ACHE 2011

Why Reform is Here to Stay…

- Provisions affecting the delivery system with new payment methodologies
  - Have support on both sides of the aisle
  - Have the potential to cut federal health spending
- Wave of fiscal conservatism will prevail
- Budget woes will continue to put pressure on payments
- Trend toward value-over-volume preceded ACA, and it is here to stay

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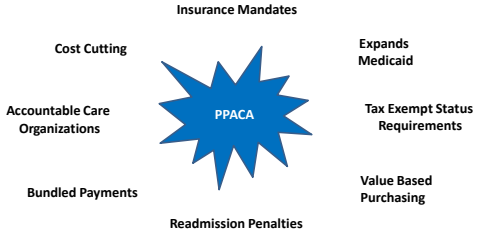
Key Legislative Provisions



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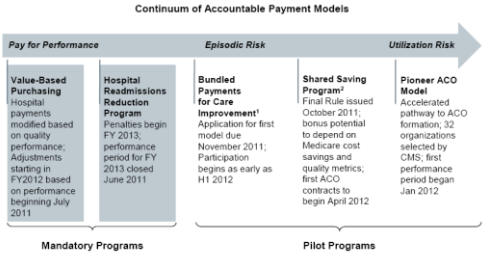
First Wave of Payment Reforms are Here



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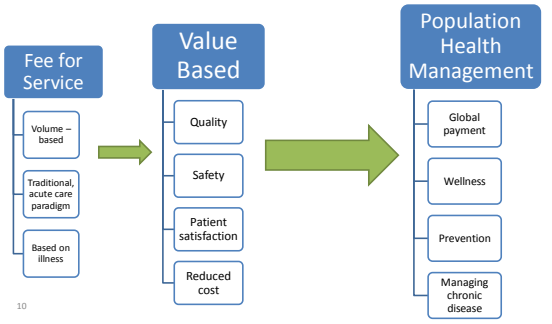
Source: Advisory Board 2011

Payment Models

Operating in the Gap



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Accountable Care Organizations

- "ACO" is an organization of healthcare providers that agree to be accountable for the quality, cost and overall care of Medicare traditional fee-for-service beneficiaries who are assigned to it
- Goal is to encourage healthcare providers to take greater responsibility for reducing healthcare costs for a given population while maintaining or improving quality of care

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Insurance Public Exchanges

- Become available in all 50 states in October 2013 for January 2014 implementation
  - Individual and families
  - Small business with fewer than 50 or 100 employees
- Operated at state or federal levels
- Must meet minimum benefit standards and be consistent
  - Platinum – 90%
  - Gold – 80%
  - Silver – 70%
  - Bronze – 60%
- Plans will compete based on price, not coverage
- Individual and small group subsidies will be provided through tax credits (avg. $4650 pp in 2014)

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Private Exchanges

- BC/BS has pay-for-performance and episode-based payment strategies in place in nearly every state
  - These have yielded hundreds of millions in savings as well as improvements in quality and patient safety
- Health plans are employing multiple payment strategies and structuring networks that reinforce primary care, enable total population management and drive greater coordination
  - BC/BS has achieved double-digit reductions in hospital admission rates, fewer ER visits, lower costs
- As employers seek new benefit models to cap the cost of their healthcare benefit subsidies, they will offer private exchanges with a broad choice of plan and coverage options
  - Private exchanges may have narrow or limited provider networks

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Source: Futurescan 2013, SHSMD/AHA; ACHE

Impact of Exchanges on Hospitals

- Payers are currently evaluating markets for exchange participation
- Contracted rates will be driven by provider competition, payer competition, current contract rates
- Contracted rates are anticipated to be Medicare (+, -) or Medicaid levels
- Private exchanges may lock out high-cost, low performing providers
- Majority of payer contracts with hospitals will contain performance-based compensation within five years

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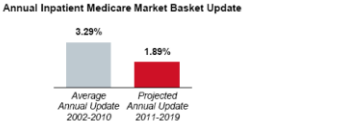
Medicare Spending on the Chopping Block

Reductions in Affordable Care Act the Opening Salvo for Future Cuts



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Source: Advisory Board 2011

Underpayments from Medicare & Medicaid

- Underpayment = Amount by Which Payment is Less than Costs
- Combined underpayments rose from $3.8 billion in 2000 to $20.1 billion in 2010
- For Medicare, hospitals received payment of only 92 cents for every dollar spent in 2010
- For Medicaid, hospitals received payment of only 93 cents for every dollar spent
- 53% of hospitals lose money on Medicare; 59% lose on Medicaid

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Source: AHA, Underpayment by Medicare and Medicaid Fact Sheet, 2012

As Medicare Margins Decrease…

- Commercial insurance companies will attempt to offload their reform costs (preexisting conditions, no lifetime caps) to hospitals in the form of lower reimbursements
- Traditional cost-shifting potential will be limited
- Focus on cost structure will be essential for hospital success
  - *Do we make money on Medicare reimbursement??*

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OPPORTUNITIES FOR PROVIDERS

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New Core Competencies Required

- Physician Integration
- Financial Strength
- Payer Relationships
- Risk Management
- Market Necessity
- Care Coordination
- Information Technology
- Service Distribution
- Cost Effectiveness

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Clinical Integration

Requirements (both human capital and dollars):

- Strong physician leadership committed to reducing cost and improving quality
- Sophisticated infrastructure, including personnel and IT
- A strong, geographically distributed base of primary care physicians
- Access to a comprehensive set of acute and post acute services
- Ability to engage patients to be responsible for their health

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The Assessment Process

- Operational Assessment
  - Productivity, supply chain, clinical quality analysis
- Financial Analysis
- Medical Staff and Leadership Interviews
- Market Analysis
  - Demographics, market share
- Findings & Recommendations
  - Partnering opportunities

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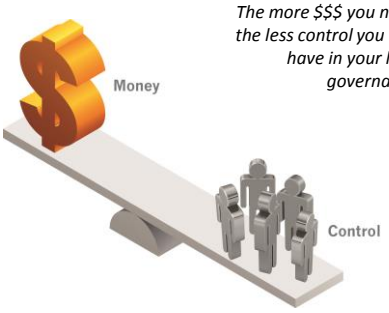
Partnership Considerations

The more $$$ you need, the less control you may have in your local governance.



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Partnership Considerations

Responsible action is more favorable than the last possible moment.

- Think proactively
- Board dynamic is critical
- Define your optimal terms

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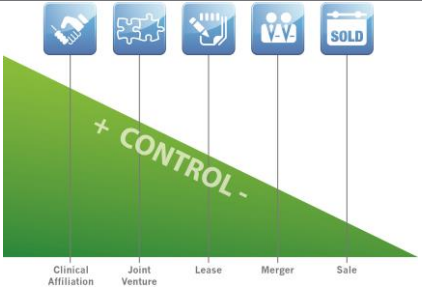
Partnership Options



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Partnership Options

Among a continuum of options, each is unique:

- Clinical affiliation
- Joint venture relationship
- Lease relationship
- Merger
- Sale

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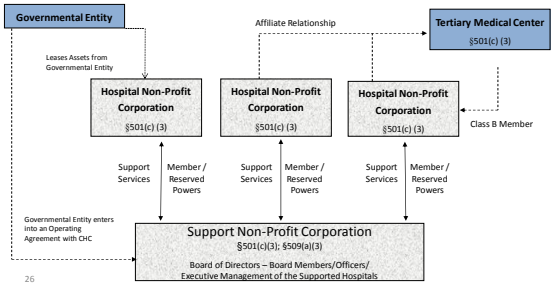
CHC §509 (a) 3 Support Organization Model



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Case Studies

Hospital Management

Mother Frances Hospital – Winnsboro
Winnsboro, Texas

Hospital Management

Memorial Health System of East Texas
Lufkin, Texas

Hospital Lease

Artesia General Hospital
Artesia, New Mexico

Corporate Member Substitution

St. Mark's Medical Center
La Grange, Texas

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Risk

- **Management:** Assess your credit **RISK** or credit worthiness.
- **Medical Staff:** Assess your ability to accept **RISK** via alignment with your Medical Staff.
- **Board:** Assess willingness of your Board to be tolerant of the status quo, to accept the **RISK** inherent with change.

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Summary

- Assess the future
- Be optimally efficient, clinically sound, geographically essential and mission-focused
- Community hospitals are an essential provider in the continuum of healthcare services

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Questions & Answers

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Thank You!

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