



Financial Sustainability - Creating a Revenue Strategy

Rural Hospital Financial Readiness: Strategies and Innovations

Rural Health Care Symposium

Hyatt Regency, Sacramento

May 14, 2019

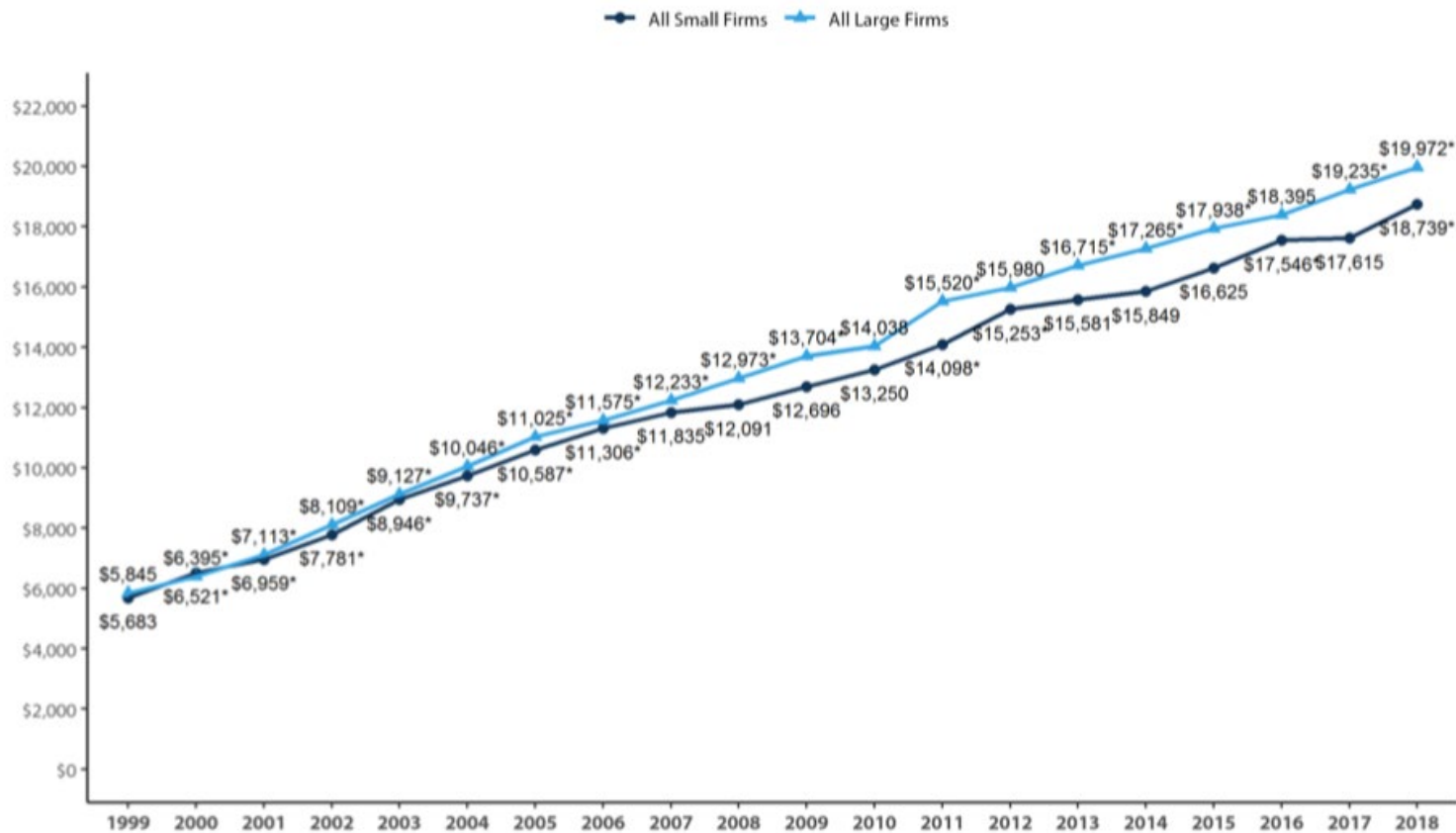
Eric K. Shell, CPA, MBA



Call to Action: Insurance Premiums

Figure 1.12

Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2018



* 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.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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Employer Health Benefits

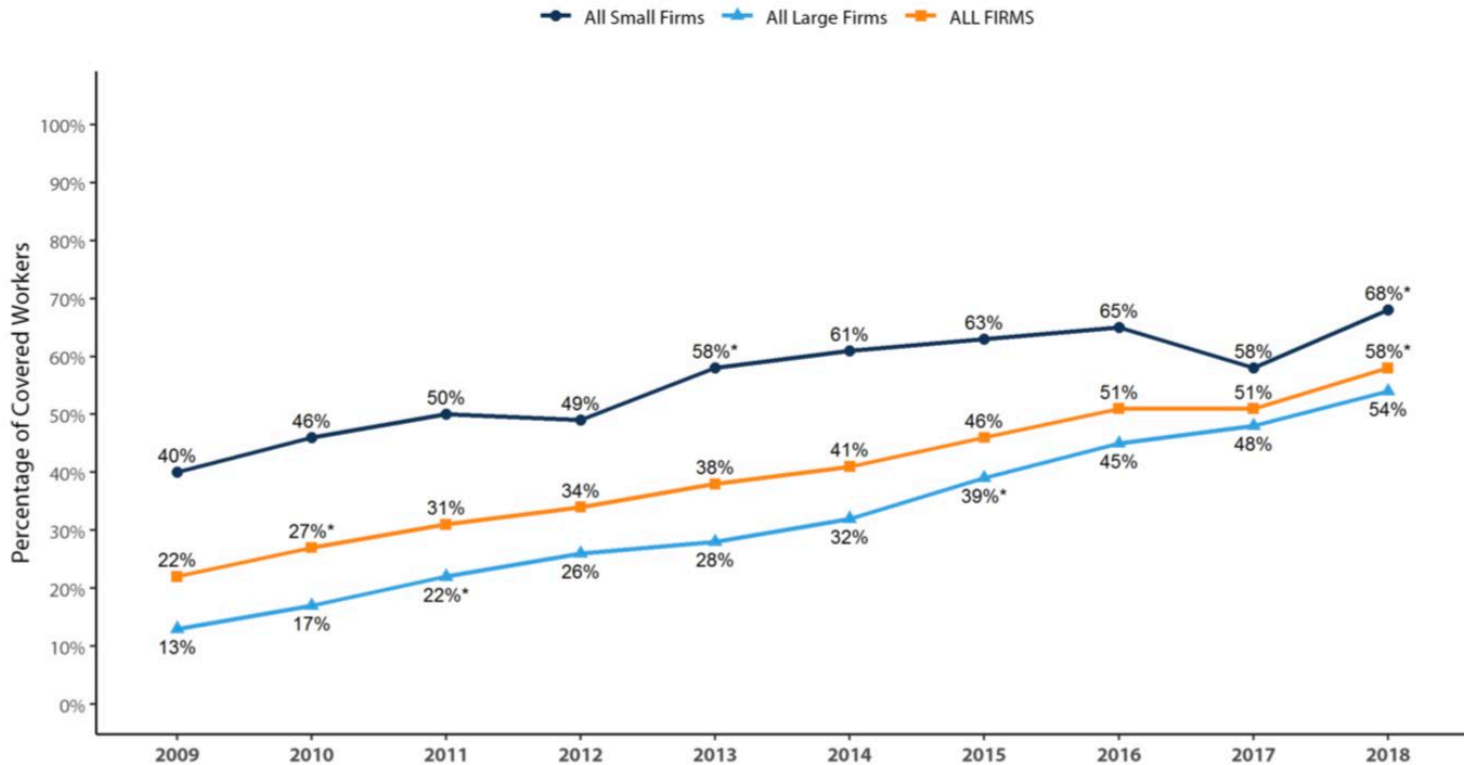
2018

ANNUAL SURVEY

Call to Action: Growth of High Deductible Plans

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

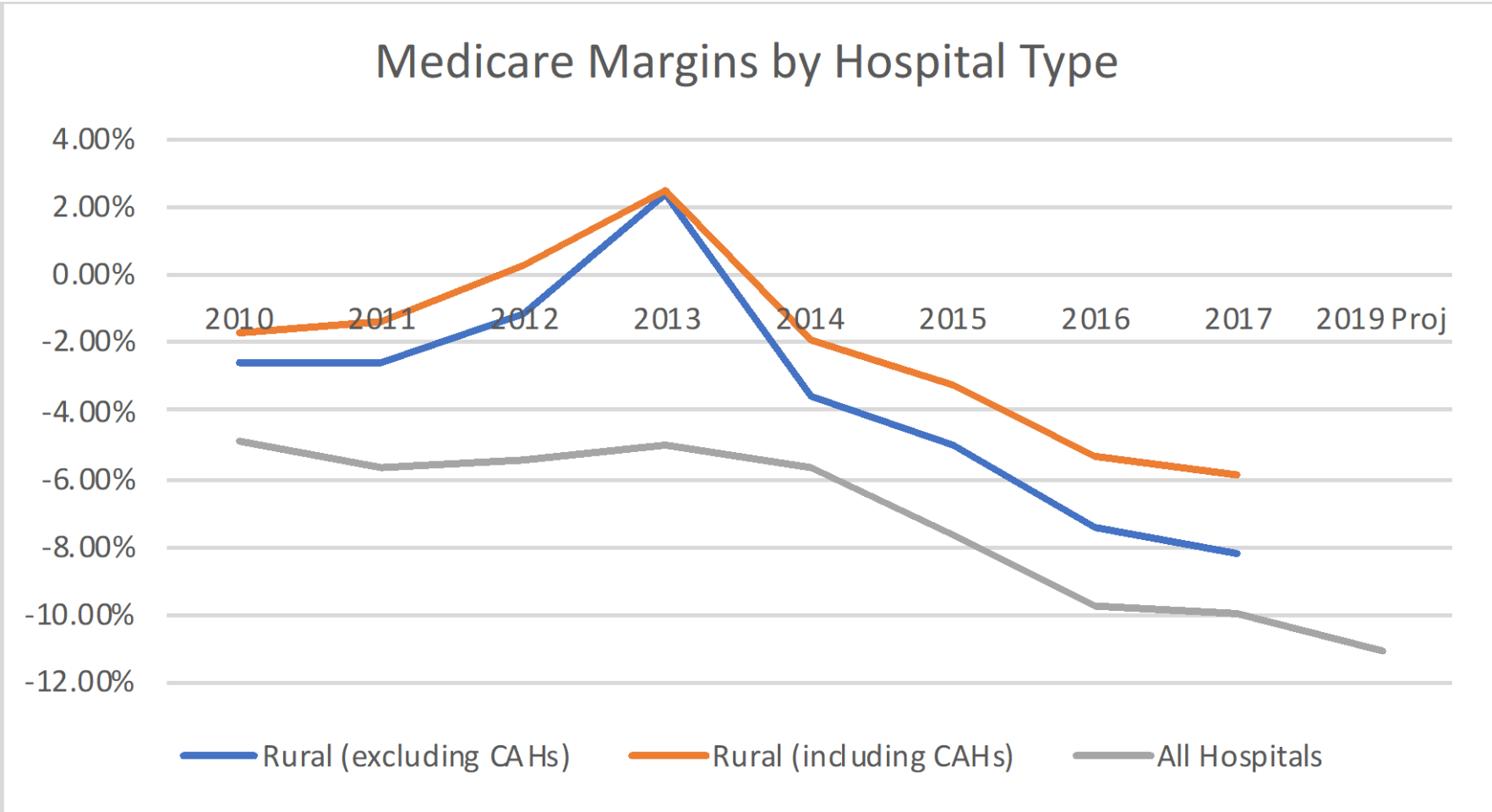
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Employer Health Benefits

2018

ANNUAL SURVEY

Call to Action: Declining Medicare Margins



Source: MedPac Report to Congress, March 15, 2019

Call to Action: Future Hospital Cost-Cutting

- Hospitals Targeted in Federal Cost-Cutting Push (3/6/19)
 - Led by Sen. Lamar Alexander (R-Tenn.), a bipartisan group including the Brookings Institution and the American Enterprise Institute submitted a set of healthcare cost-cutting recommendations that target hospitals
 - Recommendations in the letter include:
 - **Targeting merger-and-acquisition (M&A) activity**
 - Specifically, increased for antitrust enforcement by the Federal Trade Commission and the Department of Justice's Antitrust Division against both provider and health plan M&A
 - **Eliminating any willing provider rules governing network participation**
 - **Requiring participation in all-payer claims databases**
 - **Repealing certificate of need laws**
 - **Requiring contracts to eliminate surprise bills**
 - **Expanding site-neutral payments**
 - **Expanding bundled payments**
 - **Narrowing 340B**

“There’s just no getting around the fact that hospitals make up a huge chunk of healthcare spending in the United States...So, if you want to save any substantial amount of money, it’s going to be hard to do that without having any effects on the hospitals.”

Benedic Ippolito, an author of the joint letter and an economist at AEI

Source: hfma.org Healthcare Business News, *Hospitals Targeted in Federal Cost-Saving Ideas*, Rich Daly, 3/6/19, <https://www.hfma.org/Content.aspx?id=63470>

Call to Action: Nonprofit Hospitals on Unsustainable Path



- According to Moody's, **expense growth for nonprofit and public hospitals outpaced annual revenue growth in FY2017**
 - The median annual expense growth rate was 5.7 percent in FY2017, down from 7.1 percent the previous year
 - The lower expense rate was largely due to better control of supply and labor costs
 - However, the annual revenue growth rate declined faster, falling from 6.1 percent in fiscal 2016 to 4.6 percent in fiscal 2017
 - The lower revenue growth was attributable to factors including the shift to outpatient care, increased ambulatory competition and lower reimbursement rates
- Moody's expects **nonprofit hospital margins will continue to be suppressed through 2018** after median operating margins and cash flow margins fell to all-time lows of 1.6 percent and 8.1 percent, respectively, in fiscal 2017
- The medians are based on an analysis of audited fiscal year 2017 financial statements for 303 freestanding hospitals, single-state health systems and multistate healthcare systems, representing 78 percent of all Moody's-rated healthcare entities

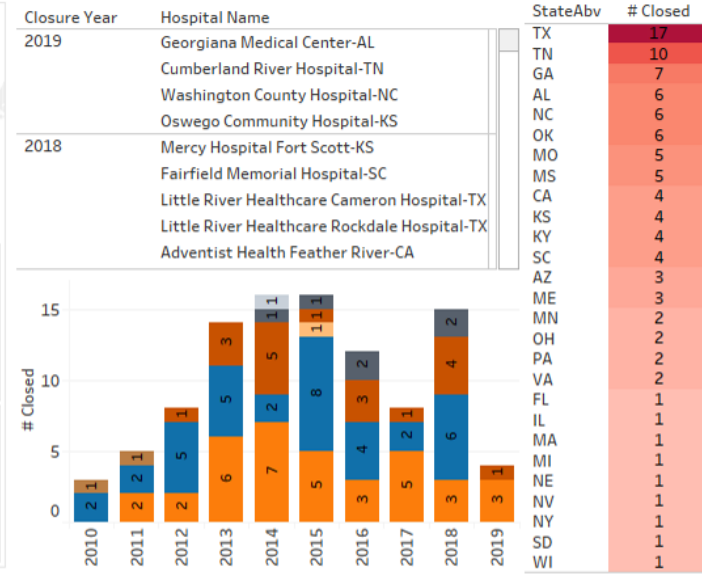
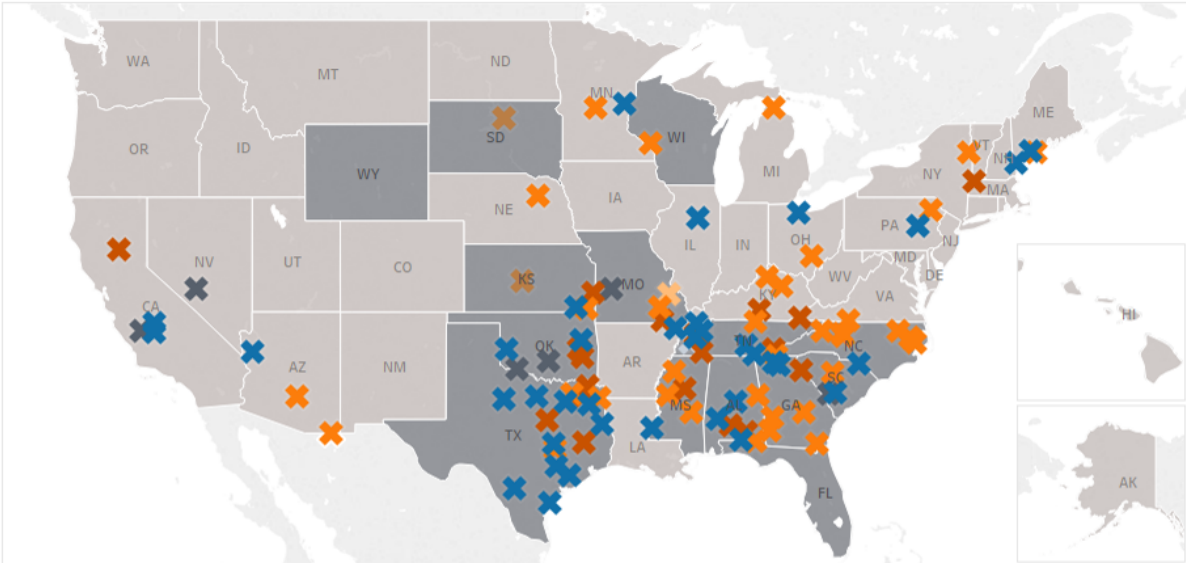
MOODY'S

Source: Becker's Hospital Review, *Moody's: Margin contraction puts nonprofit hospitals on unsustainable path*, Ayla Ellison, 8/29/18
<https://www.beckershospitalreview.com/finance/moody-s-margin-contraction-puts-nonprofit-hospitals-on-unsustainable-path.html>

Call to Action: Rural Hospital Closures

101 Closed Rural Hospitals

There have been 101 Rural Hospital closures since 2010 and 143 since 2005. These counts do not include those that have closed and re-opened.



Closure Year	Critical Access Hospital	Prospective Payment System	Medicare Dependent Hospital	Sole Community Hospital	Re-based Sole Community Hospital	Disproportionate Share Hospital	Rural Referral Center	Total
2010		2			1			3
2011	2	2			1			5
2012	2	5	1					8
2013	6	5	3					14
2014	7	2	5	1		1		16
2015	5	8	1	1			1	16
2016	3	4	3	2				12
2017	5	2	1					8
2018	3	6	4	2				15
2019	3		1					4
Total	36	36	19	6	2	1	1	101

Medicare Payment Type

- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Disproportionate Share Hospital
- Rural Referral Center

Current Status of Medicaid Expansion Decision

- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated: 3/12/2019

Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org

Design: @GreggLathrop

Source: NC Rural Health Research Program at the Cecil G. Sheps Center for Health Services and Research and KFF.org

Call to Action: Azar Lays Out Agenda for Value-Based Care

“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>

Call to Action: CMMI - Blow Up Fee for Service



- 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%

of healthcare payments tied to an APM in 2017

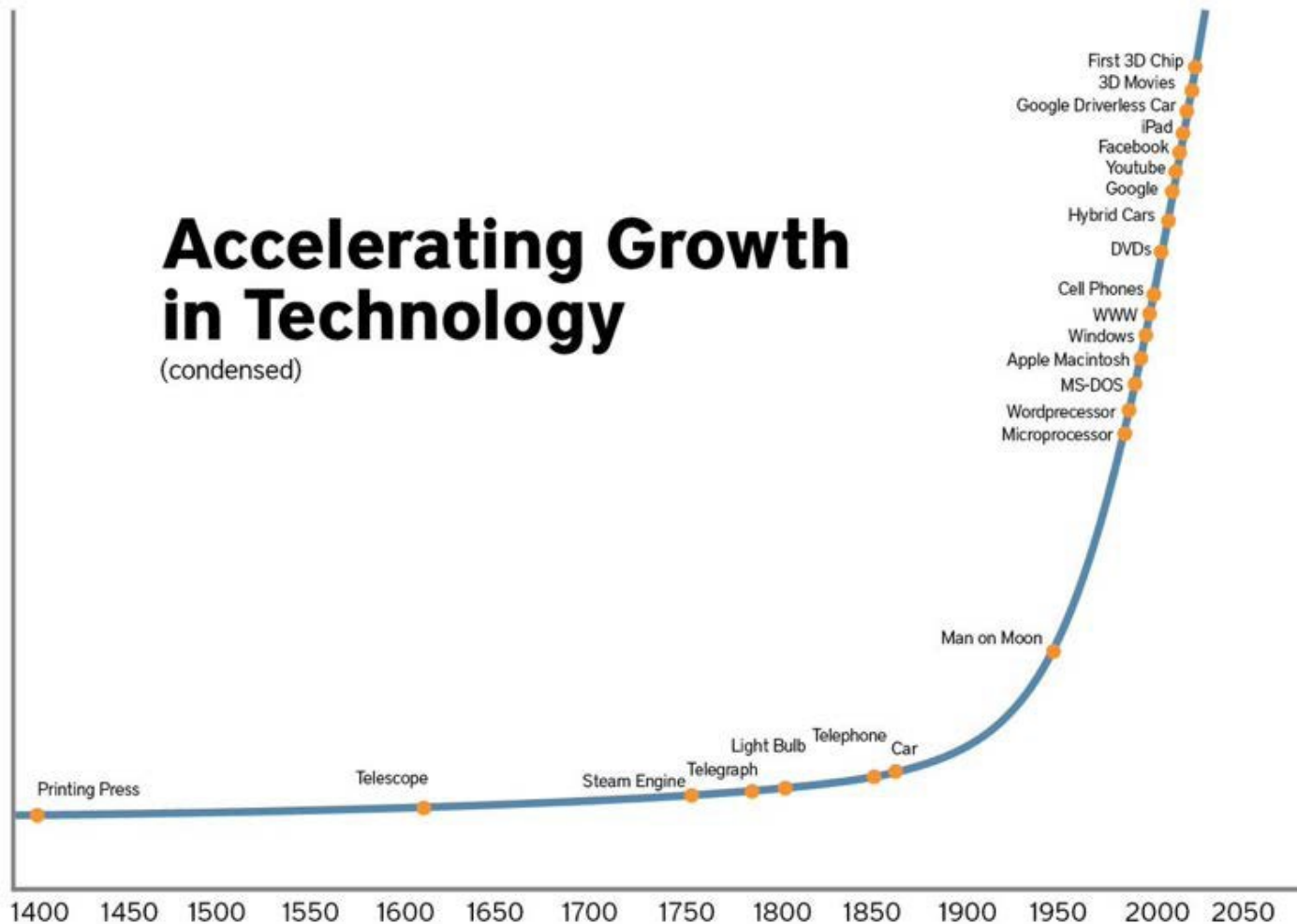
10.5%

of Medicare payments in traditional legacy arrangements not linked to quality

>50%

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>



Source: Khalid Hamdan, [Accelerating Growth in Technology](#)

Call to Action: What Could This Mean for Healthcare



- Virtual medicine
- Mobile medicine
- Artificial intelligence
- Interoperability
 - Wearables
- Environmental sensors
- Personalized medicine
 - Big data
 - Virtual reality
 - Robotics
 - Genomics
- Personalized health record

Future Hospital Financial Value Equation

- 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

- 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 Times



Source: New York Times, January 30, 2018

Source: New York Times, January 30, 2018



WHAT'S INSIDE

The Test

- Kit Registration Information for Physician Review
- Easy-to-Follow Instructions
- Sterile Collection Tools
- Pre-Paid Return Shipping
- A Warm Welcome to the EverlyWell Community!



841 views | Apr 16, 2019, 05:18pm

EverlyWell Raises \$50 Million To Make At-Home Lab Testing More Accessible

- Founded in 2015 to offer validated at-home lab tests that are reviewed by physicians at a certified lab
- Offers 35 different types of tests including ones for food sensitivity, hormone levels, Lyme disease, and sexually transmitted diseases
- Tests currently available at Target, CVS, Humana and the EarlyWell website

Source: Forbes, April 18, 2019



Walgreens and LabCorp to open 600 in-store testing sites

- Part of Walgreens broader effort to expand from retail into healthcare service companies
 - *“Reflects commitment to transform stores into neighborhood health destinations that provide a differentiated, consumer-focused experience, while provided access to a broad range of affordable health care services”*
- Handheld device that can examine heart, lungs, ears, throat and abdomen as well as measure body temperature to enable remote diagnosis of acute care situations like ear infections, sore throats, fever, cold, flu, allergies, stomachaches, upper respiratory infections and rashes
 - Information sent to a primary care provider for diagnosis through a telehealth platform
- Acquisition in line with Best Buy 2020 Strategy to enrich human lives through technology by addressing human needs

Source: Fierce Healthcare, October 11, 2018

Substitution - New Retail Services



TytoCare - TytoHome Medical Exam Kit - White

Model: G 1.5 SKU: 6332714

★★★★★ 4.8 (13 Customers) | Be the first to ask a question

HSA/FSA eligible

\$299.99 ¹ or \$50.00/mo.*
suggested payments with
6-Month Financing
[Show me how >](#)

 Add to Cart

Save for Later

Compare

 Help

FREE Shipping: Get it by Wed, Apr 24

Want it faster? More shipping options are available in checkout to 04021.

Store Pickup: Order now & Portland will have it ready for pickup by Thu, Apr 25.

Cardmember Offers

6 Month Financing

Get 5% Back in Rewards



Get a complete medical exam wherever you are with TytoCare TytoHome. This electronic health care device allows you to receive on-demand physical exams via live video chat with a doctor's office using an exam camera and a basal thermometer and otoscope, stethoscope and tongue depressor adapters. This HIPAA-secure TytoCare TytoHome digital device transmits test results to an electronic health record for easy monitoring .

Best Buy expands reach into digital health space with Tyto Care partnership

- Handheld device that can examine heart, lungs, ears, throat and abdomen as well as measure body temperature to enable remote diagnosis of acute care situations like ear infections, sore throats, fever, cold, flu, allergies, stomachaches, upper respiratory infections and rashes
 - Information sent to a primary care provider for diagnosis through a telehealth platform
- Acquisition in line with Best Buy 2020 Strategy to enrich human lives through technology by addressing human needs

Source: Fierce Healthcare, April 17, 2019

Call to Action - Final Thoughts

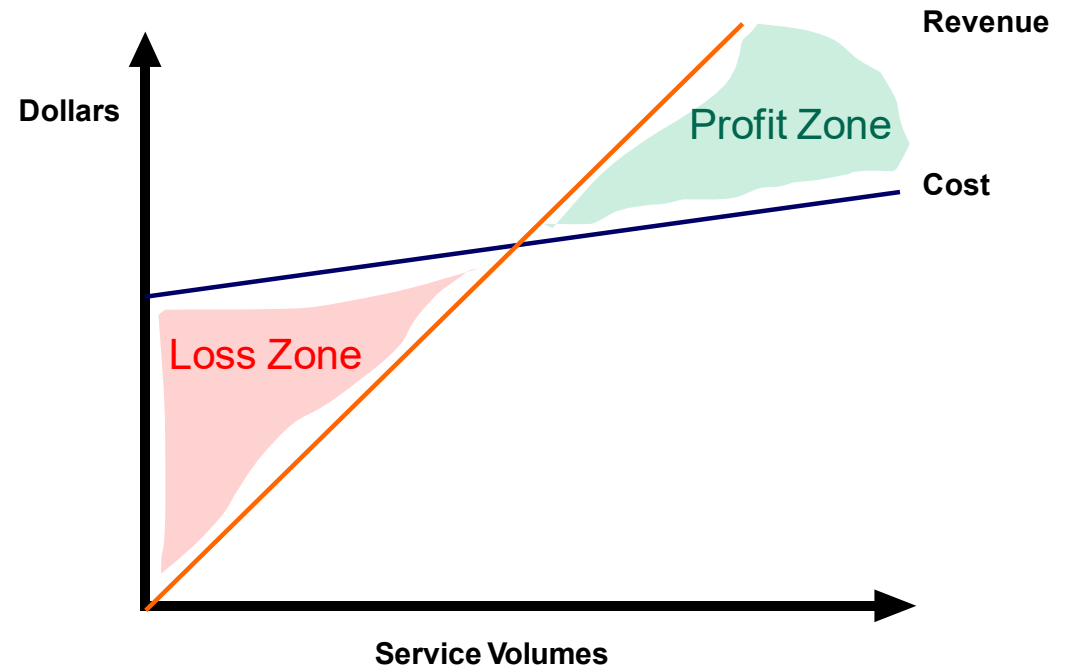
- Traditional fee-for-service payment will continue to transition to value-based payment
 - May require provider “pull” rather than governmental “push”
- Pressure for operational efficiencies and human and capital resources will continue to accelerate
- Clinical integration will create advantages to systems of accountable care (Value based payment, re-admission rates and preventable re-admissions, bundled payments, accountable care organizations, etc.)
- Flexibility must be ingrained into any short to medium term strategies as a direct result of increased regulatory and environmental uncertainty

Future Hospital Financial Value Equation

- 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

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



Future Hospital Financial Value Equation

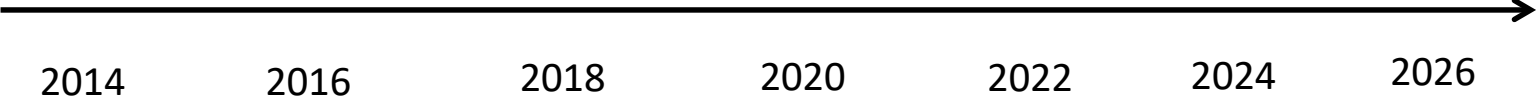
- Value in Rural Hospitals
 - Lower Per Beneficiary Costs
 - Revenue centers of the future
 - PCP based delivery system
 - CAH cost-based reimbursement
 - Step towards budget-based reimbursement
 - Incremental volume drives down unit costs
 - Once commitment to community Emergency Room, system incentives to drive low acuity volume to CAH

The Challenge: Crossing the Shaky Bridge

Fee for Service Payment System



Population Based Payment System



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





Finance

Macro-economic Payment System

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

Function

Provider Imperatives

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

Form

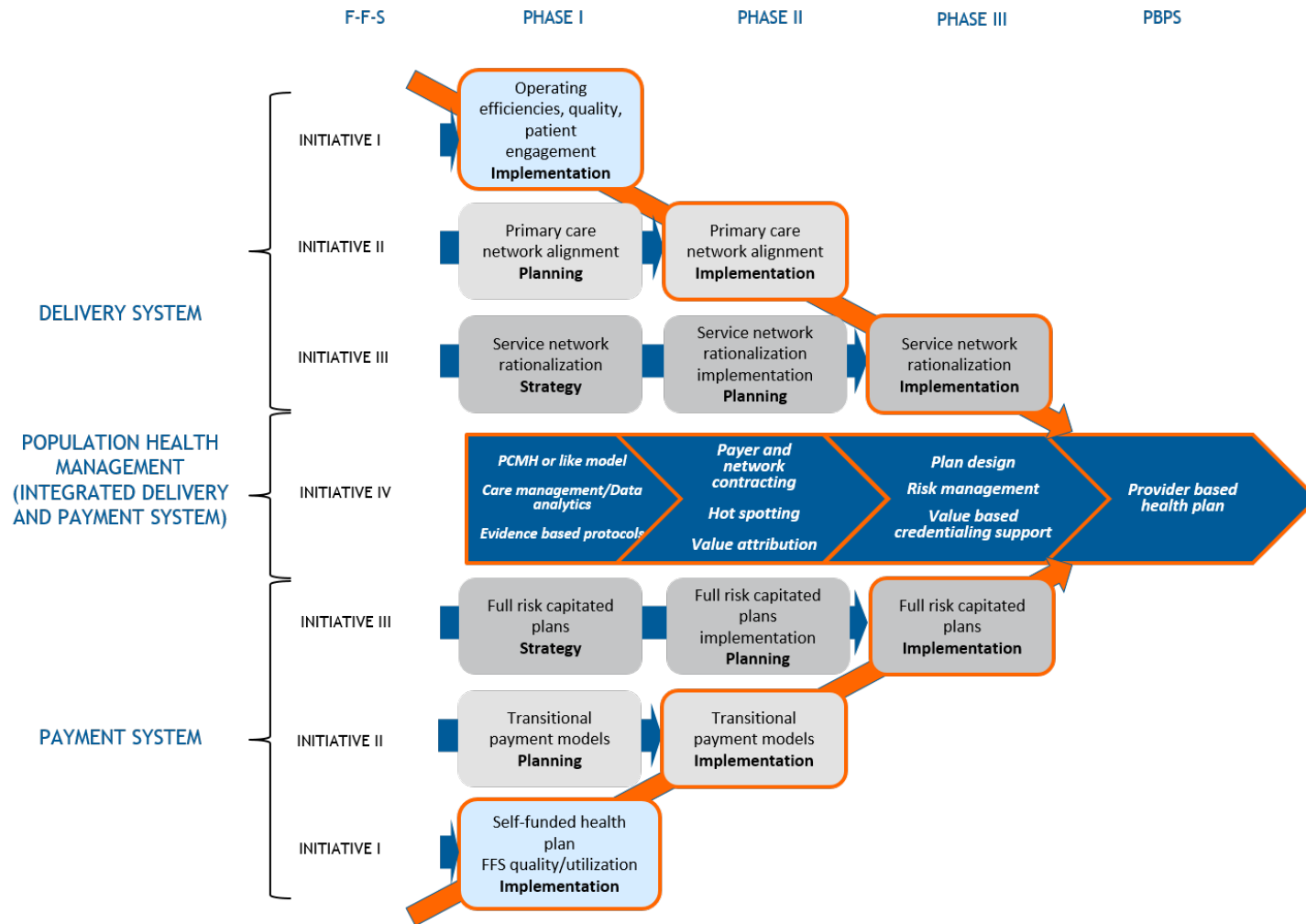
Provider organization

- 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

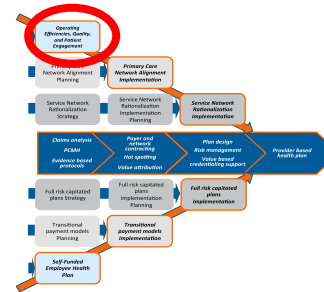
Implementation Framework - What Is It?



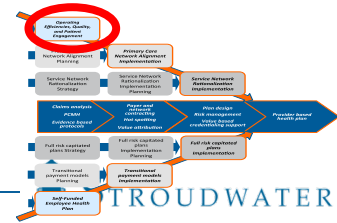
© Stroudwater Associates 2017

Initiative I - Operating Efficiencies, Patient Safety and Quality

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



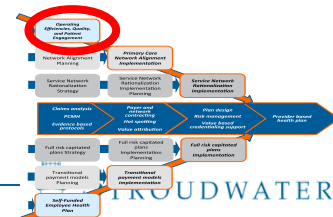
Graphic: National Patient Safety Foundation



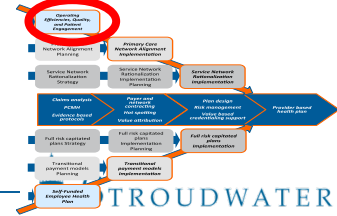
Initiative I - Economic Philosophy

- Understand difference between contribution margin and profit on fully allocated costs
 - Variable Cost
 - Definition: Expenses that change with changes in activity
 - E.g.: *Pharmaceuticals, reagents, film, food*
 - Fixed Cost
 - Definition: Expenses that do not change with changes in activity
 - E.g.: *Salaries and benefits (??), rent, utilities*
 - Rural hospitals have inordinately high fixed costs relative to revenue (E.g., ER Standby, acute care nursing costs, etc.)
 - Unit contribution margin
 - The amount from each unit of service available to cover fixed costs and provide operating profits
 - Example - If Department X's unit service price is \$200 and its unit variable cost is \$30, the unit contribution margin is \$170 (\$200 – \$30)
 - A rural hospital is made up of 1000s of Unit Contribution Margins

Initiative I - Organizational Design

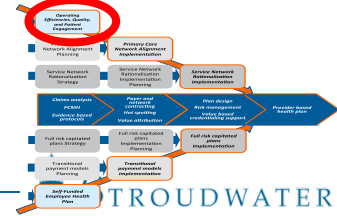


- Have an effective organizational design that drives accountability into the organization
 - Decision Rights
 - Drive decision rights down to clinical/operation level
 - Education to department managers on business of healthcare
 - Avoid separation of clinical and financial functions
 - Performance 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



Initiative I - Individual and Organizational Values

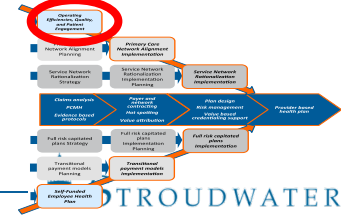
- Impact
 - Leave better than before
- Interdependence
 - We before me
 - Small cog in a larger system
- Respect
 - For oneself, others, environment, etc.
 - Golden Rule
- Abundance
 - Stephen Covey coined the idea of abundance mentality or abundance mindset, a concept in which a person believes there are enough resources and successes to share with others.
 - This is contrasted with the scarcity mindset (i.e., destructive and unnecessary competition), which is founded on the idea that, if someone else wins or is successful in a situation, that means you lose; not considering the possibility of all parties winning (in some way or another) in a given situation (zero-sum game).



Initiative I - Volume and Payment

- Grow FFS patient volume to meet community needs
 - Goal: Capture 5 percentage points more of volume by-passing your hospital
 - **“Catching to pitching”**
 - Opportunities often include:
 - ER Admissions
 - Swing bed
 - Ancillary services (imaging, lab, ER, etc.)
- 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

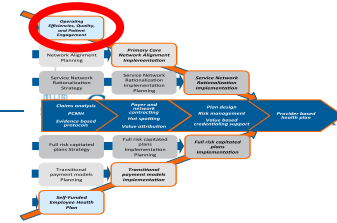
Initiative I - Management Accounting



- Hospital has developed a best practice process where all department managers actively participate in working with CFO/Controller to set department budgets
- Reported that on a monthly basis, department managers receive “Responsibility Reports” which report actual month and year-to-date revenue and expense compared to budget and prior year
 - Managers are required to report variances from budget and have access to monthly financials through the shared drive and are supposed to report variances from budget of greater than \$500 or 10%
- Hospital has also developed a program where all managers are required to develop plans to either increase revenue or decrease expenses by 5%
- Best performing peer rural hospitals establish the following practices to foster a culture of accountability: managers participate in budget development, financials are distributed monthly with expectation of variance monitoring/reporting, departmental performance dashboards are established, Department Operations Reviews (DORs) meetings are held monthly with managers to ensure accountability for performance

Initiative I - Patient Safety and Quality

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



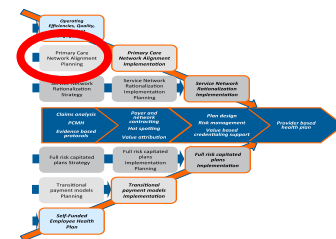
U.S. HHS Hospital Compare Measures	National Avg.	MA Average	Fairview Hospital	Berkshire Medical Center	Baystate Medical Center	Columbia Memorial Hospital	Sharon Hospital	Saint Peter's Hospital	Brigham and Women's Hospital	Mass General Hospital	Albany Medical Center	Charlotte Hungerford Hospital
Patient 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



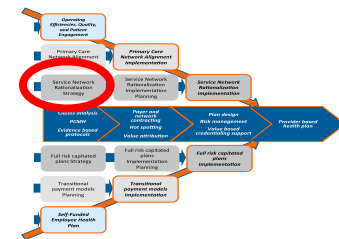
Initiative II - Primary Care Alignment

- 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*

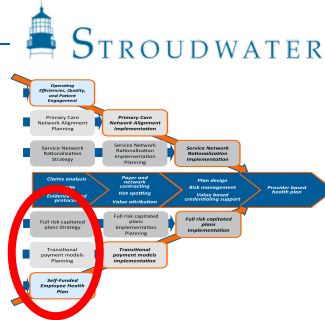


Initiative III - Rationalize Service Network

- 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)

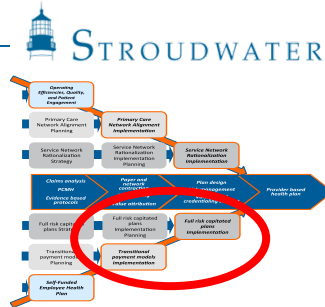


Payment System Strategy - Initiative I



- **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

Payment System Strategy - Initiatives II and III



Initiative II: Implementation planning for transitional payment models

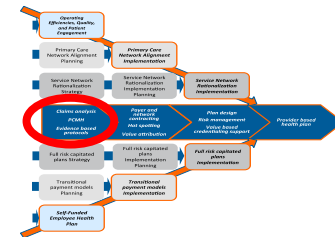
- Transitional payment models include:
 - FFS against capitation benchmark w/ shared savings
 - Shared savings model Medicare ACOs
 - Shared savings models with other governmental and commercial insurers
 - Partial capitation and sub-capitation options with shared savings
- Prioritize insurance market opportunities
- Take the initiative with insurers to gauge interest and opportunities for collaborating on transitional payment models
- Explore direct contracting opportunities with self-funded employers

Initiative III: Develop strategy for full risk capitated plans

Population Health Strategies - Phase I

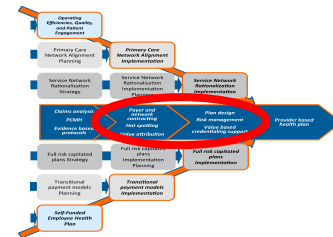
Phase I: Develop Population Health building blocks

- 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

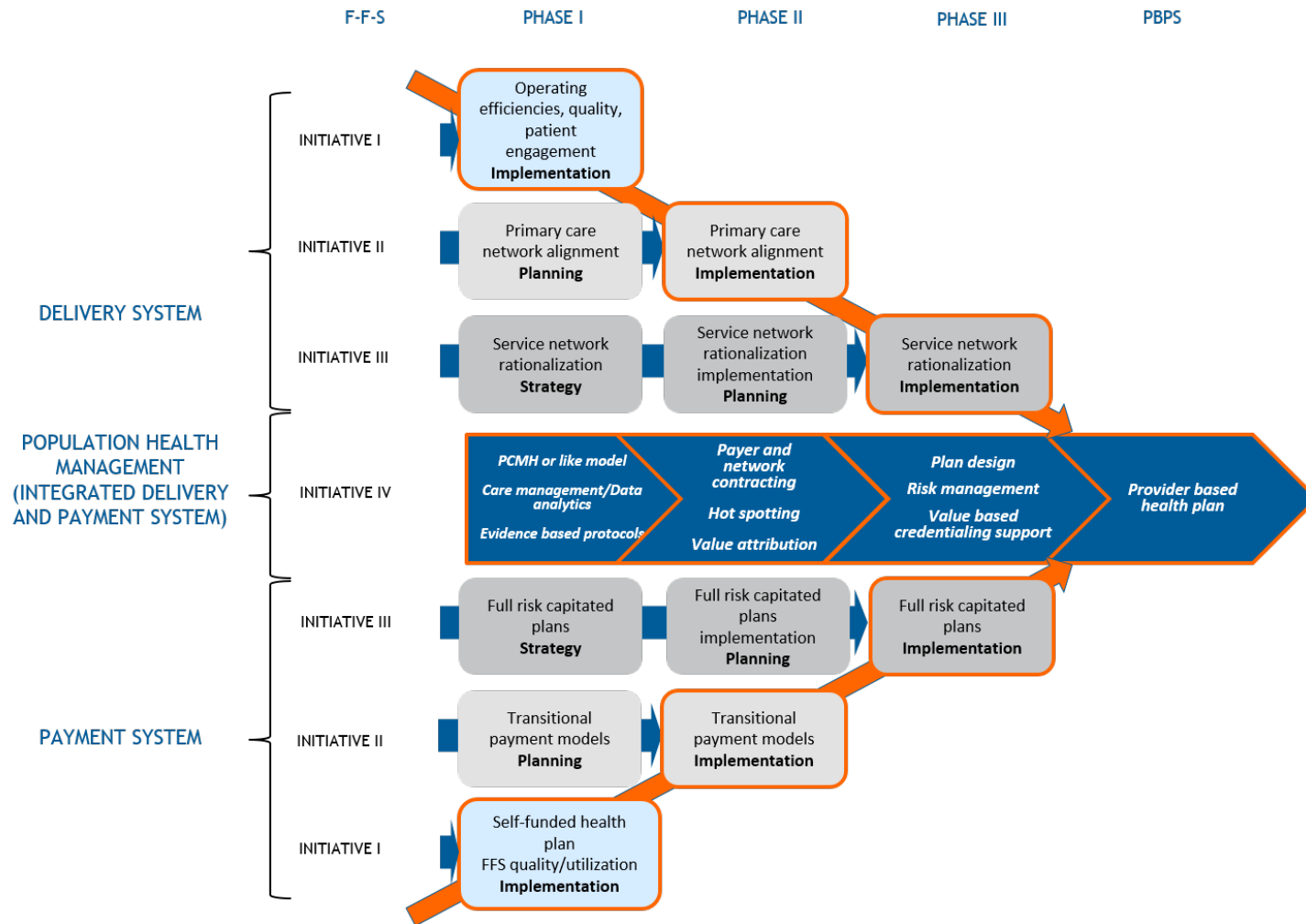


Population Health Strategies - Phase II and III

- Develop Strategy for population health management
 - Phase II Goal: Infrastructure to manage transitional payment models
 - Initiatives:
 - Develop capability to contract with third party payers including actuarial expertise
 - Acquire and analyze third party payer claims targeting high cost users
 - ***Develop payment/measurement system to attribute value and distribute shared savings***
 - PCMHs are provided tools to better manage patient care to improve outcomes and patient health
 - Phase III Goal: Infrastructure to manage care for a defined population within a budget
 - Initiatives:
 - Risk management capability (e.g., re-insurance)
 - Enhanced third-party payer “partnerships” (e.g., plan design, joint marketing, etc.)
 - Capability to support value-based credentialing



Implementation Framework - In Review



Conclusions/Recommendations

- For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.
 - The current environment driven by healthcare reform and market realities now offers a new set of challenges
 - Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes
- 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)

- Important strategies for providers to consider include:
 - Increase leadership awareness of new environment realities – Status quo no longer an option!
 - 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