The New Future of Rural Healthcare
Strategies for Success

Green Mountain Care Board

April 3, 2019

Eric K. Shell, CPA, MBA

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Market Overview – Market Events

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High Deductible Health Plans

- Increased focus on value with patients becoming consumers
  - Value = Quality/Cost

Underinsurance

- Increased bad debt/charity care

Accelerating shift to outpatient care

- Transition from traditional inpatient focused hospital care to outpatient care

Reduced Re-admissions

- Result of Value Based Payment program

Recovery Audit Contractors (RAC)

- Focus on reducing short stay inpatient admissions

MACRA

- Reduced FFS payment to physicians
- Value based incentives (MIPS)

Affordable Care Act

- More insured
- Reduced FFS price (relative to costs)
- New accountable care payment models

Market Consolidation and New Entrants

- Aetna/CVS
- Walmart/Humana
- Etc.

Growth of High Deductible Plans

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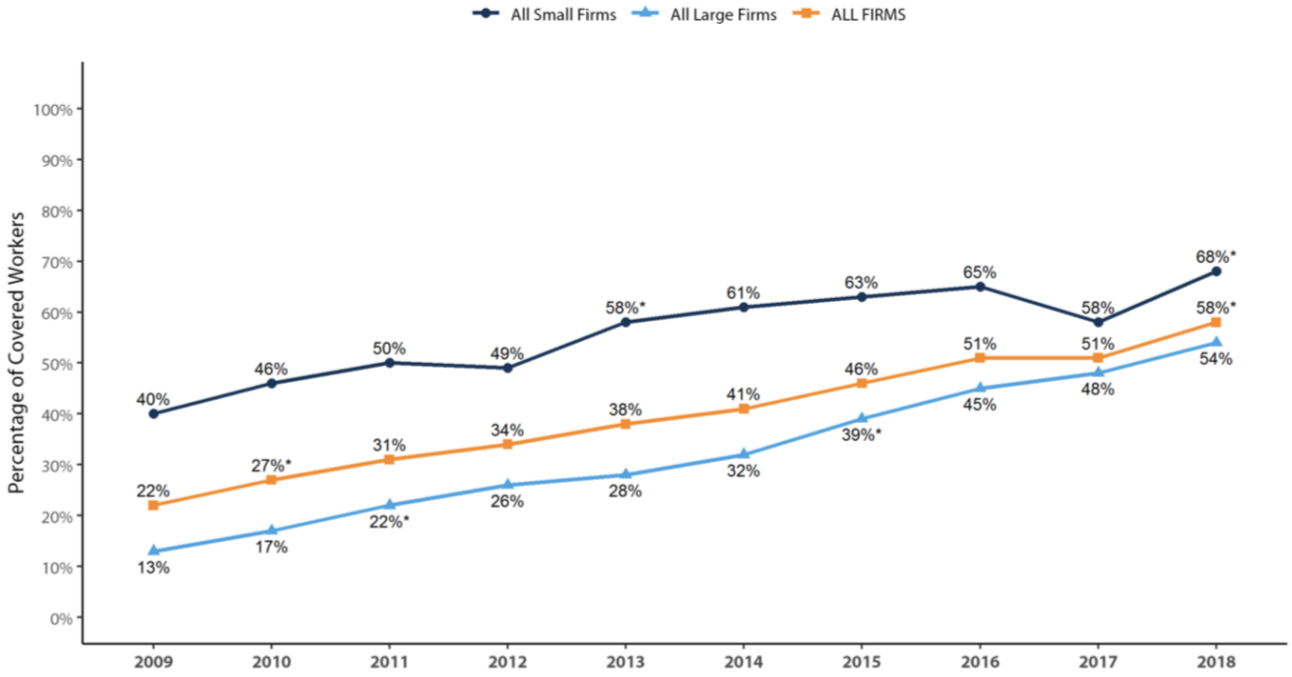
Figure 7.13

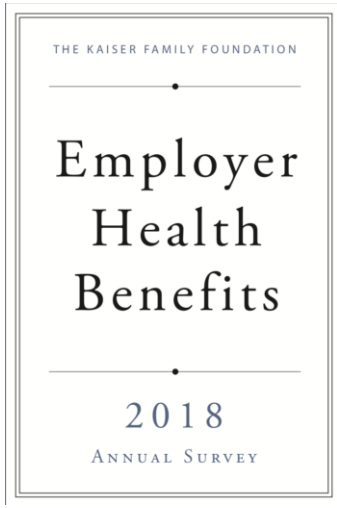
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2018



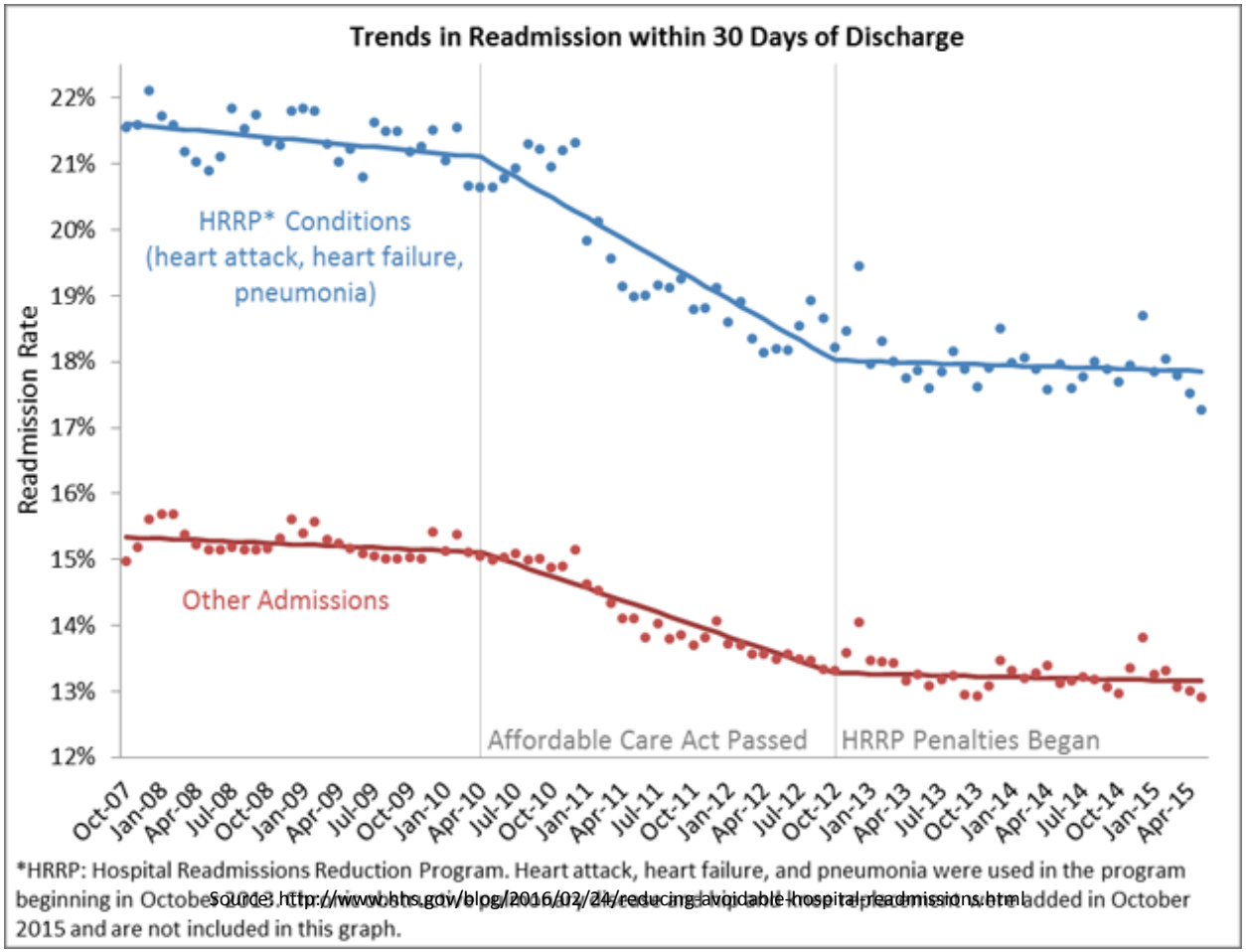
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017



Reduced Readmission Rates

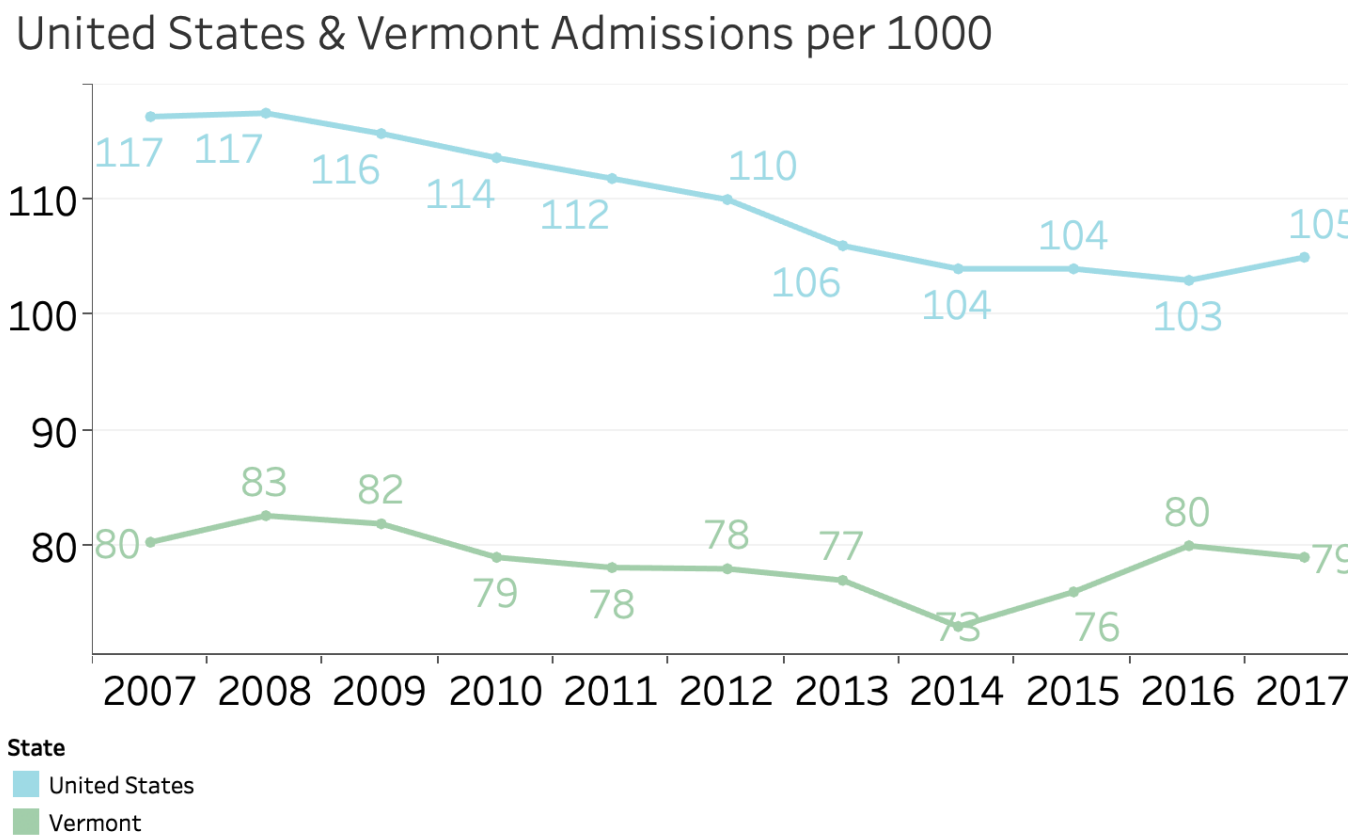


Source: http://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html

- CMS: 2,665 PPS hospitals to receive penalties in fiscal 2016

(Source: http://www.modernhealthcare.com/article/20150803/NEWS/150809981)

Market Overview – Results



Source: Kaiser State Health Facts, kff.org

MACRA – Rate Changes Summary

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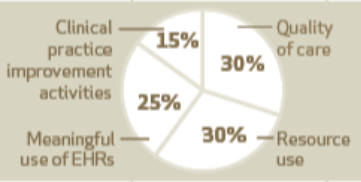
Implementing the Medicare Access and CHIP Reauthorization Act's (MACRA's) physician payment reforms, 2016–22

MIPS and APMs begin operating

	2016	2017	2018	2019	2020	2021	2022
Fee updates	0.5%	0.5%	0.5%	0.5%	0%	0%	0%
Annual fee updates as of 2026							0.25% MIPS / 0.75% APMs ▸
MIPS* (Merit-Based Incentive Payment System)				MIPS MAXIMUM BONUS OR PENALTY (+/-)			
↑				4%	5%	7%	9%
↓				-4%	-5%	7%	-9% (+/- 9% continues after 2022) ▸
APMs (Alternative payment models)				APMs ACROSS-THE-BOARD BONUS			
				5%	5%	5%	5% (5% bonus stops after 2024) ▸

Doctors treating Medicare beneficiaries will be in one of two newly designed payment paths

Doctors will be graded on four factors...



... to determine bonuses or penalties

Additional funding

- **$15 million** available every year for measure development
- **$20 million** available every year for technical assistance to small practices
- **Up to $500 million** authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019–24)

Source: "Health Policy Brief: Medicare's New Physician Payment System," Health Affairs, April 21, 2016. http://www.healthaffairs.org/healthpolicybriefs/

Market Overview – Healthcare Reform

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- 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
    - *Individual Mandate repealed as part of Tax Cuts and Jobs Act (12/19/2018)*
- 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
  - Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
  - Medicare Hospital Wage Index
  - 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
  - Summary Impact

ACA Payment Changes for Medicare and Medicaid

Payment	Payment Reductions	Potential Offsets	Reduction through 2022
Medicare DSH Payments	$10.2 Billion	$7.3 Billion new uncompensated care pool	$2.9 Billion
Medicaid DSH payments	$500 Million reduction in FY 2014 rising to $4 Billion/year by 2019	Medicaid expansion	$25 Billion
EHR Meaningful Use Incentive Payments	$5.5 Billion in 2012 and 2013 to $0 in 2016	None	$5.5 Billion
PPS Payment Reductions	1.7%		
Readmission Penalties	Increase from 1% to 2% in 2013		
Hospital Acquired Infections	1% penalty beginning in 2015		
DRG Payments	1.25% reduction beginning in 2015 to fund value-based purchasing		

2019 IPPS Proposed Rule 4-24-18/Finalized 8-2-18

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- The Final rule also would **increase IPPS payment rates by 1.85 percent**, and the base rate for long-term care hospitals (LTCHs) by 1.15 percent

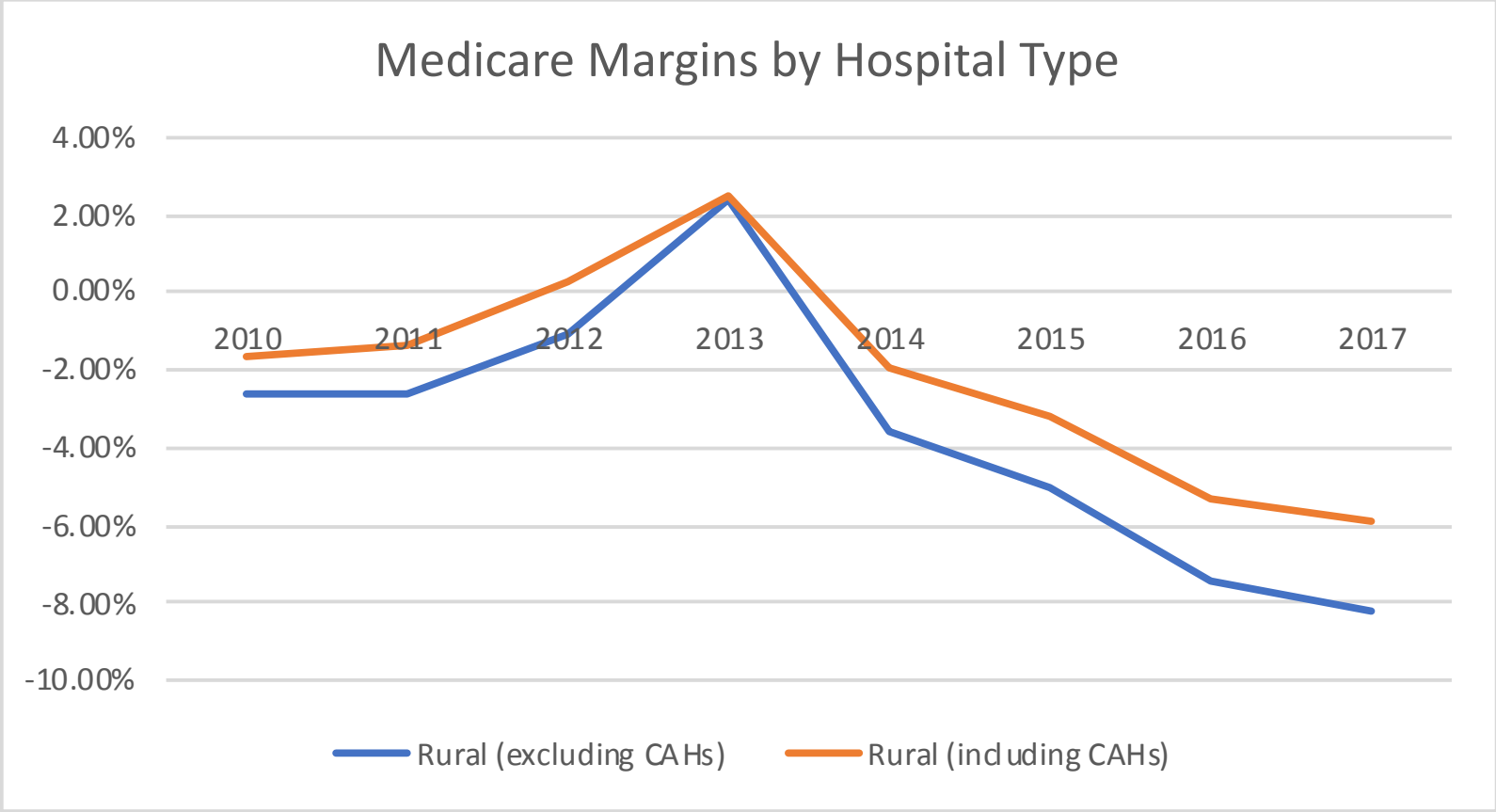
Factor	Percent Change
FY 2019 Market Basket	2.8
Multifactor productivity adjustment	-0.8
ACA Adjustment	-0.75
Subtotal	1.25
MACRA Documentation and Coding Adjustment	+0.5
Net increase before application of budget neutrality factors	1.75

- Breakout of increase among hospital categories:

Hospital Type	All Proposed Rule Changes
All Hospitals	2.1%
Large Urban	2.1%
Other Urban	2.1%
Rural	1.1%
Major Teaching	2.6%

Sources: *2019 IPPS proposed rule things to know,* Emily Rappleye, 4/25/18 https://www.beckershospitalreview.com/finance/cms-releases-2019-ipps-proposed-rule-10-things-to-know.html; CMS Fact Sheet 4/24/18 *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html

Fee-For-Service Financial Model – Results



Source: MedPAC Report To Congress March 15, 2019

Market Overview – Healthcare Reform

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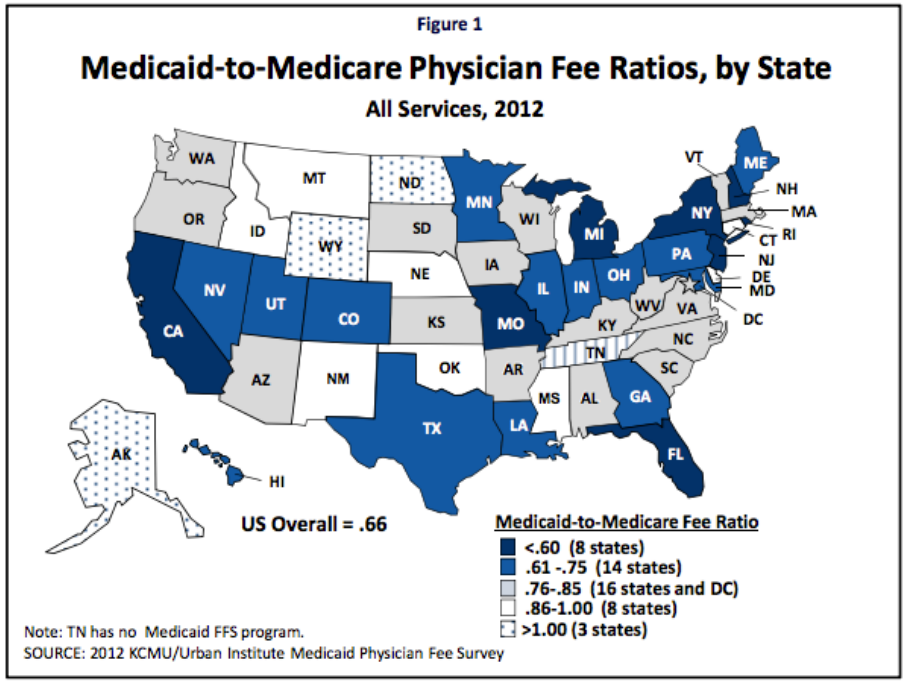
- Medicare and Medicaid Payment Policies (continued)
- Provider Implications
  - ***Payment changes will increase pressure on hospital margins and increase competition for patient volume***
  - ***"Do more with less and then less with less"***
  - Medicaid pays less than other insurers and will be forced 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

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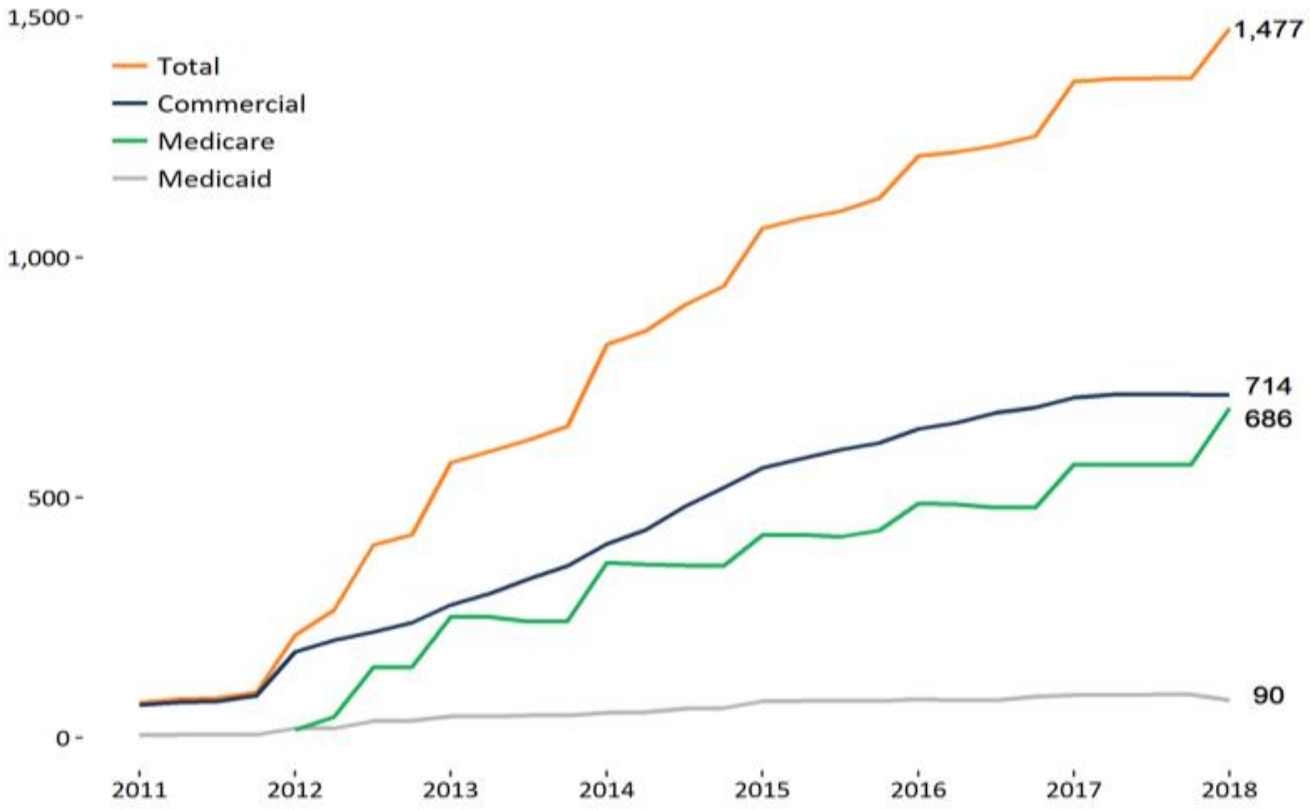
- Medicare and Medicaid Delivery System Reforms (continued)
  - Medicare Accountable Care Organizations (continued)
    - 154 ACOs effective August 2012
    - 287 ACOs effective January 2013
    - 391 ACOs effective January 2014
    - 426 ACOs effective January 2015
    - 477 ACOs effective January 2016
    - 569 ACOs effective January 2017
    - 664 ACOs effective January 2018
  - 13.8 million Medicare beneficiaries, or about 40% of total Medicare fee-for-service beneficiaries, now in Medicare ACOs
  - 159 ACOs are in a risk-bearing track including MSSP, Next Generation ACO Model, and Comprehensive ESRD Care Model
    - The Next Generation ACO model, which falls under the purview of the CMS Innovation Center, more than doubled in 2017, adding 28 new participants, and an additional 13 participants in 2018 bringing the total number to 58

Sources: http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html; https://www.kff.org/interactive/side-by-side-comparison-medicare-accountable-care-organization-aco-models/; HHS Press Release, January 8, 2018

Accountable Care Contracts Over Time



Source: Authors' analysis of Leavitt Partners' accountable care organization (ACO) database.

Source: Health Affairs, Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018, David Muhlestein Robert Saunders Robert Richards Mark McClellan, 8/14/18
https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/

ACO Growth 2010-2014

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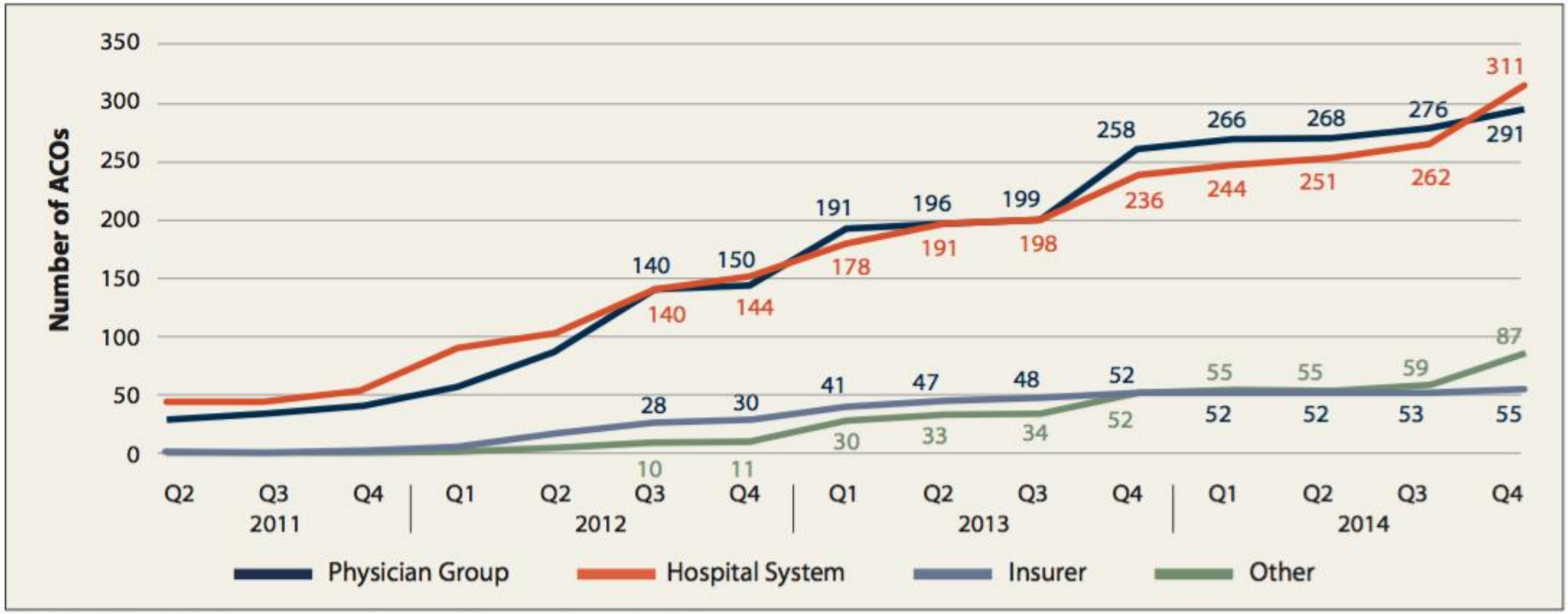

** Includes ACOs with both government and commercial contracts. Source: Leavitt Partners, 2015.*

ACO Growth 2010-2013

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Arlington's Privia Health lands $400M to begin national expansion

Sep 16, 2014, 7:50am EDT

Tina Reed
Staff Reporter- *Washington Business Journal*
Email | Twitter

Arlington-based Privia Health LLC is getting a $400 million infusion to expand nationally, the company announced Tuesday morning. An investor group led by an affiliate of Goldman Sachs & Co. is funding the expansion.

Privia, which markets itself as a platform for physicians to stay in private practice while becoming part of a larger network, will grow from Greater Washington to New York, Georgia, Florida and Texas — all areas with a significant numbers of independent physicians and strong potential health plan partners.

"This is giving us the rocket fuel to expand," said Jeff Butler, Privia's founder and CEO. He and Privia President Dave Rothenberg will continue to lead the company.

Fee-For-Service Financial Model

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Assumptions

- Utilization
  - Inpatient and Outpatient
    - Impact of ACA
    - Impact of Blue Cross steerage initiatives
- Revenue
  - Third party price increases
  - Cost based Medicare revenue
  - DSH payments (Zeroed out in 2014)
  - Bad debt % of patient service revenue (75% reduction in 2014)
    - Impact of ACA
  - Meaningful use incentive payments
  - Other operating revenue
  - Non-operating gains and
- Expenses
  - Salaries, wages and benefits
  - Productivity
  - Supplies and other

Fee-For-Service Financial Model – Results

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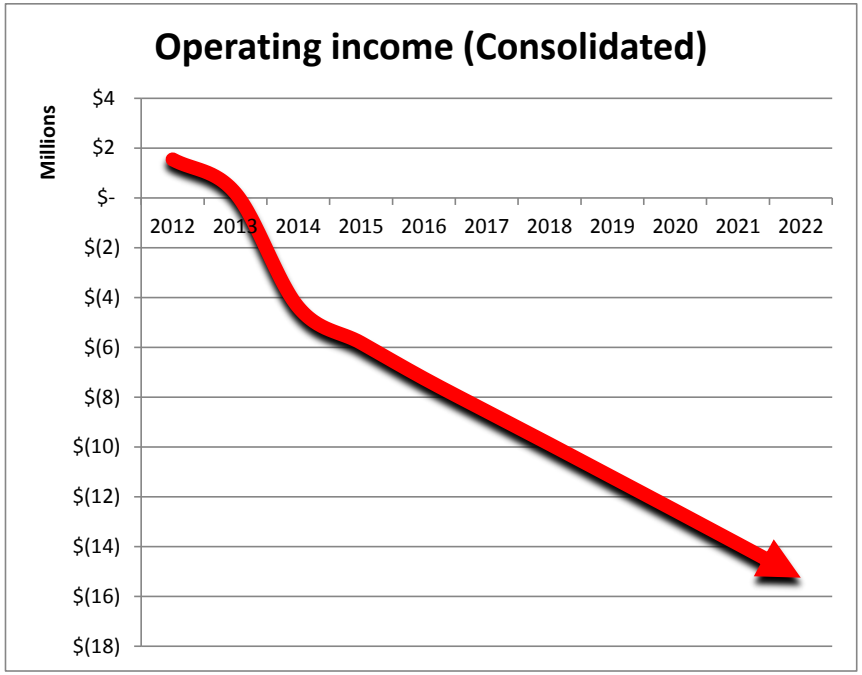
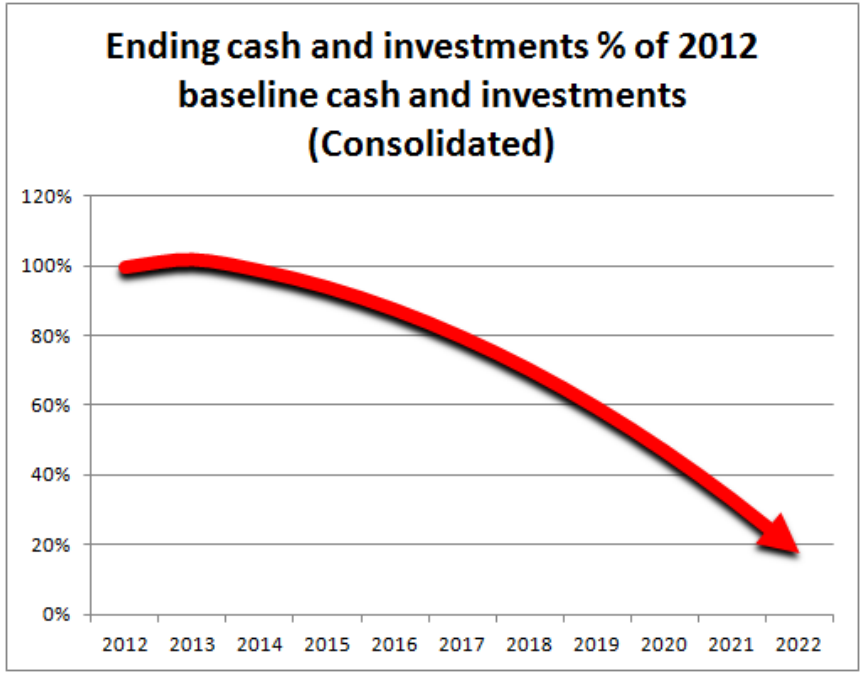
When operating income becomes negative in 2016, cash reserves start to decline





- Operational improvement and shared service economies of scale are insufficient to combat declining utilization
- Can't cut your way to sustainability

Azar Lays Out Agenda for Value-Based Care (3-6-2018)

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"There is no turning back to an unsustainable system that pays for procedures rather than value. *In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us. This administration and this President are not interested in incremental steps. We are unafraid of disrupting existing arrangements simply because they're backed by powerful special interests."*

- In an address to the Federation of American Hospitals on March 5, Secretary Azar laid out his four priorities for value-based care transformation

Give consumers control over their health information through improved HIT. Azar advocated for "putting the technology into the hands of the patients themselves," stressing the importance of empowering consumers.

Increase transparency. Azar stated that boosting transparency of services will help patients better shop for care, citing personal experience. He believes that Americans have the right to know what healthcare services and pharmaceuticals will cost.

Use of MACRA and CMS Innovation Center. The secretary cited the importance of Medicare and Medicaid in value-based transformation and cost control. He advocated for tools such as MACRA and the CMMI's ACOs that are already in place and asserted that "we will use these tools to drive real change in our system."

Reduce government burdens. Azar referred to regulatory burdens such as certain Medicare and Medicaid price reporting rules, restrictions in some FDA communication policies, and current interpretations of various well-meaning anti-fraud protections.

Sources: HHS.gov https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html; Politico.com, *What Alex Azar wants on value-based care (and how it resembles Obama's goals),* Dan Diamond 3/6/2018 https://www.politico.com/newsletters/politico-pulse/2018/03/06/what-alex-azar-wants-on-value-based-care-and-how-it-resembles-obamas-goals-123351

CMMI Direction: Blow Up Fee for Service (11/29/2018)

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- If there was any doubt about the Trump administration's desire to push healthcare towards a value-based system, Center for Medicare & Medicaid Innovation (CMMI) Director Adam Boehler makes things clear:

"I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to ***blow up fee for service…****That's one of our prime goals—is to get rid of fee for service."*

- However, getting rid of fee for service is easier said than done given the industry's current reliance on the existing infrastructure.

34%	10.5%	>50%
of healthcare payments tied to an APM in 2017	of Medicare payments in traditional legacy arrangements not linked to quality	of Medicare FFS payments with some level of pay-for-performance

Source: FierceHealthcare, *CMMI's Adam Boehler wants to 'blow up' fee for service,* Evan Sweeney, 11/29/18
https://www.fiercehealthcare.com/payer/cmmi-s-adam-boehler-wants-to-blow-up-fee-for-service

Market Overview – Healthcare Reform

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- 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

Future Hospital Financial Value Equation

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- Definitions
  - Patient Value

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

  - 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.
    - Different "this time"
      - Providers monetize value
      - Government "All In"
      - New information systems to manage costs and quality
      - Agreed upon evidence-based protocols
      - Going back is not an option

Substitution

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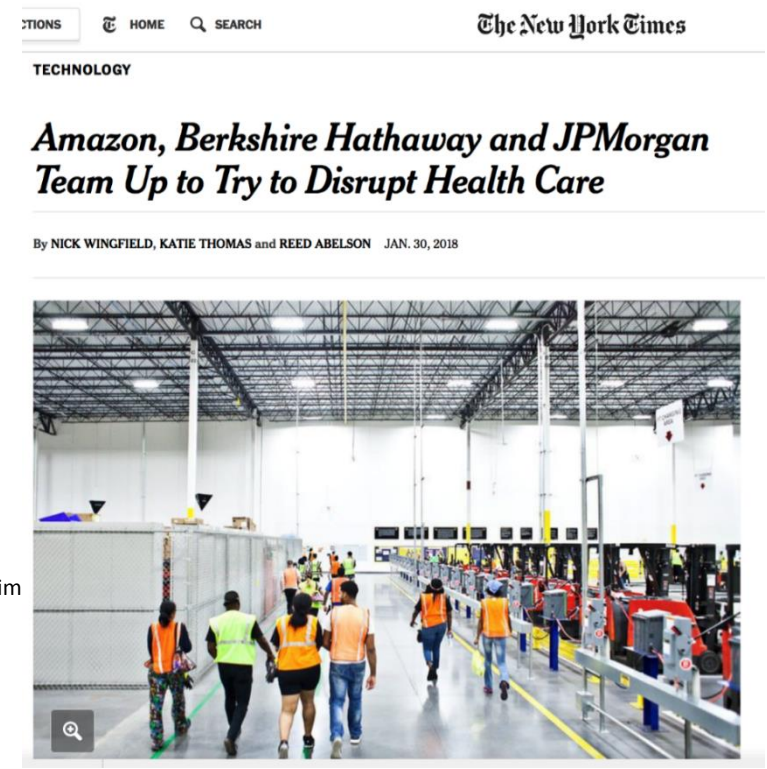
- Partnership to provide healthcare to organizations' employees and eventually expanded to benefit all Americans
- "Free from profit-making incentives and constraints" (Jamie Diamond, CEO JPMorgan Chase)
- "Reducing health care's costs and burden on the economy while improving outcomes would be worth the effort" (Jeff Bezos, CEO Amazon)

Source: New York Tim



:TIONS HOME SEARCH The New York Times

TECHNOLOGY

Amazon, Berkshire Hathaway and JPMorgan Team Up to Try to Disrupt Health Care

By NICK WINGFIELD, KATIE THOMAS and REED ABELSON JAN. 30, 2018

Source: New York Times, January 30, 2018

Source: New York Times, January 30, 2018

Source: New York Times, January 30, 2018

Future Hospital Financial Value Equation

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- ACO Relationship to Small and Rural Hospitals
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
  - Small and rural hospitals bring value / negotiating power to affiliation relationships 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:
      - 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

Future Hospital Financial Value Equation

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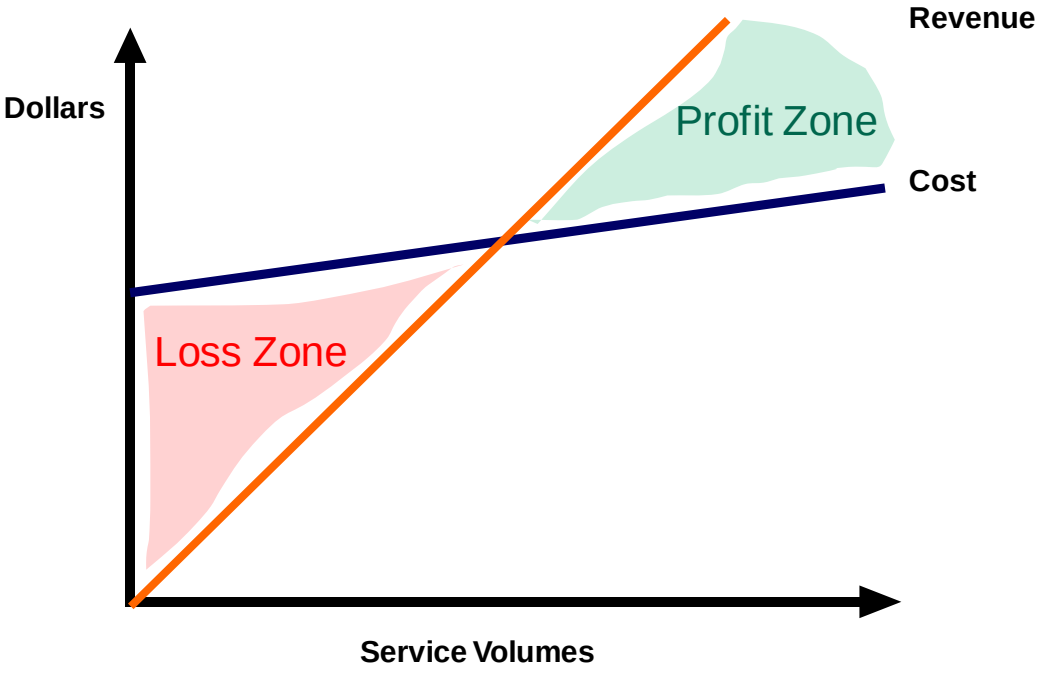
- Economics
  - As payment systems transition away from volume-based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant
    - New economic models based on patient value must be developed by hospitals, but not before the payment systems have converted
  - Economic model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp



The Challenge: Crossing the Shaky Bridge

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Fee for Service Payment System

Population Based Payment System

2014 2016 2018 2020 2022 2024 2026

Payment Transition – CMMI (Dr. Rajkumar 3/2016)

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Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	**A** APMs with Upside Gainsharing	**A** Condition-Specific Population-Based Payment
	B Pay for Reporting	**B** APMs with Upside Gainsharing/Downside Risk	**B** Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

The Premise

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Macro-economic Payment System

- Government Payers
  - Changing from F-F-S to PBPS
- Private Payers
  - Follow Government payers
  - Steerage to lower cost providers

Provider Imperatives

- F-F-S
  - Management of price, utilization, and costs
- PBPS
  - Management of care for defined population
  - Providers assume insurance risk

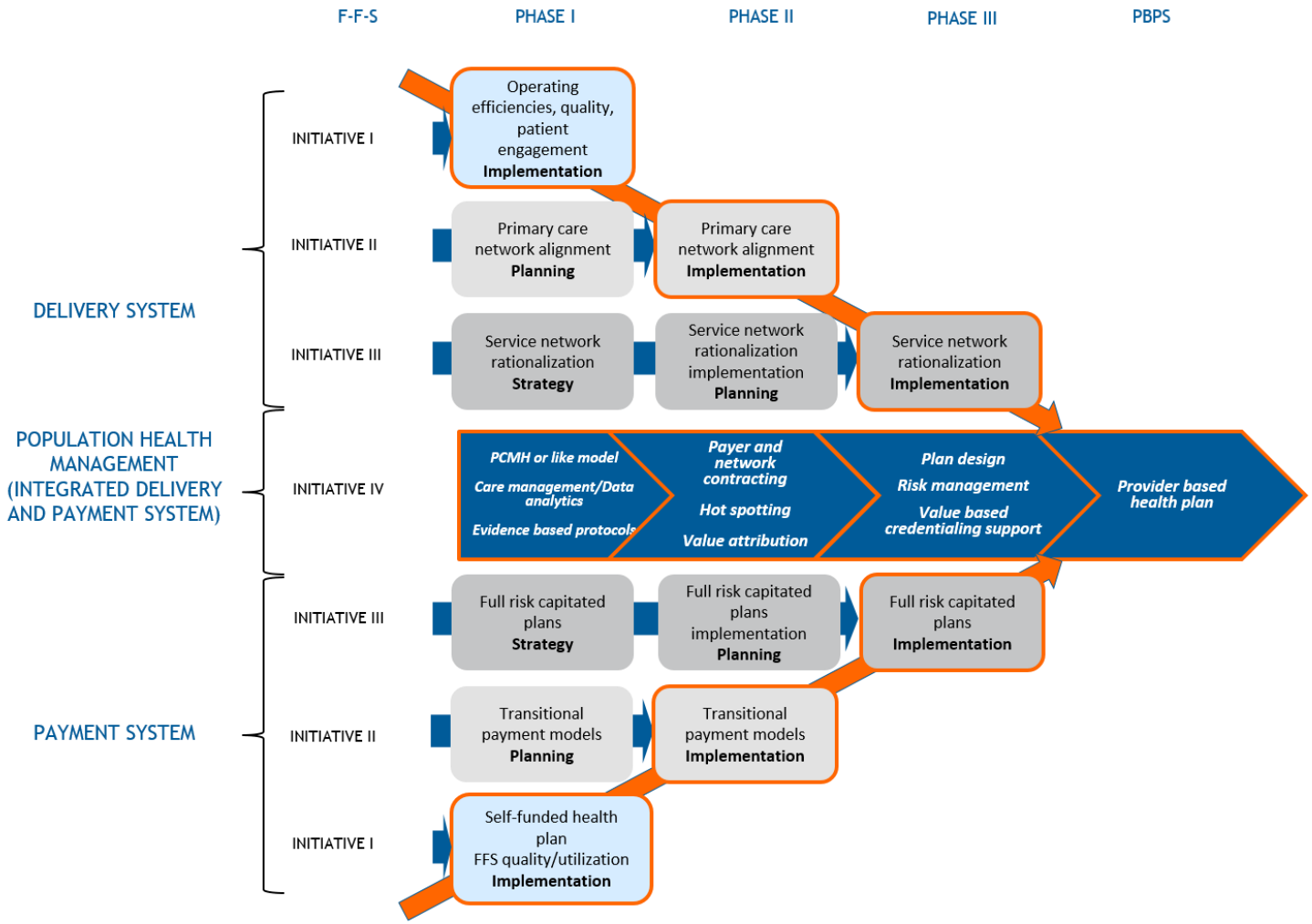
Provider organization

- Evolution from
  - Independent organizations competing with each other for market share based on volume to
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and care management organization

- New competencies required
  - Network development
  - Care management
  - Risk contracting
  - Risk management

Implementation Framework – What Is It?



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Initiative I – Operating Efficiencies, Patient Safety and Quality

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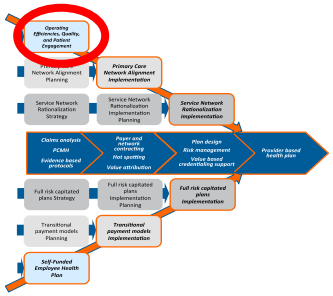
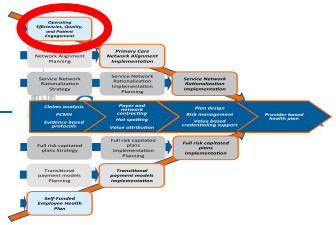
- Hospitals not operating at efficient levels are currently, or will be, struggling financially
- "Efficient" is defined as
  - Appropriate patient volumes meeting needs of their service area
  - Revenue cycle practices operating with best practice processes
  - Expenses managed aggressively
  - Physician practices managed effectively
  - Effective organizational design



Graphic: National Patient Safety Foundation

Operating Efficiencies, Patient Safety and Quality



- Focus on Quality and Patient Safety
  - As a strategic imperative
  - As a competitive advantage

U.S. HHS Hospital Compare Measures	National Avg.	MA Average	Fairview Hospital	Berkshire Medical Center	Baystate Medical Center	Columbia Memorial Hospital	Sharon Hospital	Saint Peter's Hospital	Bringham and Women's Hospital	Mass General Hospital	Albany Medical Center	Charlotte Hungerford Hospital
Patient Survey Summary Star Rating:			**5**	**3**	**3**	**2**	**4**	**3**	**3**	**4**	**2**	**3**
Patient Satisfaction (HCAHPS) Average:	**71%**	**70%**	**84%**	**68%**	**66%**	**61%**	**73%**	**67%**	**71%**	**74%**	**64%**	**65%**
Nurses "Always" communicated well:	80%	80%	92%	81%	75%	73%	84%	77%	80%	83%	75%	77%
Doctors "Always" communicated well:	82%	81%	90%	78%	77%	74%	84%	76%	80%	82%	70%	75%
"Always" received help when wanted:	68%	66%	88%	64%	59%	58%	71%	59%	69%	65%	62%	60%
Pain "Always" well controlled:	71%	71%	83%	73%	68%	70%	72%	70%	69%	72%	65%	69%
Staff "Always" explained med's before administering:	65%	64%	78%	64%	61%	56%	69%	59%	61%	66%	58%	58%
Room and bathroom "Always" clean:	74%	72%	86%	73%	67%	63%	78%	63%	66%	72%	66%	72%
Area around room "Always" quiet at night:	62%	53%	68%	46%	48%	45%	60%	47%	56%	54%	43%	40%
YES, given at home recovery information:	87%	89%	94%	89%	88%	83%	85%	87%	89%	90%	83%	91%
"Strongly Agree" they understood care after discharge:	52%	53%	70%	50%	49%	41%	51%	49%	51%	59%	46%	47%
Gave hospital rating of 9 or 10 (0-10 scale):	72%	70%	88%	65%	65%	53%	73%	69%	80%	82%	65%	60%
YES, definitely recommend the hospital:	71%	74%	91%	65%	73%	50%	72%	76%	84%	90%	70%	61%

Source: www.hospitalcompare.hhs.gov

Highest Score
Above State Avg.
Below State Avg.
Lowest Score

Initiative II – Primary Care Alignment

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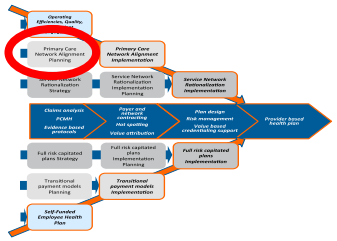
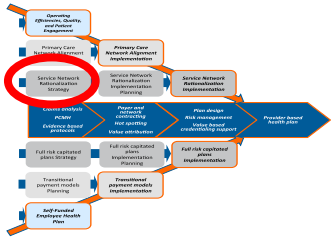


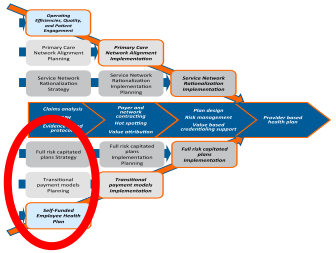
- Understand that revenue streams of the future will be tied to primary care physicians, which often comprise a majority of the rural and small hospital healthcare delivery network
  - Thus small and rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs
- Physician 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 (Board, executive leadership, planning committees, etc.)
  - *Potential Model for Rural:*
    - *New PHO/CIN/IHN*

Initiative III – Rationalize Service Network



- Develop system integration strategy
  - 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
- Identify the number of providers needed in the service area based on population and the impact of an integrated regional healthcare system
- Conduct focused analysis of procedures leaving the market
  - Understand real value to hospitals
    - Under F-F-S
    - Under PBPS (Cost of out of network claims)

Payment System Strategy – Initiative I



- **Develop self-funded employer health plan**
  - Hospital is already 100% at risk for medical claims thus no risk for improving health of employee "population"
  - Change benefits to encourage greater "consumerism"
    - Differential premium for elective "risky" behavior
  - "Enroll" employee population in health programs – health coaches, chronic disease programs, etc.
- **FFS Quality and Utilization Incentives**
  - Maximize FFS incentives for improving quality or reducing inappropriate utilization (e.g., inappropriate ER visits, re-admissions, etc.)
  - Annual Well visits, Chronic Care Management (CCM) and Transitional Care Management (TCM) FFS payments
  - Maximize MIPS incentive payments
    - MIPS ACO

Population Health Strategies – Phase I

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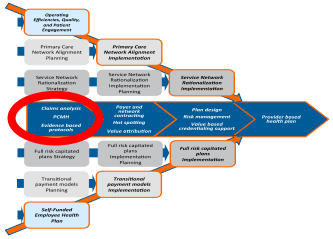
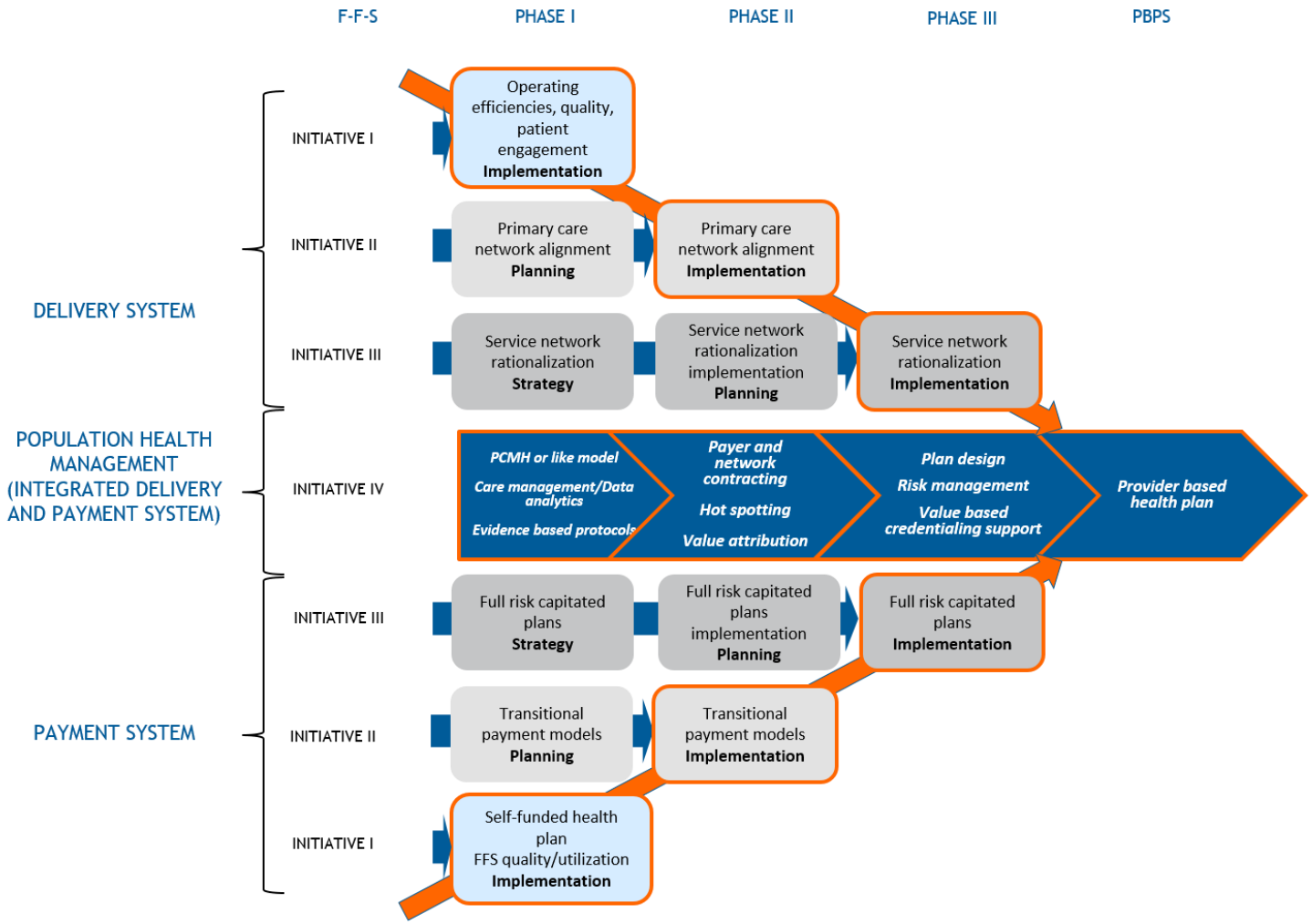


Phase I: Develop Population Health building blocks

- Goal: Infrastructure to manage self insured lives and maximize FFS Utilization and quality incentives
- Initiatives:
  - PCMH or like structure
  - Care management
    - Discharge planning across the continuum
      - Transportation, PCP, meds, home support, etc.
    - Transitions of care (checking in on treatment plan)
      - Medication reconciliation
      - Post discharge follow-up calls (instructions, teach back, medication check-in)
      - Identifying community resources
      - Maintain patient contact for 30 days
  - Develop claims analysis capabilities/infrastructure
  - Develop evidenced based protocols

Implementation Framework – In Review



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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
- "Shaky Bridge" crossing will required planned, proactive approach
  - Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system

Conclusions/Recommendations (continued)

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- Important strategies for providers to consider include:
  - Increase leadership awareness of new environment realities
  - Strategic plan to be updated to incorporate new strategic imperatives – "Bridge Strategy"
  - 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