Collaboration and Accountability in a Successful Managed Care Environment
Presentation Overview

Understanding the Changing Environment

Key Financial Changes

Key Organizational Changes

Fostering Partnerships for Success

Tying It All Together: A Roadmap for Success
Activity 1: Organizational Readiness Quick Check

- Assessing organizational readiness

- Do you track the rate of hospital readmissions of residents from your facility?
- Do you know how you compare to other facilities in your area on readmissions?
- Do you evaluate your organization's cost of care and know how you compare with peers who offer comparable quality?
Group Exercise

- Assessing organizational readiness

Does your organization have EHRs?

Do you partner with other providers in the community?

Do you have a relationship with the hospitals in your area at the C-suite level?
Group Exercise

- Assessing organizational readiness

Have you collaborated with any other providers, or with your area MCO on programs?

Have you developed or implemented any innovative care programs?

Do you have a high patient satisfaction rating?
Group Exercise

- Can you demonstrate that you deliver high quality at a lower cost?

- Does your data illustrate that you deliver high value low cost care?

- Have you implemented quality dashboards to constantly monitor baselines and progress?

- Can you identify how your quality provides value/savings?
How many no answers did you have?
Which no answer will be the most challenging for you to address and why?
Now Let’s Dive Into the Details

• We are now going to go a bit deeper and take a look at some significant shifts which have the potential to dramatically impact providers in the near future
• Nearly every aspect of provider operations have the potential to be effected

To ensure success, it is critical that providers begin examining areas of impact for their organization now, and strategizing how they will mitigate negative financial, operational, and clinical areas of risk in the near future
PREPARING FOR FINANCIAL CHANGE
Eligibility: Impact

- Once the ACA becomes effective on Jan. 1\textsuperscript{st} 2014, there will be a significant influx of newly insured individuals requiring care.
- The Congressional Budget Office estimates that 14 million uninsured non-elderly individuals (19-64) will become insured, and that 16 million more will be added through 2021.
- Those states which face the most significant impact are as follows:

<table>
<thead>
<tr>
<th>State</th>
<th>Total of Newly Insured per Jan. 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>6,067,100</td>
</tr>
<tr>
<td>Texas</td>
<td>4,843,000</td>
</tr>
<tr>
<td>Florida</td>
<td>3,158,700</td>
</tr>
<tr>
<td>New York</td>
<td>2,211,500</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,622,000</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,566,500</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,331,100</td>
</tr>
<tr>
<td>Ohio</td>
<td>1,283,500</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1,126,500</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1,117,100</td>
</tr>
</tbody>
</table>
Financial Ramifications

- Financial ramifications of healthcare reform will be significant and will go well beyond the level of Federal Reimbursement for Medicaid eligibles.
- The industry is seeing significant shifts across the following areas which will have a global impact on the financial stability of providers:
  - Movement from fee for service (value based purchasing)
  - Quality Based Payments
  - Financial Penalties tied to Readmissions
  - Financial Penalties tied to Acquired Conditions
  - Decrease in Disproportionate Share Hospital (DSH) Payments
## Financial Ramifications

### Financial Impacts on U.S. Hospitals & Providers

<table>
<thead>
<tr>
<th>Payment Area</th>
<th>Payment Reduction Over a 10 year period in Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>New payments for uncompensated care</td>
<td>177.3</td>
</tr>
<tr>
<td>Market Basket Updates</td>
<td>-112.6</td>
</tr>
<tr>
<td>Disproportionate Share Hospital Payment Cuts</td>
<td>-36.1</td>
</tr>
<tr>
<td>Reduced Readmissions</td>
<td>-7.1</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>-1.5</td>
</tr>
<tr>
<td>Accountable Care Organizations</td>
<td>-1.5</td>
</tr>
<tr>
<td><strong>Net Financial Impact on Hospitals</strong></td>
<td><strong>17.06</strong></td>
</tr>
</tbody>
</table>

Source: Health Care Facilities Managed Care Analysis, Bank of America; Merril Lynch March 1, 2010 pg. 9
The Future of How Healthcare Will Be Financed

- Beginning in 2014 coverage for newly eligible adults will be fully funded by the federal government for three years.
- When this funding ceases, State payments that are filtered through to providers are expected to significantly decrease.
- This funding will phase down to 90% by 2020, but many providers may see a reduction in payments before then via several detailed financial changes that we will discuss in a moment.

Providers who are not strategizing now on how their organizations will operate in a non Fee for Service (FFS) environment can face significant financial difficulties in the reform environment.
Potential Financial Impacts

- A provider payment provision of the ACA is causing significant concern as organizations will be forced to provide more care to more individuals with less money.
- If the volume of enrollment in insurance does not reach anticipated benchmarks, the decrease in DSH payments combined with the requirement to continue to provide care for the uninsured could spell financial catastrophe for hospital and provider organizations.

Beginning in 2014 the payments the DSH payment to hospitals is set to be reduced by 75%, with the assumption that most will be insured. However organizations should be concerned over whether the increase in insured patients will be able to make up for this decrease in revenue.
As the volume of those receiving healthcare increases, the way that providers delivery care – and their accountability – is shifting dramatically from fee for service to “at risk” delivery models.
The Shift From Fee For Service

• New fee for value (rather than fee for volume) service delivery models which are being explored include:
  • Bundled payments
  • MCO/ACO Organizations
  • Value Based Purchasing; and
  • Fixed reimbursement costs (PMPM)
• New models will put providers at significant risk by tying reimbursement to both outcomes, and cost of care

Up to $500 Billion dollars in clinical risk will shift from payers to providers under healthcare reform, constituting 20% of the current costs managed in the U.S. Healthcare System
Transitioning Payment Models

**Fee for Service**
- Negotiated payment based on volume of service

**Performance-based fee for service**
- Negotiated payment for volume plus additional incentives for managing costs, quality, patient experience

**Shared Savings**
- Shared savings if interim costs are less than target

**Risk Sharing**
- Shared savings and shared losses

**Full capitation**
- All savings/losses are assumed by provider

© BHM Healthcare Solutions 2013
The ACA establishes a value based purchasing program which will tie a percentage of payments to hospitals/providers to performance on a number of quality measures.

Quality measures and reporting requirements which are needed are likely to incur high internal costs for hospitals/providers and without careful balance there is the potential that payment increases will not offset these expenditures.

When a hospital meets quality standards payment is increased by a % for the fiscal year following the period.

When a hospital does not meet a standard, the payment amount is decreased by a % for the fiscal year following the period.

Providers will need to meet all standards across a number of conditions or face payment reduction.
The ACA has established a bundled payment pilot program which is aimed at integrating care across hospitals, providers, and post acute care providers during and episode of care.

When appropriately applied bundled payments serve to allow one fixed cost for all providers who are involved in a single episode of care.

Bundled payments are highly dependent upon care coordination between providers, and allow for added transparency and predictability related to health care cost as well as alignment of incentives providing for the best outcomes of the patient in the most efficient manner possible.
Bundled Payments

- Risks results when providers do not appropriately negotiate the bundled payment for an episode of care (which is often caused by lack of appropriate data concerning the patient population, and failure to account for critical variables)
- Risk has also occurred when all providers have not been able to appropriately coordinate care and track cost putting them at a financial deficit for the provision of some episodes of care
Key Provider Impacts: Financial Strain

- Provider organizations will face significant financial strain in the next 5-7 years

- Increased administrative cost due to quality and reporting requirements
- Clinically complex residents
- Preferred provider networks
- Payment reductions
- Increased hospital integration
- Value based care requirements
Market Pressure from Provider Risk

- Provider organizations will need to align themselves with newly emerging, industry prevalent thinking and determine a way to address cost containment in order to remain viable.
The following key elements are critical prior to at risk contracting:

<table>
<thead>
<tr>
<th>What to Know</th>
<th>Why Its Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Payer mix</td>
<td>Know what % of patients are Medicaid/Medicare, Private Insurance, and self-pay so that you can gauge the risk of your organization</td>
</tr>
<tr>
<td>Cost of Care</td>
<td>Know your average cost of care by care type, and by patient demographic to determine what a base “at risk” rate for the provision of services is realistic for your organization</td>
</tr>
<tr>
<td>Know Your Outliers</td>
<td>Know what outliers impact your system, from specific patients, to specific payment requirements – be prepared to have a plan to address these outliers if participating in an “at risk” payment model</td>
</tr>
<tr>
<td>Service Profitability</td>
<td>Know which service lines are most profitable for your organization and which are loss leaders</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>Know the reporting requirements dictated by the contract and evaluate if you have this infrastructure in place, or will need to invest</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Know your care outcomes and be prepared to establish a case for how your organization provides value</td>
</tr>
</tbody>
</table>
Activity 2: Financial Focus

What do you envision to be the greatest financial risk for your organization in the coming years?

Do you have a solid understanding of your financial position today? (patient mix, payer mix, contracting)

What do you envision to be the greatest challenge for your organization in the next five years?
Quick Tips to Get Started

• Understand your payers and your contracts
  • You are limited, to an extent, in Medicaid/Medicare reimbursement negotiations; emphasis should be on putting optimal contract provisions in place through commercial payers to offset the financial risk.
  • Understand your payer mix, and how its proportions impact your organization – adjust accordingly.
  • Re-evaluate existing contracts, know your contract terms, and when re-negotiation is appropriate.
  • Benchmark contracts against one another; look for areas which are problematic for your organization, document them, and target them for renegotiation.
Quick Tips to Get Started

• Conduct a financial risk analysis immediately
• Know what changes will impact you on the State and Federal Level
• Create an impact timeline for your organization
• Understand what puts your organization at the greatest risk, and begin planning to mitigate this risk immediately
KEY ORGANIZATIONAL CHANGES
A new emphasis will be placed on monitoring the quality of care provided to patients, and new models of healthcare delivery systems such as Managed Care will require that you have robust reporting in place.
• Why is population health important?

- Healthcare costs are rising at astronomical rates
- The US population health is not improving as quickly as many other nations.
- Chronic conditions account for 75% of health care costs
- Provides a foundation for productivity, creativity, and viability.
Organizations which are not moving toward data driven management will not be successful in the post reform environment:

- Necessitates robust quality measurement systems
- Requires automated data collecting process
- Emphasis on reductions for cost of care
- Changing gain-sharing payer expectations
- Necessitates better payer contracting data
Providers will need to understand how “value” is defined by their partner organizations (State, MCO, and other partner providers) in order to meet the challenge.

### New emphasis for the value based provider

<table>
<thead>
<tr>
<th><strong>Reducing total cost of disease management</strong></th>
<th><strong>Early interventions to improve outcomes</strong></th>
<th><strong>Impact of treatment modalities on long term outcomes</strong></th>
<th><strong>Clear rationale on product usage and proven efficacy in target groups</strong></th>
<th><strong>Economic rationale for pharmaceutical product effectiveness</strong></th>
<th><strong>Understanding of patient populations that will see greatest cost savings and outcome benefits</strong></th>
</tr>
</thead>
</table>
Value Based Payments

- Encourage use of evidence based medicine
- Reduce fragmentation, duplication and inappropriate use of services
- Encourage effective management of chronic disease
- Accelerate the adoption of health information exchange
- Empower and engage consumers
Performance based payments will drive change

Different practice arrangements will be accommodated

Multidisciplinary team members will be recognized

Accountability will be across multiple levels and sites of services

Plan will be budget neutral

Focus will be to change FFS and there will be a short term and long term strategy

© BHM Healthcare Solutions 2013
What Providers Need to Demonstrate in Relation to Value

1. That they have examined care delivery to reduce cost and improve value

2. That they can quantify value of their organization
   1. What is your value compared to other comparable providers
   2. Measure, track, communicate, and work to improve value

3. Build new provider relationships and collaborations

4. Develop more robust quality measurements
   1. Ensure that you are working toward predictive modeling, process and outcome measures

5. Understand the need for health information and plan to make this critical IT investment
   1. Tracking, quality, claims, cost, care transitions, and disease management will be critical
Financial pressures in the system combined with the new value based emphasis will create a need for providers to examine their patient mix, and respond appropriately to address new emphasis

A significant shift in current provider marketing resources will need to occur to address this new customer segment and respond to their needs with deeper value propositions, strong cases for effectiveness, and shared risk pricing models

How will you respond to both payers and consumers, and what will your new marketing message be?
Key Provider Impacts: Consumer Buying Practices

- Future consumer buying practices will not reflect historical patterns

- Increased value focus
- Desire of choice and flexibility
- Patient satisfaction is key
- New marketing message
- Short stay residents
- Patients staying in their own home
Key Provider Impacts: Changing Referral Patterns

- Changing referral patterns based on different payment models:
  - Relationship building with hospitals and physicians
  - Changing role of the provider
  - Integration of care through new delivery models
  - Best practice protocols
  - Community and post acute setting care delivery
Consumer Expectations

- Future of person centered care
  - Optimize choice and control of services
  - Ensure placement decisions are based on need
  - Provide coordinated high quality care with seamless transitions
  - Reward excellence by reflecting performance on QM in payment
  - Recognize role of family utilize HIT

© BHM Healthcare Solutions 2013
Marketing

• Marketing to Payers
  • Be prepared to emphasize cost efficiency and value of care
  • Know your differentiators
  • Know how you stack up to other providers (cost, outcomes, and satisfaction)
  • Emphasize partnerships that you have with other providers

• Marketing to Consumers
  • Patients in the reform era can’t be satisfied – they must be delighted and your reimbursement could be tied to it – know your satisfaction rating and use this in your marketing messages
  • Emphasis on wellness, prevention, and educational programs which set your organization apart
  • Emphasis on reducing healthcare access burdens
The Program Integrity provisions of reform hope to accomplish the following:

- That a high level of care is provided
- That organizations are held financially accountable for care provided
- That fraud, waste, and abuse are eliminated
Program Integrity

• Providers will be required to meet strict requirements to provide care under ACA including applications, attestations, and credentialing.

• If a provider is terminated under any Medicare/Medicaid plan, or any State plan, they will be terminated from participating as a provider under any program or form of the ACA.

• Fraud related to Medicaid/Medicare will be a particular focus under ACA, with increased attention on:
  • Coding and Billing
  • Medical Necessity Criteria
  • Clinical Documentation
What the Future Ideal Provider Will Look Like

- Low/no readmissions
- Demonstrated patient centered approach to care
- Meaningful use of HER
- Cost of care is low in comparison to peers with comparable quality
- High quality demonstrated by data
- Top of class in provider comparisons
- High patient satisfaction ratings
- Innovative care delivery approaches
- Good community reputation

© BHM Healthcare Solutions 2013
Activity 3: How Do You Show The Value of Your Organization

What type of reporting do you utilize?
Where are you in terms of EHR implementation?

What is your current marketing strategy?
Is it attracting the “right” consumer?

Do you have any innovative programs established related to prevention?
Do you have evidence that they bring value for payers/consumers?
• Utilize the following slides to define your organizations value
• Determine where you are today, and identify where you need to be for success in the future
• Utilize your organizations defined value to map changes required, and to establish a new organizational vision for the future
FOSTERING PARTNERSHIPS FOR SUCCESS
Partnerships Will Be Critical

• Partnerships for providers will be a critical component for future success
• It will allow you to collaborate to improve outcomes
• Innovative partnerships which work provider value for all parties and make your organization more valuable to payers
Identifying Partners

• Identify specific hospitals – Identify hospitals in your area with high utilization or readmission rates
  • Think about hospitals that serve your target population in sufficient numbers to justify your presence

• Identify complimentary providers –
  • Complimentary service offerings: there is great room for collaborative partnerships to be formed between general medical providers, and behavioral providers
  • Complimentary payment offerings: do you provide a certain service, but don’t accept a specific form of payment – look for cross referral opportunities
  • Identify complimentary specialists – for the primary care provider there is the opportunity to form partnerships with multiple area specialists in order to form a referral network for your patients
Partnership Foundations

- Successful partnerships are often made or broken at the contracting stage, the following are key partnership foundations:
  - Have a formal agreement in place
  - Establish formal referral protocols
  - Establish key staff from each organization to be “point people”
  - Cross train staff when applicable
  - Conduct joint marketing and outreach efforts for maximum impact
  - Coordinate consumer services
  - Establish protocols for sharing patient data
  - Examine QI opportunities to measure partnership impact
  - Track key metrics and hold regular meetings to examine the outcome of your partnership and plan for improvements
Key Considerations for Formalized Partnerships

- Contract Legalities
- Payer Mix and Consumer Mix
- Partnership mission/vision
- Fiscal and other resources
- Systems
- Planning and decision making
- Communications
- Oversight requirements
- Data sharing and documentation
- Marketing and promotional planning
- Break down of expenses
- QI metrics and benchmarking
- Internal Training/Cross Training

© BHM Healthcare Solutions 2013
Cultural Components of Great Partnerships

- Partners may have significantly different cultures when it comes to the provision of care; discuss the cultural differences of your organizations up front (particularly if there is a difference in care settings)
- Address partner expectations
  - How quickly will you respond to a referral?
  - What is the volume of referrals anticipated?
  - How will you deal with complaints?
  - What data access do you need?
- Communicate frequently
  - Communicate with your partner frequently
  - Communicate with all internal staff and consumers about partnership
  - Plan collaborative education and outreach as a joint activity
  - Consider staff site visits to your partner locations for your staff
  - Address conflict immediately, don’t wait to address those things which are not working
Developing the Business Case For Partnership

- Understand where your organizations overlap in mission, vision, and population served
- Partners should have a clear understanding how the partnership benefits both organizations, and why it is worth the time and resources in terms of collaboration
- Diffuse the value of partnership throughout your organization to encourage staff buy in
- Have a clear understanding of where the value lies
  - Financial value
  - Value to consumers
  - Value in terms of improved outcomes
  - Value in terms of quality improvement

© BHM Healthcare Solutions 2013
### Partnership Quick Tips

<table>
<thead>
<tr>
<th>Look for commonalities, despite history or lack of history of partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let your champions be your cheerleaders</td>
</tr>
<tr>
<td>Finding win-win opportunities</td>
</tr>
<tr>
<td>Identifying low hanging fruit for partnership to build trust that will open doors for other opportunities</td>
</tr>
<tr>
<td>Cross pollinate</td>
</tr>
<tr>
<td>Not all partners benefit proportionally</td>
</tr>
<tr>
<td>Understand your risks and manage them to the best ability possible</td>
</tr>
</tbody>
</table>

© BHM Healthcare Solutions 2013
Is your potential partner in the room right now?
Putting it All Together

Critical Issues

- Healthcare reform
- Access to capital
- Technology
- Relationships
- Accountability for quality and value
Quick Tips to Get Started

• Understand your payers and your contracts
  • You are limited, to an extent, in Medicaid/Medicare reimbursement negotiations; emphasis should be on putting optimal contract provisions in place through commercial payers to offset the financial risk.
  • Understand your payer mix, and how its proportions impact your organization – adjust accordingly.
  • Re-evaluate existing contracts, know your contract terms, and when re-negotiation is appropriate.
  • Benchmark contracts against one another; look for areas which are problematic for your organization, document them, and target them for renegotiation.
Quick Tips to Get Started

- Make the Continuum of Care a focus for your organization
  - Focus on quality based measures
  - Cultivate partnerships with other providers
  - Understand all aspects of the patient process – from entry to care to discharge and beyond
Quick Tips To Get Started

• Define value in your organization and market this new message
  • Evaluate all programs at least quarterly to determine their return
  • Evaluate new service line offerings to offset net payment reductions
  • Understand what makes your organization different, and promote these differences to payers and consumers
Quick Tips to Get Started

• Make Data an integral part of your organization
  • If you are not managing with data you are doomed to failure. Setup key performance measures which are examined by your organization daily, weekly, monthly, quarterly, and annually.
  • Base decisions on data, not subjective reasoning, and set aggressive benchmarks to target waste, improve outcomes, and boost patient satisfaction.
  • Track chronic illness by establishing health management and preventative programs – this will allow you to target health issues before they are more severe and more costly.
  • Get on the EHR bandwagon immediately, and determine how you will share data with other organization, and how you will analyze data as part of a greater patient population health management strategy.
Quick Tips To Get Started

• Actively pursue partnerships with other providers, and work to collaborate with MCOs
• Relentlessly pursue expanding your vision beyond your practice to the population at large
• Understand what makes partnerships value to all stakeholders involved
Taking the First Steps

Step 1: Educate Yourself About the Coming Impacts
- Know your potential areas of risk and reward including how to deal with decreased payments, shifting models of reimbursement, value emphasis, and data requirements in a shifting healthcare paradigm.

Step 2: Analyze Your Organization
- From a financial analysis, to an objective look at billing and coding to contractions, now more than ever organizations need to know where their organizations are so that they can plan and allocate for the future.

Step 3: Examine Your Programs and Internal Processes
- Reform will change the way you will operate on a day-to-day basis, begin planning for change now. Examine what internal programs will need attention with emphasis on compliance and Quality Improvement.

Step 4: Invest in Infrastructure
- Make sure that you have infrastructure in place to deal with patient capacity and stringent IT and coding demands. Early adopters will see rewards, while those who wait could face financial penalties.

Step 5: Pursue Partnerships
- Begin identifying partnership opportunities for your organization today, target both hospitals, and complimentary providers, and keep in mind critical actions required for partnership success.