

THE FUTURE OF HEALTHCARE FINANCE





Focusing Your Strategies Amid Uncertainty

By Laura Ramos Hegwer

▼ With a new White House administration promising wholesale change to the government's role in promoting healthcare coverage, the future of patient access and healthcare services reimbursement remains uncertain. During this time, providers need guideposts to continue their momentum toward delivering high-value care.

“A number of proposals out there could easily affect payment,” says Steven Berger, CPA, FACHE, president, Berger Healthcare Executive Training and Consulting, Henderson, Nev. One major change would be terminating the Affordable Care Act's individual mandate, which Berger predicts will be among the first casualties of any renewed repeal-and-replace efforts on Capitol Hill.

“Without the individual mandate, many young people, as well as others who do not see the benefits of health insurance for themselves or their families, will no longer sign up for insurance,” he says. “When they all of a sudden need health-care, providers will struggle to get paid for the care, amounting to a loss of revenue.”

The second significant policy change could be scaling back the state and federal insurance exchanges, through which about 12.2 million beneficiaries are currently enrolled, or eliminating the subsidies provided for individuals to purchase that coverage. “If the exchanges are scrubbed, the revenues [to providers] associated with many of these individuals will likewise be scrubbed,” Berger says.

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The third significant change could be a pullback on Medicaid expansion, which has brought coverage to an additional 10 to 12 million beneficiaries in 31 states. “Although nobody can correctly predict the future, it is still relatively certain that the hospital and physician side of the healthcare industry will experience revenue reductions in the very near future because of the potential loss of 20 to 25 million insurance beneficiaries,” Berger says.

Academic medical centers are among the players that may be most affected by an ACA repeal plan that does not provide an adequate replacement for coverage. “Teaching hospitals have been on the front lines of taking care of not only Medicare and Medicaid patients but also patients who are uninsured,” says Darrell G. Kirch, MD, president and CEO, Association of American Medical Colleges, Washington, D.C. Teaching hospitals that are members of AAMC make up only 5 percent of U.S. hospitals but provide more than 20 percent of all hospital care. This includes 18 percent of hospital care for Medicare patients, 25 percent of inpatient care for Medicaid patients and 34 percent of uncompensated care.

“Our hospitals were helped greatly by the ACA, which brought many people into insurance coverage through the exchanges and Medicaid expansion in those states that did so,” Kirch says.

With insurance coverage, more patients were able to access care through a primary care physician rather than using emergency departments. “Any replacement that destabilizes or decreases that increased number of insured patients will hit teaching hospitals first and hardest,” he says.

Such instability could have a significant impact on the financial health of academic medical centers. “Under the best of conditions, teaching hospitals often operate on thin financial margins,” he says. Under the ACA, teaching hospitals receive reduced disproportionate share hospital payments that were intended to help care for large numbers of uninsured patients prior to the Medicaid expansion. Since the ACA was enacted, teaching hospitals have remained solvent despite reduced DSH allotments. But if the number of uninsured increases again without hospitals having access to those DSH payments, many institutions will struggle financially, especially those in areas where the number of uninsured patients is high, Kirch says.

Continuing the Momentum Toward Value

Whatever the future holds for the ACA, healthcare executives should continue to make reducing costs a top priority to maintain a strong financial margin. “Yet, many leaders have still not come close to taking

out dollars [from the expense line] that are easily available through greater efficiency,” Berger says. “Efficiency can be gained through an understanding of the tasks being performed and the value of the outcomes being produced.”

Forward-thinking healthcare executives recognize that improving operational efficiency can help them protect their organization’s bottom line.

Case Study: Trinity Health, Livonia, Mich.

Repealing the Medicaid expansion would affect 1.1 million patients served by Trinity Health, one of the largest multi-institutional Catholic healthcare delivery systems in the nation. Meanwhile, if lawmakers eliminate the subsidies for marketplace coverage, more than 700,000 patients in Trinity Health’s markets would lose access to financial assistance to purchase an exchange plan, according to estimates from Trinity Health.

In addition to this impact on patients, repealing the ACA’s coverage provisions could reduce revenue, creating tough decisions for healthcare executives.

“Facing substantial reductions in revenue, we would need to reduce expenses or seek other revenue streams in order to sustain ourselves,” says Richard J. Gilfillan, MD, president and CEO, in

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a letter to the new White House administration shared with *Healthcare Executive*. “It will also force us, and community hospitals like ours, to reexamine our ability to offer service lines that generate significant losses, like behavioral health and substance abuse, where we are often one of only a few providers of inpatient services in a community. It would negatively impact our ability to invest in upstream solutions that could improve the social determinants of health for the most vulnerable patients. Or, it would mean generating additional revenue elsewhere, leading to higher prices for our

commercial payers and ultimately higher premiums for employers.”

Trinity Health has been actively engaged in new payment models, with 16 Medicare Shared Savings Program accountable care organizations and five markets participating in next-generation ACOs. The organization has invested nearly \$40 million a year in its ACOs, with the annual investment expected to grow to \$54 million during the next year. Trinity Health also has 43 hospitals participating in Model 2 of the Bundled Payments for Care Improvement initiative, as well as 13 of

its skilled nursing facilities engaged in Model 3 of BPCI (see sidebar).

“We feel confident that participation in these models is both reducing costs and improving quality, and continuing them will have a positive impact in the communities we serve,” says Cindy Clemence, CPA, FHFMA, interim CFO. “Payment reform really begins in the markets with a push from payers and providers, and we believe the trend is not going away anytime soon. It can be made easier and more achievable with policy, so we are advocating for policies that support those efforts. Providers will be able to achieve people-centered care with alignments of payments to quality and wellness. Incentives that reward for the Triple Aim—better health, better care and lower costs—will drive continuous improvement.”

Bundled Payments for Care Improvement

In Model 1 of BPCI, the episode of care is defined as the inpatient stay in the acute care hospital, according to the Centers for Medicare & Medicaid Services. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule.

Models 2 and 3 involve a retrospective bundled payment arrangement, where actual expenditures are reconciled against a target price for an episode of care. In Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. Under these retrospective payment models, Medicare continues to make fee-for-service payments; the total expenditure for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditure compared with the target price.

To maintain its financial health and deliver better value, Trinity Health is committed to improving operational efficiency across its 93 hospitals and 120 continuing care locations. Such activities are part of the health system’s Transforming Operations initiatives, which reduced costs by \$200 million in fiscal year 2016, its first full year. The largest category of savings was nonlabor, thanks to strategies such as increasing the use of generics to reduce pharmacy costs and centralizing sourcing of implants and medical/surgical supplies.

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Over the past few years, leaders at Trinity Health have implemented an initiative to improve operations and reduce costs by self-distributing all the system's medical and surgical supplies. Under this centralized model, Trinity Health expects to realize significant cost savings by eliminating an intermediary and channeling its supply chain operations through four strategic supply distribution centers. "We want to ensure that we are paying a fair price for the services and products we obtain as well as collaborate on the effective use of supplies across our system," Clemence says.

Keeping an eye on financial and clinical metrics is important for leaders to stay grounded when significant changes to healthcare financing may be around the corner. "I believe our success in the transition is based on our ability to focus on efficiency and excellence in care," Clemence says. "That is good for us and even better for the people we serve."

The Important Role of Physicians

Despite the uncertainty shared by various stakeholders across the healthcare industry, Berger predicts that the momentum toward value-based payment will continue—with or without the government's involvement. "Private insurers see the value in value-based payments, especially when it comes to patient safety," he says. "As long as these insurers believe the use of a

metrics-based system to evaluate provider behavior is working to improve clinical, quality and safety outcomes, they have no reason to stop it. Meanwhile, if the government, through Medicare and Medicaid, decides to continue the value-based purchasing penalties, the hospitals and physicians will be required to continue implementing and improving policies that aid the patient with better outcomes."

One example of how providers need to keep focused on value is the Medicare Access and CHIP Reauthorization Act of 2015. Even in states like California, where hospitals have been working with advanced value-based payment models such as capitation for 20 years, healthcare leaders are taking steps to ensure their physicians are prepared for Medicare Part B payment changes through MACRA. Unlike the ACA, MACRA was passed with bipartisan support and is not likely to change significantly under the new administration. Under MACRA, physicians who accept Medicare payments pick their pace of participation this year and choose to either report quality data through the Merit-Based Incentive Payment System or join an alternative payment model such as an ACO.

Leading hospitals across the country are helping their clinicians prepare for MACRA, as physicians' performance will affect their Medicare payments beginning in 2019.

Case Study: St. Joseph Hoag Health, Irvine, Calif.

Like other California health systems, St. Joseph Hoag Health has held capitated contracts with commercial payers for more than two decades.

"We would like to take on more capitation because we believe we can do a better job of coordinating care through integration by managing care on an ongoing basis and by being paid prospectively," says Richard F. Afable, MD, president and CEO.

St. Joseph Hoag Health includes seven acute care hospitals and an expansive ambulatory network and is part of St. Joseph Health, a multistate system that recently merged with Providence Health and Services in Renton, Wash. Today, St. Joseph Hoag Health manages 220,000 lives, with most of the recent growth in its Medicare Advantage plan. Yet leaders at St. Joseph Hoag Health realize their physicians could use some help transitioning to value-based payment, particularly with their non-Medicare Advantage patients.

"Medicare Advantage allows us to have full knowledge of whom we are caring for so we can do much more for them," Afable says. "Our physicians are very knowledgeable about these models and have really been able to achieve care that is high quality and high value. The challenge for our doctors is that not all of their

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patients want to go into Medicare Advantage and prefer the fee-for-service model. Where physicians need help is that portion of their practice that is not capitated yet but will be paid via value-based models, such as MACRA. Even though they are familiar with achieving high quality and value, we have to spend time getting our physicians ready for the new model.”

Specifically, leaders at St. Joseph Hoag Health have developed strategies that tie outcomes to payment and help physicians better coordinate care. One example is its ACO with Children’s Hospital of Orange County. The ACO, which provides coordinated care to patients of all ages, includes eight hospitals, nine medical groups and other providers. Additionally, the organization launched a breakthrough collaborative with Cigna wherein physicians, hospitals, the health plan and employers all work together toward employee health. “Coordination of care, whether through an ACO or an entirely new model, makes sense regardless of the payment system,” Afable says.

Afable also encourages organizations to create systems through which physicians can track their own patient outcomes and not rely on insurers for data. However, he concedes, building this infrastructure can be difficult for small organizations. “A certain level of scale is needed to put these very

expensive systems in place,” he says. “It is not just the technology, but also the people required to manage it.”

Even though Afable cannot predict how the new administration will alter healthcare access and payment, he believes the greatest impact could be on Medicaid. “If changes to Medicaid reduce the number of individuals who have health insurance, we as hospitals and physicians will feel the impact. We will have challenges like we did before 2010,” he says. “So we would advocate to improve access for our communities in a significant way.”

Whatever happens on Capitol Hill, Afable does not see the transition to value slowing down. “The movement toward greater value—most notably seen in the Medicare program—will continue unabated with or without the repeal of Obamacare,” Afable says. “To achieve true value, hospitals and doctors need to improve care coordination and prepare for greater accountability. Working together to care for patients is the primary goal of all healthcare providers. I don’t see any evidence to suggest otherwise, mostly because it is working.”

Proactive Strategies

Focusing your strategies amid uncertainty takes conviction and commitment. Healthcare executives should consider the following advice in this effort.

Make improvements now. “Hospitals and doctors need to improve care coordination and begin preparing for greater accountability now,” says Afable.

Strategically invest in IT. “Big data is now readily available to leaders who are ready to accept 21st century tools to improve their bottom line,” Berger says. “Most hospitals have not taken the necessary steps to acquire the tools that can save 15 to 25 percent of total costs if implemented with vigor and foresight.”

Clemence agrees. “IT provides us with the critical ability to have analytics tools that we need to be successful in the transformation and with alternative-based payments,” she says. “We also must continue to invest in the infrastructure so we can continue to thrive and serve the people in our communities.”

Stay aware of the day-to-day policy developments at the state and federal levels. CEOs might delegate the information gathering to their CFO, chief planning officer or another member of the C-suite. As Berger says, “In these times of very high uncertainty with some kind of change on the horizon, a regular briefing for the CEO, by the delegated executive, is mandatory.”

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