



2014 Payment Reform Summit

COMMUNITY HOSPITALS AT THE CROSSROADS

December 11, 2014
Wyndham Grand Hotel
Pittsburgh, PA



PITTSBURGH
REGIONAL
HEALTH
INITIATIVE
Spreading Quality
Containing Costs.

*Proceedings of a Multi-stakeholder Conference on Payment Reform Options for the
Community Hospitals of Pennsylvania and West Virginia*

PITTSBURGH REGIONAL HEALTH INITIATIVE

EDITORS

Susan Elster, PhD
David Golebiewski

THANK YOU

To PRHI staff for their ideas and organizational expertise:

Laurie Gottlieb
Allison Maksin
Scott Frost
Millie Greene

DEAR COLLEAGUE:

Most of us agree that we can do more to reduce the cost of care and improve population health, but there is an avalanche of research demonstrating that we're not getting the job done. It's been more than a decade since the *New England Journal of Medicine* reported that only about half of Americans receive recommended care for preventive, chronic, and acute conditions. One in five Medicare patients continue to be readmitted to hospitals within 30 days of discharge. Anywhere from 180,000 to 400,000 (depending on who's doing the counting) die every year from preventable medical error. And if we weren't concerned enough, in 2013, the Institute of Medicine published *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. The report presents a grim indictment of the status quo, showing that, in return for spending more than twice as much on health care as any other developed country, Americans shoulder a higher burden of disease, illness, and injury than their peers in other developed countries and have the shortest life expectancy.



Karen Wolk Feinstein,
PhD

The Pittsburgh Regional Health Initiative (PRHI) is committed to proving that we can achieve better outcomes at lower costs. We hypothesized several years ago that, by introducing certain services and system enhancements, we could keep more people healthy and out of hospitals and emergency rooms. This work began with the successful launch of a COPD readmissions reduction project at UPMC St. Margaret and Forbes Hospitals in 2007. This project and subsequent experiments all demonstrated a return on investment when we introduced certain clinical and system enhancements that cut across all settings, including care management, pharmacy consultations, patient engagement, education activities, behavioral health services, training in quality engineering techniques, and incentives for performance excellence. Despite their impact on patient outcomes and costs, most insurers do not provide reimbursement for their provision. How long are we going to keep saying, "If only we would pay for these services, we'd get better population health at lower costs!"?

The **2014 Payment Reform Summit** gave leaders of community hospitals and staff, insurers, physicians, business leaders, federal and state agencies, foundations, hospital trade organizations, and consumer groups the opportunity to revisit — and reinvent — the financing alternatives that can make community hospitals major regional partners in advancing the health of our communities. It is our hope that our region's community hospitals, in partnership with all of us who care passionately about the health of our region, will embrace the winds of change in ways that ensure their survival as the protectors of community health and the hearts of their communities' healthcare system.

Karen Wolk Feinstein, PhD
President and CEO
Pittsburgh Regional Health Initiative
Jewish Healthcare Foundation

ACKNOWLEDGMENTS

We acknowledge with appreciation the Robert Wood Johnson Foundation's legendary commitment to creating a culture of quality across the United States, and for making possible the 2014 Payment Summit via its Payment Reform for High Value Care grant to the Pittsburgh Regional Health Initiative. We further thank the following individuals who agreed to share their ideas and expertise as session speakers, panelists, moderators, and facilitators:

Keith T. Kanel, MD
Program Coordinator

John Bluford III, MBA
Tony G. Farah, MD
Karen Wolk Feinstein, PhD
Martin S. Gaynor, PhD
John Harty, AB, LLB
Joseph Martin
Marion McGowan, RN
Harold D. Miller
Jennifer Perloff, PhD
Hoangmai H. Pham, MD, MPH
Edward J. Roth III
Steve Tringale
Secretary Michael Wolf

TABLE OF CONTENTS

| | |
|--|----|
| PURPOSE OF THE SUMMIT | 5 |
| KEYNOTE SESSION If You Want to Change the Dance, Change the Music..... | 7 |
| SECRETARY'S ADDRESS The View from Harrisburg: Preserving our Community Hospitals..... | 10 |
| PANEL ONE Community Hospitals at the Crossroads | 11 |
| PANEL TWO From Volume to Value: New Directions in Payment Reform..... | 16 |
| PROVIDER TRACK SESSION | 24 |
| EXECUTIVE TRACK SESSION | 29 |
| GOVERNANCE TRACK SESSION | 36 |
| REFLECTIONS AND SUMMIT WRAP-UP | 40 |
| SPEAKER BIOGRAPHIES | 42 |

PURPOSE OF THE SUMMIT

Speaker

Keith T. Kanel, MD

Chief Medical Officer, Pittsburgh Regional Health Initiative

Community hospitals — the backbone of American health care — are at a crossroads. At a time of declining admissions, shrinking reimbursements, and mounting regulations, hard decisions must be made by the institutions that provide the majority of health care for the cities and towns of America. Community hospitals are the geographic center of health services in most regions, and in many cases they are the largest employer with inseparable ties to the local economy. The decisions community hospitals make in a rapidly changing environment transcend health care. They will also affect the economics of a region and the livelihood of its citizens — underscoring the “community” in community hospital.

In the fee-for-service payment environment of the last decade, community hospitals rightly responded to economic forces, adopting medical staff models, acquiring physician practices, sometimes pursuing mergers with other systems, opening off-campus diagnostic facilities, and developing new service lines to help maintain volume and provide services at the same time. Driven in large measure by the Affordable Care Act, this is now beginning to change. More and more, payments are attached to value rather than volume. We are seeing vibrant new ways to pay for services, such as affordable care organizations and bundled payment models. It is thrilling, intimidating, and complex.

As the nation assertively moves toward a future focused on population health, what will be the new role of the community hospital? With many community hospitals re-inventing themselves as small health systems, how should clinical integration and payment reform be approached? Are the newly proposed models of accountable care organizations (ACOs) and bundled payment arrangements the right direction? How much can similar organizations collaborate without risking antitrust exposure? Is integration into an outside health system the most sensible solution — and if so, which one? What is most important is that, if the options don’t seem like good fits, how can we forge better ones?

Hospital leaders must decide which way to turn. In most regions, community hospitals are increasingly involved in care coordination and wellness promotion beyond their own walls. Innovative partnerships with medical practices, community agencies, government, and business groups are creating exciting new patient-centered models of care.

However, the healthcare marketplace of western Pennsylvania and West Virginia is unique. The region has a substantial foundation of freestanding hospitals with strong cultural and economic ties to their regions, but with unfavorable utilization rates and precariously low operating margins. Many have re-invented themselves as *de facto* health systems, strategically acquiring physician practices, and venturing into new endeavors such as



Keith T. Kanel, MD

urgent care and ambulatory surgical centers. Such investments with high fixed costs are harder to sustain as payment moves from volume-driven fee-for-service to population-based payments.

Furthermore, western Pennsylvania has been slower than other markets to enter the ACO world or to engage in bundled payment pilots. In fact, of the 600 ACOs in the country, only a few are just now being created for the western Pennsylvania and northern West Virginia markets. Very little has occurred in the way of bundled payments.

As we explore options, we propose that the region's tentativeness to engage in these new payment models may actually present an immense opportunity. We can look at lessons learned and early outcomes from around the country for guidance in planning our own next steps.



The **2014 Payment Reform Summit** brings Pittsburgh regional stakeholders together with voices from around the country to help community hospitals define a path that makes sense in these times of great change. Our goal is to shed light on new payment models and innovative opportunities for reducing costs. Our overarching question: What is right for *this* region and exactly how might we take the initial steps to move in exciting new directions?

In exploring these questions, the Summit specifically challenged two myths. The first is that, unless a

community hospital is ready to become a formal ACO, it has no place in the new world of value-based payment. In fact, as numerous speakers will demonstrate, there are other possible payment reform paths that are much smaller in scope, and perhaps a much more sensible first step for western Pennsylvania. Second, we seek to dispel the myth that a community hospital's options are limited to either merging with or selling to a regional or national corporation. In today's session, we will be highlighting thrilling new virtual collaborations of hospitals and health systems, where community hospitals can retain their independence and local identity while still benefiting from the economy of scale in being part of a greater business collective.

It is our hope that the expertise, experiences, and ideas shared during the Summit will help community hospitals as they forge new directions in ensuring their ongoing contribution to the health and well-being of their communities.

KEYNOTE SESSION: If You Want to Change the Dance, Change the Music

Speaker **John Bluford III, MBA, FACHE**
President Emeritus, Truman Medical Centers
President, Bluford Healthcare Leadership Initiative



John Bluford, III

OVERVIEW

John Bluford’s keynote address reminded us that community hospitals are indeed businesses, but they also have a “soul.” We hope that payment reform models will better align clinical services with value, but the models must do so only if they advance the hospital’s mission of culturally compatible, patient-centered care. Bluford shared an inspiring vision of the ways in which a community hospital can fully embrace its responsibility for population health by reinventing itself. He described how Truman Medical Centers (TMC) — a half billion dollar operation of two facilities and 600 beds — began to get serious about the real barriers to health for its Kansas City population. Guided by an old African proverb — *If you want to change the dance, change the music* — he challenged the conference participants to alter their thinking *and* their actions on behalf of their communities’ health.

KEY POINTS

Achieving population health requires collaboration.

- ❖ **Population health dynamics require the integration of a whole range of health, education, and community development activities.** Bluford pointed out that the primary determinants of disease are social and economic, and that collaboration with those not considered traditionally a part of health care is essential. Investments in public safety, education, housing, and employment all affect the well-being of our communities and translate into population health.

As hospital administrators, we need to collaborate not only with healthcare providers, but with epidemiologists, public health officials, community organizers, and others to get us to where we need to be. — John Bluford

- ❖ **Behavioral health and oral health should be integral to this mix.** So many of those coming to hospital emergency rooms have behavioral health problems, including addiction. Further, we know that oral health impacts heart failure and diabetes, among other chronic conditions; dental care should be part of ongoing preventive care.

Case management can redress damage caused by fragmented healthcare systems.

- ❖ **Improving care for dual-eligible patients.** TMC received a grant from the Center for Medicare and Medication Innovation (CMMI) to pilot a case management demonstration project for

Medicare/Medicaid dual-eligible patients. Bluford highlighted one such patient to demonstrate what has been achieved to date.

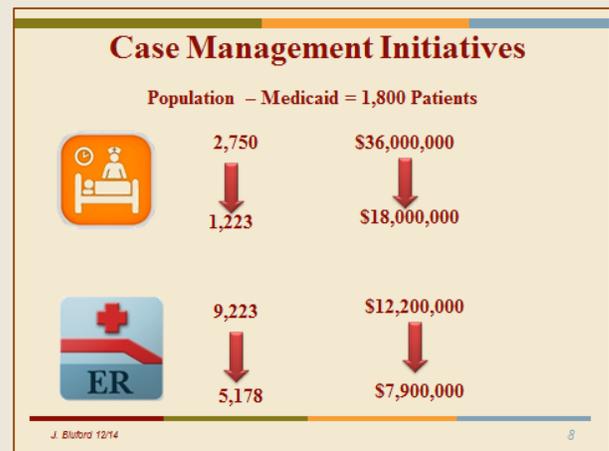
- “Jim” is 46 years old, with 13 different medical conditions, including chronic heart failure, hepatitis C, diabetes and hypertension, a history of cocaine and PCP use. His leg was amputated following gangrene. He lives alone, has been unemployed for three years, and “couch surfs” in the homes of friends and family members, or would otherwise be homeless. He had no regular doctor for 10 years and had been prescribed 10 different daily medications:

Jim is a heavy utilizer of our facilities (I never use the term “frequent flyer”) — and it’s our fault. You can’t fix him in a 20-minute encounter with a physician.

— John Bluford

- Intensive case management support for Jim, along with 214 other dual eligible patients, has had a major impact. Hospital admissions costs have dropped from \$5.8 million to \$1.61 million. Outpatient costs dropped from \$924,000 to \$464,000, and emergency room costs from \$2 million to \$586,000.

- ❖ **Improving care for Medicaid patients.** Case management services for a population of 1,800 Medicaid patients (see graphic) have cut both hospital admissions and inpatient costs by half, and sharply reduced emergency room visits and ER costs.



Everyone’s happy with these numbers... except the CFO. Until there’s payment reform, such interventions are cost beneficial for everyone but hospitals.

— John Bluford

Partnerships are essential to the survival of community hospitals.

- ❖ Bluford and his staff have experimented with a wide array of innovative programs that have placed his community hospital at the center of his community’s health. Bluford shared a few examples of community partnerships and programs:
 - **Touchdown Family Fest:** An annual health fair, organized in partnership with the National Football League’s Kansas City Chiefs, attracts up to 3,000 participants
 - **TMC Health Harvest:** A bus converted into a mobile market brings fresh fruits and vegetables to multiple neighborhoods each week
 - **Public Library Partnership:** Provides the community with written resources, computers linked to health information, scales, blood pressure machines, health education and exercise classes, and health fairs at four public library branches. Bluford noted that libraries are also going through a transformation as more people access written material via the internet. With branches centrally located throughout neighborhoods, they are a perfect place to provide health activities. He anticipates a time when health clinics may operate out of libraries.

- **Healthy Harvest:** A weekly, seasonal farmer’s market located on the hospital grounds brings 400–600 people who buy fresh produce at cost
- **Grocery Store** (in planning): The hospital is raising funds to build a grocery store that will have nurses and nutritionists on staff who will help people shop and cook (a community kitchen will be part of the structure). The facility will be a nonprofit and linked to the hospital’s IT system, so that physicians can write prescriptions to the grocery store.
- **Walgreens:** A partnership resulted in a branch of Walgreens serving as the hospital’s in-house retail pharmacy.

Hospital employees must lead the way.

❖ Bluford shared his conviction that the hospital’s employees are also part of his community. If employees are happy and healthy, they’re in better position to care for patients. Further, the wages, education and health practices of employees affect the health of their families and the broader community. Towards this end, TMC has struck up some atypical partnerships and programs:

- **Partnership with USBank:** Hospital leadership discovered that many of its entry-level employees had no banking relationship (there are no banks in the city’s urban core) and, instead, relied on check-cashing services for high fees. In response, TMC asked USBank to open a full service branch in the hospital and started a financial literacy program for employees. The branch now has 1,400 members.
- **TMC Corporate Academy:** A partnership that began 12 years ago with two-and four-year colleges has provided degree-level courses to employees, as well as literacy and GED preparatory courses. To date, 250 undergraduate degrees have been obtained at TMC through these partnerships and a couple of dozen master’s degrees.
- **Employee Literacy Class:** Discovering that literacy wasn’t just a problem experienced by young people who didn’t finish high school, TMC offers literacy classes for employees.
- **Encouraging (and in some cases, mandating) Employee Health and Wellness:** TMC initiatives include removing excess sugar and salt from cafeteria food, removing the hospitals’ vending machines, requiring leadership to eat and drink better; building a full-service work-out gym available for a charge of \$25/year. In addition, eight years ago, TMC stopped hiring smokers. Employees who apply for a job must sign an affidavit asserting that they don’t smoke. Smoking results in an automatic termination.

DISCUSSION

➔ *How can rural hospital located in regions without public transport system improve public health?* Despite efforts to distribute primary care clinics throughout the hospital service area, its region still has poor health rankings and poor public health indicators (like low access to healthy foods). In response, Bluford asserted that, eventually we are going to take medical care to the patient’s home. Currently, experiments are attempting to make the case to insurers that this is cheaper and safer to do.

➔ *At the root of so many chronic conditions is behavior change. Are you successfully training staff to support patient behavior change?* Bluford noted that the CMMI grant has enabled TMC to hire social workers and psychologists who use motivational interviewing techniques in their work with patients. Further, they’ve implanted training in ‘trauma-induced care’ to help staff uncover the trauma patients have experienced that may be affecting their health status. In this regard, he also emphasized that staff

diversity needs to reflect patient diversity. Encouraging behavior change at a minimum requires an initial understanding of the life experience of diverse groups of patients.

The View from Harrisburg: Preserving our Community Hospitals

Speaker **Michael Wolf**
Secretary, Department of Health, Commonwealth of Pennsylvania



Secretary Michael Wolf

OVERVIEW

Nearly half of all hospital revenue comes from federal and state sources, so the public sector is an essential partner to community hospitals. Beyond revenue, the state departments of health impact hospitals in multiple ways – as the licensure authority, regulator, and overseer of public health. Secretary Michael Wolf provided insight into the state’s perspective on the role of community hospitals.

KEY POINTS

- ❖ Secretary Wolf noted that Pennsylvania has approximately 2.2 million people whom the federal government considers to be medically underserved – a total that is approximately one-sixth of the state’s overall population. Pennsylvania also has one of the largest rural populations in the country.
- ❖ Community hospitals play key roles in rural and underserved communities and are often the subject of enormous emotional attachment.

We recognize that we have community hospitals in locations that have struggled economically, but at the same time, those hospitals are often one of the largest employers and often the largest contractors in those communities.

— Secretary Michael Wolf

- ❖ Secretary Wolf noted that the Department of Health (DOH) has focused on improving care access, distinguishing between merely having insurance and having healthcare services that are timely and close to home. On the consumer service side, the focus has been on strengthening community-based primary care clinics and Federally Qualified Health Centers (FQHCs), and integrating behavioral health into primary care. To reduce costs, the focus has been on developing new payment methodologies, shortening hospital stays, and addressing IT expenditures that are challenging hospitals.
- ❖ Through a loan repayment program, the DOH has helped place 105 primary care physicians in rural or underserved areas. The DOH has also increased use of the federal VISA waiver program, revitalized the Appalachian Commission’s J-1 Visa program for primary care physicians, and pushed for the development of community-based primary health care throughout the state.

- ❖ In partnership with physicians, hospitals and payers, the department is exploring ways (including reducing regulatory barriers) for telemedicine to be used to improve access to specialty and/or primary care. This technology may open up roles for small, rural hospitals to have access to specialists, and for patients to receive care from their homes. Pennsylvania is exploring ways to link its telemedicine services with those in other states.
- ❖ Both providers and consumers are currently living through a healthcare evolution/revolution. The Secretary noted that providers are asking for help from a regulatory standpoint, and asked what the Department could do differently. PA is the home to 216 hospitals, including 27 teaching hospitals that training more than 6,000 medical students, among other healthcare providers.

It is imperative that we work harder to retain more of the healthcare professionals we train.
 — Secretary Michael Wolf

PANEL ONE Community Hospitals at the Crossroads

Moderator **Karen Wolk Feinstein, PhD**
*President and CEO of the Pittsburgh Regional Health Initiative
 and the Jewish Healthcare Foundation*

Panel **Joseph Martin** *Executive Director, Pennsylvania Health Care Cost Containment Council (PHC4)*
Martin S. Gaynor, PhD *E. J. Barone Professor of Economics and Health Policy at CMU, and
 Chair of Governing Board, Health Care Cost Institute*
Tony G. Farah, MD, FACC, FSCAI *Chief Medical Officer, Allegheny Health Network, and
 President, Allegheny Clinic*

PANEL INTRODUCTION

The healthcare marketplaces of western Pennsylvania and West Virginia feature many freestanding hospitals with strong cultural and economic ties to their regions, but those facilities are challenged by unfavorable utilization rates and precariously low operating margins. Many have re-invented themselves as de facto health systems, strategically acquiring physician practices, and venturing into new endeavors such as urgent care and ambulatory surgical centers. Such investments with high fixed costs are harder to sustain as payment moves from volume-driven fee-for-service to population-based payments. This panel explored the current state of regional community hospitals.

Speaker **Joseph Martin**
By the Numbers: The State of Community Hospitals in Pennsylvania

OVERVIEW

The Pennsylvania Health Care Cost Containment Council (PHC4) is a national leader in public reporting, accurately tracking trends in many aspects of healthcare, including hospital utilization and finances. PHC4 is a

unique state agency, created by legislative mandate in 1986, to collect data from hospitals, physicians,) and insurance companies (totaling some five million records annually) to produce public reports on provider costs and quality. Some 150 separate entities, especially hospitals, request data in order to analyze quality, market share and costs for multiple purposes, including strategic planning and physician recruitment. Martin drew on PHC4's notable data resources to highlight challenges facing community hospitals in western Pennsylvania.

KEY POINTS

The data paint a picture of community hospitals in western Pennsylvania facing declining utilization, an unfavorable public to private payer mix, and a population with high rates of chronic illness.



Joseph Martin

- ❖ **Declining Utilization:** Hospital admissions dropped by 11%, and inpatient days dropped by 8% between 2003 and 2013 in western Pennsylvania.
- ❖ **Unfavorable Public to Private Payer Mix:** There are fewer places to make up the losses represented by changing utilization. Medicare and Medicaid increased their market share relative to commercial insurers over the same period, but Medicare payments have been flat and Medicaid payments, though slated to increase, have been low. The uncompensated care percentage in the Johnstown area is the largest in PA.
- ❖ **High Rates of Chronic Illness:** Western Pennsylvania has relatively high admissions rates for key chronic conditions, such as diabetes, heart failure, COPD/asthma and bacterial pneumonia.
 - Super Utilizers: 25 in every 10,000 residents in western Pennsylvania have 5 or more hospital discharges per year, accounting for 15% of Medicare (FFS and HMO) and 17% of Medicaid payments.
- ❖ **Financial implications** include negative operating margins (29 of the 62 hospitals in the three regions comprising western PA).
 - In the Pittsburgh area (PHC4's Region 1), in FY 2013, smaller hospitals are more likely to have *both* negative operating and negative total margins:
 - 2 of 3 hospitals with fewer than 100 beds
 - 8 of 12 hospitals with 100–250 beds
 - 5 of 14 hospitals with 250+ beds
- ❖ **Medicare Area Wage Index** in the Pittsburgh area is 12% lower than it was in 1997 (in Philadelphia, it is 26% higher).

In looking at these data, mostly we see that the numbers we'd like to see going up are going down, and those we'd like to see going down are going up — and it's worse in western Pennsylvania.

— Joe Martin

Speaker **Martin S. Gaynor, PhD**
National Trends in Market Consolidation: A Mixed Picture

OVERVIEW

In response to tightening reimbursements, skyrocketing costs, a need to keep up with technical advancements, and difficulties in recruiting medical talent, community hospitals often entertain mergers into larger systems. While this creates sensible economies of scale as organizations move toward population health management, the impact of market consolidation reveals interesting influences on both quality of care and overall costs. Professor Gaynor concludes that the verdict on consolidation is far from clear.

KEY POINTS

A poorly functioning U.S. healthcare market results in cost and quality deficits.

- ❖ **The United States relies on markets for the provision and financing of health care, but those markets don't work as well as they could and should.** The result is high and rising prices, quality problems, a paucity of organizational innovation, and a fragmented delivery system.
- ❖ **High and increasing private healthcare spending (which ultimately affects Medicare spending) is largely driven by increasing prices, and not by utilization or intensity of services.** (Contrary to other views expressed at the Summit, Gaynor disagreed that health care is a force for economic growth. Hospital and physician services comprise just 9% of GDP. In fact, Gaynor asserted that healthcare spending is actually a drag on the economy, ultimately costing the U.S jobs.)



Martin Gaynor, PhD

Consolidation and concentration are at least partly to blame for high prices, and for poorer quality of care.

- ❖ **There has been a tremendous amount of consolidation in the hospital industry,** with more than 1,200 mergers and acquisitions since 1994. Consolidation slowed in 2000s, but has picked up recently. Hospital consolidation occurred as an early response to the rise of managed care, but also as an attempt to coordinate and improve care, and achieve economies of scale. As a result, hospital markets have become substantially more concentrated over time.
- ❖ **Physician-hospital consolidation peaked in the mid-1990s, and has declined steadily since.** Nevertheless, the employment of physicians by hospitals has been growing, with a 32% increase in the number of physicians employed by hospitals over the last 10 years; 20% of physicians are now employed by hospitals.

- ❖ **Evidence does not support the claim that there are benefits from consolidation** (e.g., improved coordination of care; investment in care coordination and quality; reduction of costly duplication; achievements of scale).

We have 20 years of experience now with consolidation and we have yet to see evidence that costs are lower on average or that quality is higher.

— Martin Gaynor

- ❖ **Mergers between close competitors can lead to higher prices, lower quality, less dynamic/innovative marketplaces.** They also mean lower wages and benefits, fewer jobs, and more uninsured. Gaynor shared data showing that hospital mergers have led to substantial price increases (evidence shows increases between 20% and 50%), and there is no difference between non-profits and for-profits. These price increases are passed on to consumers. Gaynor cited data that also show substantially lower quality (his data show a 1.46 percentage points higher mortality rates for Medicare heart attack patients, in the most concentrated markets).

Employers care about total compensation, unless a worker has become more valuable, then the rest of their compensation is going to have to fall. We've seen that. Healthcare costs have eaten up a larger and larger portion of American family income. And there are more uninsured. The ACA is helping, but it was never designed to achieve universal coverage.

— Martin Gaynor

Addressing the cost and quality problems emerging from consolidation requires strong competition policies.

- ❖ **Antitrust enforcement is key to vital healthcare markets and should be seen as a key part of healthcare reform,** although Gaynor concluded that it will be difficult to undo the current problematic arrangements. It is important not only to prevent damaging price, quality and service effects, but also to encourage opportunities for new, innovative services and providers to enter the market and compete.

Speaker **Tony G. Farah, MD**

Building the Health System of the Future: Musings from the Executive Suite

OVERVIEW

Hospital and health system leaders are given a daunting challenge. They must confront the realities of today's complex healthcare landscape, while crafting a future that aligns with the industry's movement toward population health management and value-based payment. A physician leader of one of the largest, most advanced health systems in the region, Dr. Farah shared his personal insights, and offered lessons learned to others on the same path.

KEY POINTS

Three major challenges face the western Pennsylvania healthcare market: an excessive over-utilization of medical services, significant outmigration of care from communities and community hospitals to the city, and insufficient competition.

- ❖ **Care out-migration:** Farah estimated that \$579 million of total care for Highmark’s western Pennsylvania members out-migrates from the community to Pittsburgh quaternary care hospitals annually. Almost half of that total (\$282 million) he believes could be provided in the member’s community.



Tony Farah, MD

The Allegheny Health Network (AHN) is exploring various ways to help keep some of this care in members’ communities.

- ❖ **Efforts to increase care in communities include:** deploying AHN physician specialists in community hospitals, expanding existing services and adding new capabilities; forming partnerships with independent physicians; developing telemedicine capabilities for community hospitals and patients (including Telestroke, Telederm, Teladiagnosis, Retinal Eye Exam Program, and rural access to care).
- ❖ **A post-acute, home-based care strategy** is under development to reduce care fragmentation. The program would serve AHN providers, but also independent community hospitals and physician practices.

We have to reinvent ourselves to focus more on outpatient care (like ambulatory care settings and home-based care). The best way to accomplish this is to work with our payers and employers.

— Tony Farah

- ❖ **Highmark’s Transformation Office:** a collaboration with AHN to increase value (which Farah defined as quality, patient experience, and appropriateness of care) by enhancing insurance products to support an integrated delivery and financing system, designing value-based reimbursement models, implementing post-acute care programs, streamlining decision-making and strategic planning, and developing a coordinated population health management program.

DISCUSSION

- ➔ *What is the value of antitrust in a consolidated healthcare marketplace in which consumers rarely make decisions based on prices or quality?* Martin Gaynor noted that merger activity is still ongoing post-ACA. Further, he argued that even in areas where there has been a great deal of concentration, there is still an important role for anti-trust, particularly around problematic anti-competitive practices that should be the focus of anti-trust investigation and enforcement. These practices are not confined to the hospital sector; a lot of activity is related to the acquisition of physician practices. Gaynor also noted that the Federal Trade Commission doesn’t just do anti-trust law enforcement, but also engages in important advocacy and policy work at the state and federal level to help shape the ground rules that determine competition. He concluded that competition is still payer-driven, and that payers can act as effective healthcare shoppers.
- ➔ *What are the most important activities that can preserve community hospitals?* Martin suggested that community hospitals expand their community roles, in keeping with the examples shared by John

Bluford in his keynote address. Gaynor asserted that being small in the current healthcare market could actually be a strength, giving community hospitals the ability to be more nimble and innovative. Farah said that the focus needs to be on the patient, driving a need to change reimbursement and limit outmigration.

- In response to a question citing hospital consolidation as an important method of care integration, Gaynor clarified that not all mergers are detrimental to cost and quality. But consolidation between close competitors is especially problematic. Gaynor said that 20 years of research on consolidation has uncovered few benefits, and mergers promising integration often fail to deliver because achieving true integration is difficult. Providers merging to achieve integration may discover that, once they dominate the market, they can get what they want from payers. Gaynor concluded that future consolidation is likely to be even more problematic because the market is already highly concentrated.

PANEL TWO **From Volume to Value: New Directions in Payment Reform**

Moderator **Keith T. Kanel, MD**
Chief Medical Officer, Pittsburgh Regional Health Initiative

Panel **Hoangmai H. Pham, MD, MPH** *Director, Seamless Care Models Group, and Director of the Pioneer ACO Project, CMS Innovation Center*
Edward J. Roth III *President and CEO, Aultman Health Foundation, Canton, Ohio*
Marion McGowan, RN *EVP & Chief Population Health Officer, Lancaster General Health; President, Lancaster General Health Innovative Solutions, Inc.; and President, Lancaster General Health Community Care Collaborative, LLC*

PANEL INTRODUCTION

A goal of payment reform efforts is to move away from volume-driven fee-for-service to alternative models and population-based payment. This has been a primary focus of the Center for Medicare and Medicaid Services, and the foundation upon which it has constructed some of its current payment reform models, such as accountable care networks and bundled payments. These models require reasonably high levels of clinical integration, provider buy-in, predictability of utilization pattern, and data control. Because of the multi-payer marketplace, providers may be forced to simultaneously align themselves with a variety of payment models. Despite having a high prevalence of Medicare beneficiaries, western Pennsylvania and West Virginia community hospitals have been slow to embrace solutions such as accountable care organizations. A very recent development is the move of many smaller hospitals to collaborate in “virtual networks,” allowing them to negotiate as a group while maintaining their independence. Creating a larger target for new models of payment may carve a path for insurers — both regional and national — to begin moving toward innovative payment design.

Speaker**Hoangmai H. Pham, MD, MPH***CMS's Plan for Engaging Multiple Payers in Payment Reform***OVERVIEW**

CMS recognizes that the ultimate goal of population-based payment requires clinical integration, data control, and patient engagement, which may be beyond the means of all but a few providers. To create interim steps on the road away from fee-for-service, CMS has offered a framework within which providers can build upon a traditional platform in innovative ways. For community hospitals with small networks of physician practices, enticing new models are being advocated.

**Hoangmai Pham, MD, MPH****KEY POINTS**

There is a clear trend in Medicare toward greater emphasis on value and quality in both inpatient and outpatient care.

- ❖ **Value-based purchasing (VBP) in Medicare will only grow over time.**
- ❖ **Fiscal pressures motivate these trends.** In hospitals, Medicare's readmissions and healthcare acquired conditions programs, the EHR Incentive Program and the Inpatient Quality Reporting program all clearly indicate the growing importance of VBP. For physicians and other clinicians, VBP now constitutes up to 10% of Medicare revenues via the physician value-based modifier, the PQRS system, and the EHR incentive program. By 2016, 8–9% of FFS payment will be at risk.

The combination of delivery system and payment transformation is driving the healthcare system to be people-centered, outcome-driven, sustainable, and coordinated.

- ❖ **New payment systems** and other policies supporting this transformation include VBP, ACOs, shared savings, episode-based payment, medical homes and care management, and data transparency.

Close to 10% of Medicare payments to physicians and hospitals is going to link to outcome and quality metrics.

— Hoangmai Pham

CMS intends to retain and increase the number of ACOs and to gradually shift more organizations to higher-risk tracks. It intends also to use CMMI to test new ACO design elements, foster an environment in which providers work together (e.g., providing better information, data sharing), and provide a forum for shared learning around successful strategies.

- ❖ **Medicare's current accountable care strategies:**
 - ACO participation is growing rapidly. More than 360 Medicare ACOs have been established, including 123 new Shared Savings (MSSP) ACOs in 2014. The Pioneer ACO Model (with 700,000 beneficiaries) and the Medicare Shared Savings Program (with 4.9 million beneficiaries) are prominent.

- Also relevant is Medicare Advantage/Medicare Part D (with 16.1 million beneficiaries) and VBP/Value-Based Modifier (affecting all FFS beneficiaries).
- ❖ **The Pioneer and MSSP ACOs have resulted in initial, favorable financial and quality outcomes.**
 - Together these programs have resulted in over \$372 million in total program savings. The Pioneer ACOs shared savings payments of \$68 million. And, in the MSSP, 53 of 56 ACOs kept spending below their targets.
 - The Pioneer ACOs improved average quality scores between 2012 and 2013 by 19%, and improved in 28 of 33 quality measures. MSSP showed improvement in 30 of 33 quality measures.
- ❖ **CMS is also testing an ACO Investment Model** aimed at helping existing small ACOs that do not include any inpatient facilities (or have critical access and/or low-volume rural hospitals) to accelerate performance and graduate to higher accountability, or two-sided risk. The prepaid shared savings must be spent on staffing and/or infrastructure that support population care management, financial management, or other essential ACO functions.

Speaker **Edward J. Roth, III**
Independent Hospitals in Virtual Collaboration: An Ohio Experience

OVERVIEW

Over 17 years ago, the Aultman Hospital began collaborating with nearby hospitals to integrate services within the community and build an infrastructure for purchasing, quality improvement, training, staffing, and patient engagement. This “virtual” organization has proven to be a highly successful model for community collaboration. By working with surrounding systems (including a new multistate endeavor), the Aultman consortium is positioned well for the future.

KEY POINTS

The innovative spirit that eventually led to the creation of the Independent Hospital Network (IHN) began in the early 1980s with the leadership of Aultman Hospital (consisting of community-based clinics, an outpatient care center, and a college).



Edward J. Roth, III

- ❖ **Responding to premium increases in the 1980s:** Roth noted that, as the diagnosis-related group (DRG) system was implemented in the 1980s, large insurers initiated cost-shifting in health care by passing along double-digit premium increases. Aultman Hospital responded first by trying to reduce costs using the Deming Management Method, among others, and succeeded in becoming a very-low-cost provider. It wasn’t enough to offset premium increases, however, so in 1985 the hospital’s leadership developed their own insurance product, Aultcare, to pass their low costs and high quality on to the business community. With 2,600 client employer groups and 444,000 beneficiaries, Aultcare is run as a break-even business, and has a 95% retention rate over the past 30 years.

As the healthcare sector began to change in the early 1990s, community hospitals faced the choice of joining for-profit or regional hardware networks and losing control of their local markets OR forming a network with other nonprofit hospitals. Leadership from regional community hospitals chose to form a network.

❖ **The Independent Hospital Network (IHN) was launched in 1996 with five Ohio hospitals:**

- Aultman Orrville Hospital (Orrville)
- Alliance Community Hospital (Alliance)
- Pomerene Hospital (Millersburg)
- Union Hospital (Dover)
- Aultman Hospital (Canton)

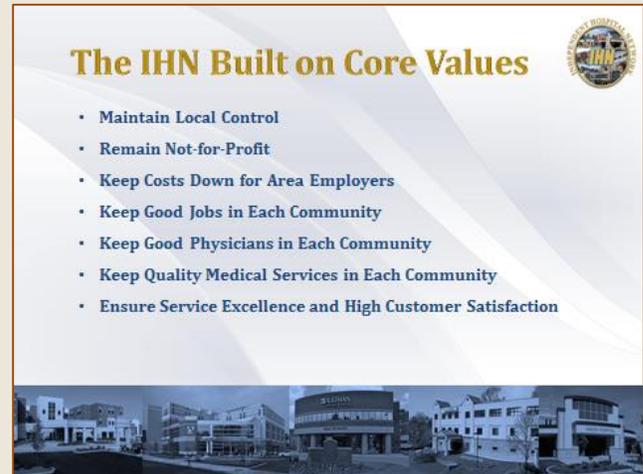
❖ **The group was motivated by core values that continue to inform their business decisions** 18 years later (see image at right), which reflect an overarching desire to “remain accountable to our communities.”

❖ **Operations:** The hospital CEOs meet monthly and, although sizes differ, there is equal representation and equal voting power. A board member from each of the four hospital boards also sits on the IHN board (of 40 members). Core services have always been provided by Aultman, the largest hospital in the network. More recently, the Orrville hospital merged with Aultman, becoming Aultman Orrville Hospital.

A number of initiatives have increased quality and decreased the cost of services for the IHN network and, more recently, for a broader network of 23 hospitals in Ohio and neighboring states.

❖ **The hospitals have done a lot of work on supply chain management and have established an IHN sourcing group.** In addition, they created a Physician Information Network Data and Information Exchange, so that patient information could be available across hospitals. Roth noted that the group also streamlined and standardized certain processes of care across the hospitals, including door-to-balloon procedures.

- An LLC sourcing group was established in 2011 that allowed a larger group of 23 hospitals to engage in joint purchasing and collaborative activities. Roth noted that, starting with supplies, current shared service lines include data processing, purchasing, warehousing, billing and collection, dietary services, clinical services, industrial engineering, laboratory services, printing, communications, records center, and personnel services. Jointly, the 23 hospitals have about \$673 million in supply spending. The sourcing group resulted in an



estimated savings of \$8.2 million from June to December of 2014, with a 7:1 return on investment.

- ❖ **The hospitals continue to experiment with various level of integration** (see image), and have engaged in joint ventures:
 - Developed a regional cancer center with radiation therapy services, saving patients 4 million miles of driving
 - Launched a community blood product program, cutting costs by about a third
 - Engaged in developing an integrated health collaborative (a clinically integrated network). The goals are to improve quality and efficiency, promote hospital–physician partnerships, and build an integrated care delivery system — all to enable success under value-based reimbursement. Roth notes that the IHN hopes to form an ACO in 2016.

- ❖ **IHN has invested in ongoing leadership training and cross-hospital management support.**
 - IHN created its own “Network College.” Roth noted that each hospital was sending people to different conferences, schools, and/or development classes, so they decided to create their own leadership development program. As of 2014, 280 people — nearly all managers and executives across the hospitals — had participated, fostering a collaborative culture.

 - A managers group meets quarterly to solve problems, benchmark progress, and improve service outcomes and cost performance.

- ❖ **Future challenges and plans include the development of a statewide collaborative of six healthcare systems across Ohio** (announced in January 2015), using the bylaws of IHN. Its goals are to share best practices, design care enhancement innovations, master population health, and collaborate to significantly reduce costs.

Speaker

Marion McGowan, RN

Independent Hospitals in Virtual Collaboration: A Pennsylvania Experience

OVERVIEW

Lancaster General Health (LGH) is a highly integrated system in central Pennsylvania that includes 613 acute-care beds, 90 acute-rehabilitation beds, seven ambulatory facilities, 250 employed physicians, a regional home health agency, an accountable care organization, and an innovation company. LGH has also entered both the CMS Medicare Shared Savings Program (MSSP) and the CMS Bundled Payment Program. Realizing the merits of larger collaborations, LGH entered a novel virtual relationship with six other facilities in Pennsylvania and New Jersey in October of 2013. Marion McGowan shared LGH’s experiences in the ACO world, and the lessons learned from creating these provider relationships.



Marion McGowan, RN

KEY POINTS

LGH’s close community ties have led to new and innovative relationships.

- ❖ **LGH operations:** Over 100 years old; \$1.1 billion in revenues; 7,100 employees (including 925 medical staff); two community hospitals; one acute-care rehab facility; seven ambulatory care centers (with a nationally recognized family medicine program)
- ❖ **Programs:** Pennsylvania College of Health Science; the Community Care Collaborative (an ACO); LGH Innovative Solutions, Inc. (an incubator for researching and developing innovative products and services to help transform health care, which was formed about 2½ years ago)

AllSpire — an alliance of seven health care systems serving 9 million people in Maryland, New Jersey, New York, and Pennsylvania — emerged as LGH began to plan to ensure its survival, as well as its ability to meet “triple aim” goals (improving population health, reducing costs, and improving patient experience) in a rapidly changing healthcare market.

- ❖ **LGH leadership was convinced that it had to become more innovative,** a conviction that fueled its efforts to look beyond the immediate LGH community for solutions.
- ❖ **McGowan noted that LGH leadership believed that consolidation and/or integration needed to occur on three fronts:** Horizontally (among payers), vertically (between providers and across their own health system), and virtually (building a novel structure, developing a product/partnership process that taps into other industries when necessary, and finding new ways to solve community issues)

We recognized that to make an impact we had to think differently — structuring novel partnerships, and developing novel solutions to healthcare delivery.
— Marion McGowan

- ❖ **LGH also recognized that consolidation had not necessarily created value for the consumer, and that competition was increasing — not between hospitals, but between value chains.** At the same time, LGH recognized that even with a large market penetration and a reasonably large community health system size, it could not create the level of scale, infrastructure, and competencies necessary to take on at-risk arrangements or value-based alternative arrangements.
 - McGowan said that LGH brought in their own actuaries to help build a provider-based model for some of these arrangements. They worked with four key payers, one at a time, to interpret different kinds of methodologies for sharing risk, from shared savings to upside-downside risk. Even though LGH had over 75% of the inpatient visits, 85% of the ED visits, and 50% of the ambulatory care visits in its marketplace, they determined that it was financially unfeasible. As a result, LGH determined that it had to look at scale if they wanted to create value for its community.

AllSpire’s Vision

- We collectively embrace a “value-based” care delivery model, and its goals:
 - to improve the experience of care,
 - to improve the health of populations
 - and to reduce the per capita costs of health care.
- The unprecedented challenge of health care reform and the sophistication required to provide population health management inspires and drives AllSpire to collaborate in the **development of value-oriented solutions that will ensure sustainable, high-quality, affordable care to our communities.**

<http://www.allspirehealthpartners.org/our-health-care-partners>



- ❖ **AllSpire Health Partners was the response.** Created about a year ago, AllSpire is an alliance consisting of seven founding members with 9 million beneficiaries in the markets they serve:
 - Atlantic Health System (N.J.), Hackensack University Health Network (N.J.), Meridian Health (N.J.), Lancaster General Health (Pa.), Lehigh valley Health Network (Pa.), Reading Health System (Pa.), and Wellspan Health (Pa.)
 - \$7.5 billion in total operating revenue
 - \$2.4 billion in materials and services spend
 - 127,000 employees and families insured by member self-funded plans (total claims costs of \$719 million)

AllSpire’s goal is to mimic strategies used by large chain systems, but not be distracted by asset integration. Its key priorities include:

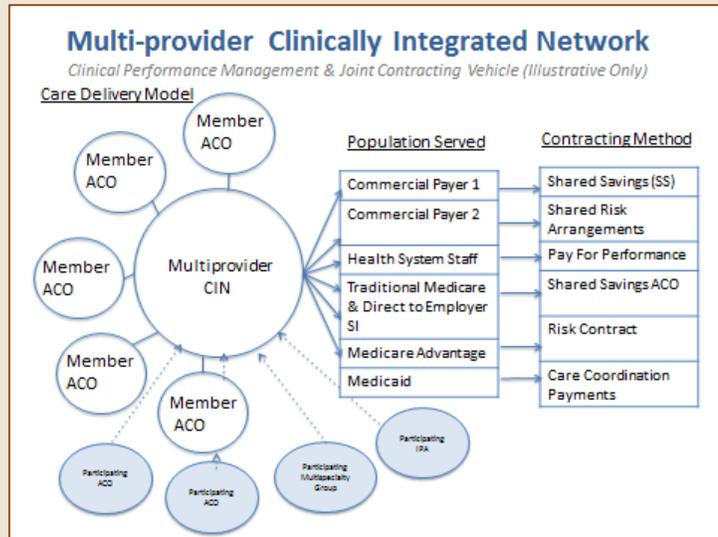
- ❖ **Improve clinical practice through shared learning:** The alliance worked with outside data experts to help profile the members and share transparently. This uncovered opportunities to adopt the best clinical practices of members.
- ❖ **Pursue population health goals and institute a payer strategy:** McGowan pointed out that AllSpire can create points of collaboration and business arrangements on a regional front to mimic what large systems can accomplish.
- ❖ **Advance direct-to-employer relations, as well as innovative payer partnerships that advance value to the community:** McGowan noted that the employment base in Lancaster County extends across Pennsylvania and New Jersey. The alliance provides the opportunity to advance similar standards, combined payment methodologies, and integrated infrastructure support.
- ❖ **Achieve economies of scale and shared services:** So far, AllSpire has done this for laboratory and IT services.
- ❖ **Engage in group purchasing** (integrated supply chain management and private label solutions): This not only yields reduced spending, but allows AllSpire to build novel approaches with physicians to advance the utilization of physician preference items and other elements of clinical spend. Toward this end, AllSpire plans to launch an AllSpire group purchasing organization in the near future.
- ❖ **Launch an “Innovation Alliance”:** Hoping to attract big vendors (which gravitate toward very large health systems like Kaiser and Intermountain), the Innovation Alliance aims to enable AllSpire partners to work together to build venture capital opportunities, a joint innovation portfolio, and internal innovation accelerators.

Moving forward, the AllSpire partners are exploring the launch of a clinically integrated organization (CIO) and payer strategy.

- ❖ **CIO Strategy:** The aim is to introduce a clinically integrated organization built off of a virtual platform so that community members can amass relationships with payers and others, creating value for members.

- ❖ The CIO would serve as a joint contracting entity on behalf of the organizations, and would also serve as a Management Services Organization — the consolidation infrastructure necessary to care quality and value.

- ❖ The roll-out plan is to start small, perhaps with their own employees. Preliminary cost calculations show that members could reduce about a third of their spending by working together — creating economies and promoting health and wellness for employees (see image at right for potential model).



- ❖ Still under discussion: sharing risk pools, the level of integration related to infrastructure (e.g., a number of companies for which there would be implications of consolidation), and how to bring together physicians and clinical teams from disparate ACOs to create something better than what they can accomplish individually.

DISCUSSION

- ➔ McGowan said that LGH’s ACO is participating in Track 2 of the MSSP program, with 18,000 beneficiaries. They are one year into the process and have learned a lot. In particular, McGowan noted that LGH has focused on the ACO’s primary care components. They are trying to address challenges associated with attribution, and how to motivate and align rewards/recognitions of physicians around performance in patient-centered medical homes (PCMH). In addition:

- LGH remains a participant in a bundled payment program (Model 4), which began with 30 organizations, but is now down to 10. The program has about 1,000 beneficiaries and one year’s worth of experience, and nine different bundle types (including hip and joint replacement, and cardiovascular procedures of all types, including open heart surgery, pace makers, etc.).
- All of LGH’s patient-centered medical homes are now at Level 3 National Committee for Quality Assurance (NCQA) certification status. They have integrated their care management process system and organized it around primary care PCMHs.
- LGH has introduced a population health fellowship program as an extension to its primary-care/family-medicine residency program.

- ➔ Pham emphasized the importance of core leadership in successfully launching ACO initiatives: “If you don’t start with an organization’s leadership culture, nothing else follows. It’s the key to success — a measurement of transformation.”

- Pham, in response to a question about how small, independently owned primary care and internal medicine practices will be able to participate in the ACO future, noted that if these practices are what a community needs, they should have options. The majority of practices in CMS’s comprehensive primary care initiative have 4–5 physicians, the majority of whom are independent. Nevertheless, Pham noted that it *is* hard for small practices to make the up-front investments necessary to participate in ACOs or other consortia. CMS is trying to help, and Pham urged interested practices to search the CMS website for primary care opportunities.
- Ed Roth, describing an alternative available without CMS help, remarked that many physicians in the Aultman service area are either sole practitioners or two-physician practices. They created a primary care physician collaborative that enables small practices to identify scale opportunities previously available only to larger practices.

PROVIDER TRACK SESSION

Speaker

Harold D. Miller

President and CEO, Center for Healthcare Quality and Payment Reform

Win–Win–Win Approaches to Accountable Care: How Physicians, Hospitals, Patients, and Payers Can All Benefit from Healthcare Payment and Delivery Reform

OVERVIEW

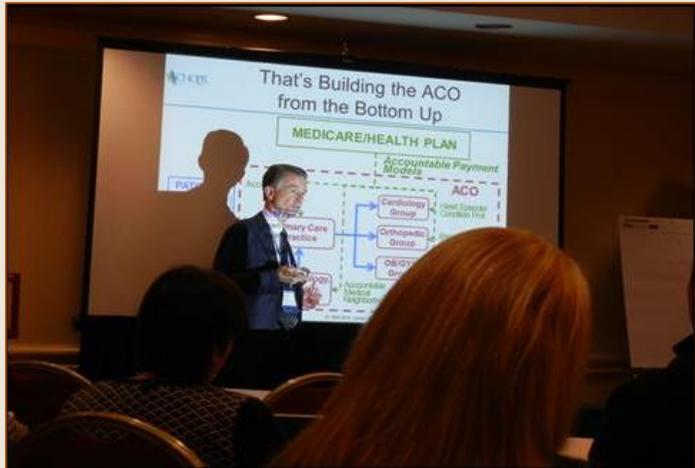
Can healthcare spending be reduced without financially harming community hospitals and physician practices? Does higher payment for primary care require cutting payments to specialists? Must community hospitals and physician practices merge into large health systems in order to deliver “accountable care”? This session shared detailed examples of how revenues for both primary care physicians and specialists can increase, hospital margins can be improved, spending for employers can be reduced, and patients can receive better care if the right kinds of payment systems and benefit designs are in place. Harold Miller used examples from primary care, cardiology, oncology, and other specialties to illustrate how small physician practices and hospitals can remain independent, but work together to create successful Accountable Care Organizations.

KEY POINTS

Healthcare spending is the single largest driver of federal deficits. Spending on major healthcare programs (Medicare, Medicaid, and insurance subsidies) is projected to grow by over \$800 billion from 2014 to 2024.

- ❖ Traditionally, Congress has viewed its healthcare cost containment policy choices as either reducing Medicare services offered to seniors, or reducing reimbursements to providers for those services through the Sustainable Growth Rate (SGR) system.

- ❖ Although SGR adjustments are frequently delayed to avoid major Medicare reimbursement cuts, **physicians' Medicare payments have been flat for a decade, while physician practice costs have continued to rise.** With rising practice costs and flat Medicare reimbursements, practices experienced an effective 23% reduction in operating margin from 2001 to 2014. Hospitals have fared better by comparison, with increases in Medicare payments that outpace inflation, but hospitals are the largest and fastest-growing part of health spending and will likely become a prominent target for reining in the federal deficit.



Provider Track Session, led by Harold Miller

- ❖ **There are many ways for frontline workers to improve patient care while controlling costs,** including emphasizing prevention and wellness services, encouraging chronic disease management, reducing medical errors that lead to complications and hospital readmissions, and eliminating overutilization of healthcare services that are not evidence-based. However, there is little incentive to keep patients healthy and out of the hospital in a fee-for-service (FFS) model that largely reimburses doctors and hospitals based on how frequently patients utilize health care.

There are three building blocks of payment reform, which move away from an FFS model and have the potential to simultaneously improve patient outcomes, increase hospital margins for hospitals and physicians, and lower spending for payers.

- ❖ **Building Block 1: Bundled payment, with single payment to two or more providers who are now paid separately**

Miller provided an example of bundling hospital and physician payments in Medicare, citing Medicare's Acute Care Episode (ACE) demonstration project, which bundled payments for cardiac and orthopedic procedures in in four states. The payment was made to a physician–hospital organization, which then divided the payment between the hospital and the surgeon for patient care. Surgeons could receive up to 125% of the standard Medicare payment for reducing costs. The project achieved significant savings for hospitals, while also increasing physician payments.

- ❖ **Building Block 2: Warrantied payment, which provides higher payment for quality care**

The Geisinger Health System's ProvenCareSM system is an example. Geisinger provides a single payment for an entire 90-day period of care for a variety of conditions and treatments, including cardiac bypass surgery, cardiac stents, total hip replacement, lower back pain, and chronic kidney disease. This single payment includes all pre-admission care, inpatient hospital and physician services, post-acute care, and

any related complications or re-hospitalizations. Miller said that warranties can be offered by individual doctors and small hospitals as well.

- ❖ **Building Block 3: Condition-based payment, with payment based on the patient's condition rather than particular procedures used**

There are four types of bundling demonstration models offered by CMS for hospital care, post-acute care, and readmissions. All four CMS models share the same problem: The bundles reward savings only after a hospital admission occurs. If a patient avoids the hospital, then only the payer receives a financial benefit.

- ❖ **Model 1 (Inpatient Gainsharing, no Warranty):** Hospitals can share savings with physicians, but there is no actual change in the way Medicare payments are made.
- ❖ **Model 2 (Virtual Full Episode Bundle, with a Warranty):** Provides a budget for hospital, physician, and post-acute care, as well as related readmissions. Medicare pays a bonus if the actual cost of care is lower than the budget figure provided. Providers repay Medicare if the actual cost exceeds the Medicare budget.
- ❖ **Model 3 (Virtual Post-Acute Bundle, with a Warranty):** Provides a budget for post-acute and physician care, plus related readmissions. As in Model 2, bonuses and penalties are paid based on the actual cost of care versus the Medicare budget.
- ❖ **Model 4 (Prospective Inpatient Bundle, with a Warranty):** A single hospital and physician payment is provided for inpatient care and readmissions.

There are a number of post-acute (Model 3) projects in western Pennsylvania. This is problematic because this model does not engage hospitals.
— Harold Miller

An alternative, condition-based payment model can provide greater flexibility and higher potential cost savings by incentivizing the management of chronic conditions and avoiding hospital stays. In this model, physicians and hospitals can share savings from fewer and lower-cost procedures, lower post-acute care costs, and fewer readmissions.

- ❖ **Condition-based payment example:** Miller shared an example of a condition-based payment model that can increase hospital and practice margins, save money for payers, and improve outcomes for a population of 500 patients with moderately severe chronic disease.
 - **Currently:** These patients see their primary care provider for a brief office visit and are prescribed medications, perhaps without explanation. Miller estimated that half of these patients are hospitalized each year for exacerbations of their conditions, and specialists only see patients during hospital stays. In the current system, primary care physicians are reimbursed \$600 per patient each year (for a total of \$300,000 in revenue), hospitals receive \$10,000 per admission (\$2.5 million yearly total, with half of patients being admitted), and specialists receive \$400 per inpatient visit (\$100,000 yearly total). Overall, yearly spending on these 500 patients with moderately severe chronic diseases totals \$2.9 million.
 - **Anticipated change in reimbursement:** In a condition-based payment model, reimbursement to physicians would increase to \$900 per complex patient, to support proactive care

management during office visits. Specialists would receive \$300 per patient for visits in primary care settings, rather than only when a patient is admitted to the hospital. And \$80,000 yearly in salary and benefits would support hiring a registered nurse to serve as a care manager. Overall, spending on ambulatory care in this scenario would increase from \$300,000 to \$680,000 (a 127% increase).

- **Impact on costs:** Miller noted that, while ambulatory care costs increase in this condition-based payment scenario, those cost increases could be offset by a 14% reduction in hospitalizations for the 500 moderately severe chronic disease patients. He estimated that, with greatly improved chronic disease management, hospitalizations for these complex patients could decrease by as much as 40%.
 - Such a decrease in admissions might seem unpalatable to hospitals, which would stand to lose a significant amount of revenue in Miller's scenario (\$1 million per year, if hospitalizations are reduced by 40%). However, he pointed out, hospitals should be concerned about operating *margins* rather than total revenue. Hospitals have high fixed costs that remain constant regardless of patient volume, but they can also save money by reducing variable costs if fewer patients are admitted to the hospital.
 - Miller estimated that the hospital in his scenario has about \$6,000 in fixed costs per patient, \$3,700 in variable costs, and a 3% operating margin. If hospitalizations are reduced by 40%, the hospital's variable costs decrease significantly (from a total of \$925,000 to \$555,000) and its operating margin increases to 3.9%. The hospital receives less total revenue, but its bottom line improves.

❖ **A condition-based payment model can benefit all stakeholders:** The practice receives larger payments to support chronic disease management and a care manager; specialists see more patients in primary care settings than in in-patient settings, resulting in a larger reimbursement total; the hospital boosts its operating margin; the payer decreases its total spending on the 500 patients who have moderately severe chronic diseases from \$2.9 million per year to \$2,817,500 (a 3% decrease); and patients benefit from improved management of their conditions. Miller then contrasted the “win-win-win” scenario offered by the condition-based payment model with a shared savings model. He said that in a shared savings model, participants do not receive any shared savings unless they hit a minimum threshold and meet quality targets, and that all shared savings payments end after three years (after which the payment structure reverts back to a fee-for-service model).

Each specialty must look for opportunities to reduce overutilization of services that are not proven to enhance patient outcomes and that may even cause harm.

❖ **Examples:** For patients suffering from back and joint pain, physical therapy could be emphasized instead of imaging and surgery. Patients suffering from chronic diseases could be supported through care management services, regular primary care physician contact, and a post-discharge plan to reduce avoidable hospitalizations and readmissions. Less invasive cardiology procedures could be used for those suffering from chest pain, and more babies could be delivered full-term rather than through early elective delivery.

Unfortunately, most ACOs are not truly reinventing care or payment. Instead, Miller recommends, the ACO should be built from a targeted patient population.

- ❖ **Start with a population of patients who select and use a primary care practice:** With this focus, Miller argued, the practice would take responsibility for outcomes that it can control or influence, such as avoidable emergency department visits and hospitalizations, and unnecessary tests and referrals. For complex cases, the practice consults with a “medical neighborhood” featuring specialties such as neurology, endocrinology, neurology, and psychiatry, and together the practice and specialists co-manage outcomes. The specialists are responsible for unnecessary procedures and complications. This sort of ACO “built from the bottom up” allows practices and specialists to make the case to CMS that they can manage a population of patients with global payment.
- ❖ **This would not be traditional capitation.** There is a distinction between this sort of risk-adjusted global payment system and traditional capitation, which did not provide incentives for improving quality. With a risk-adjusted global payment model, payment is adjusted based on patient conditions — there are limits on the total risk that providers accept for unpredictable events; bonuses and penalties are based on quality measurements; and providers receive higher payments if patients remain healthy.

To redesign care and payment mechanics in a manner that benefits providers, hospitals, and payers, Miller offered a number of suggestions.

- ❖ **Define the change in care delivery,** identifying opportunities to improve quality and reduce costs by asking physicians.
- ❖ **Analyze expected costs and savings with shared, trusted data.** Physicians and hospitals must know current utilization rates of services, and the costs of delivering different types and volumes of services, to know if costs will be covered under a new payment model. Purchasers/payers must know current utilization rates and the amount being paid for those services to determine whether a new payment model offers a better deal financially. These sorts of analyses require claims, clinical, and cost data.
- ❖ **Design a payment model that supports change,** offering flexibility to change care delivery, accountability for cost and quality outcomes, and protection for the provider from insurance risk.
- ❖ **Design an appropriate internal compensation system.** Miller used oncology as an example of an opportunity to better align revenue with the sort of care provided to patients. Cancer care pays predominantly for treatment, but relatively little for post-treatment follow-up even though providers spend a considerable amount of time on follow-up. A condition-based payment, Miller said, would reimburse oncologists based on how they actually spend their time.
- ❖ **Get payers to use the payment model.**

DISCUSSION

- ➔ Brainstorming on starting points for using condition-based payments, the group mentioned reducing unnecessary C-sections and scheduled deliveries; repatriating surgeries, oncology, and other types of care to the community; improving chronic disease management; reducing hospital-acquired infections; and providing integrated behavioral and physical health services in primary care, particularly as providers recognize that comorbid physical and behavioral health conditions exacerbate one another.

(Miller agreed that behavioral health should not be a “carve out,” but rather part of the payment for managing the overall outcomes of patient care, similar to coordinated care models being developed in Oregon.)

- The group then discussed potential barriers to condition-based payments for the services mentioned above as starting points, including: different payment mechanisms for physical and behavior health that present a challenge for integrated primary care; payers who are not receptive to provider-driven payment reform; and the time, effort, and financial resources necessary to put together a business case/payment model. In response, Miller suggested that providers could approach payers and inquire about what sort of payment structures they would support, rather than having providers create a model from scratch.
- Miller emphasized that the goal should be to align the incentives of providers, hospitals, and payers, rather than just a subset. He said that, currently, insurers take on both insurance risk (risk that the patient will be sick) as well as performance risk (given that a patient has a condition, how much will it cost and how will it be managed?). He wants to separate the two types of risk, with health plans keeping the insurance risk and providers taking on the risk of managing a condition. The ensuing discussion emphasized that practices differ in terms of their readiness for new care and reimbursement models. Practices committed to condition-based payments must be financially viable, embrace the role of the care manager, and possess a culture that values team-based care.

EXECUTIVE TRACK SESSION

OVERVIEW

An increasing number of options between fee-for-service and global payments are emerging, including patient-centered medical home models, bundling for episodes of care, shared savings, and a range of blended models. Each requires different infrastructure and culture. Several different approaches were presented in this session, including episode and global payment models that link rewards to performance on quality and total spending for a defined population. The session also examined how these models could be made feasible for community hospitals and physicians.

Speaker **Steve Tringale, CEO**
Tringale Health Strategies, LLC
Advanced Concepts in Payment Reform

KEY POINTS

There are both challenges and opportunities in moving to value-based reimbursement, but there is nothing in these models that should force community hospitals to consider mergers.

- ❖ **The movement from volume-driven care to performance-based care is happening fast.** Once it takes hold of a market place, the practical tipping point tends to occur much faster than anticipated. This is because a small actuarial shift has an enormous impact in the market.

- For example, primary care physicians (PCPs) comprise about 10–11% of a market’s total medical expenses. If a value-based reimbursement model saves just 1–2% and redirects it to PCPs, this will fundamentally change incentives for PCPs.
- The lesson for community hospitals is that if they don’t move to this environment, physicians *will* move to the big system platforms. Rather than posing a threat, this reality provides an incentive to maintain a strong hospital–physician environment and a real opportunity to grow the hospital’s physician base.



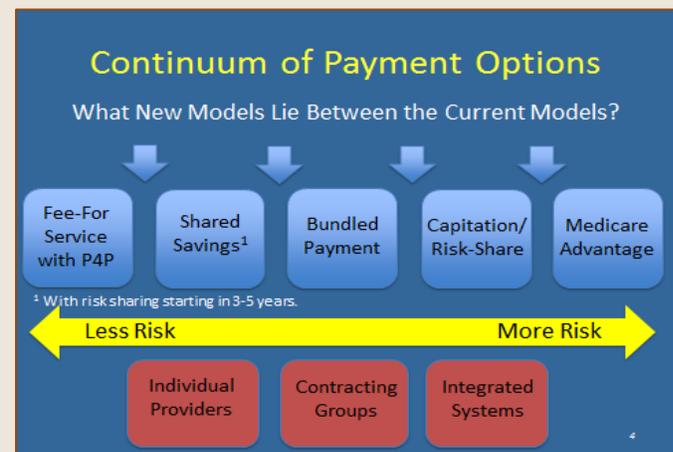
Steve Tringale

- ❖ **A continuum of payment options is available to community hospitals,** from FFS pay-for-performance to shared savings; from bundled payments to capitation/risk sharing, to moving from less risk to more risk; and from individual providers to contracting groups to integrated systems (see image on previous page).

- The hospital needs to handle the full care transition, and to refer within its own system as much as possible. The share of the medical market it controls is critical.
- Tringale observed that western Pennsylvania is somewhere between FFS pay-for-performance and shared savings.

Your overall strategy in terms of how to build out a system — your relationship with nursing homes and other post-acute providers — is extraordinarily important. The hospital–physician relationship has to extend to the full delivery system.

— Steve Tringale



The goal in adopting a particular reimbursement strategy in performance-based contracting should be that it is a derivative of the hospital’s overall strategic plan.

- ❖ **Community hospitals need to get insurers to say ‘yes’ to new payment models.** Tringale urged hospital CEOs to begin first meetings with insurers by presenting a report on “the state of the institution” — to talk about local issues and the hospital’s activities, platform, quality metrics, and reasons for favoring an alternative model in terms of controlling total medical expenses. Community hospitals can learn from

the financial losses some of the big systems have incurred with their mistakes because the big systems can afford to build the platform and absorb some of the losses.

Numerous strategies can help make a non-merger model work for community hospitals.

- ❖ Citing his research, Tringale said that, with the right blend of services, quality, and branding, a community hospital should expect to keep up to 90% of orthopedic admissions — a much higher retention rate than what most experience currently. It works for the PCP because they receive a performance payment, and the specialists experience an increase in volume. He emphasized that there is a huge service component to succeeding in this model. The hospital doesn't need to take as much because it's picking up the contribution margin from the extra procedures as well.
- ❖ **A comprehensive approach to negotiating a value-based insurance partnership is best.** All terms of the contract have potential financial implications. There are no longer boilerplates for such contracts. Hospitals must ask, for example: Do we have the right of first refusal? Do we have guarantees that if we control medical expenses, the insurer will put us in a third tier? Ultimately, community hospitals should be looking at joint ventures. And hospitals can't separate the value-based benefit design issue from the reimbursement issues. The result needs to be supportive of and consonant with the hospital's overall strategic plan.
- ❖ **Develop contracts that aren't restricted to traditional risk adjustment models** (e.g., related to clinical diagnosis), as there are also socio-demographic and psycho-social aspects to risk that aren't accounted for in these models. It is important to segment risk by different groups.
 - The "win" for payers is that they will have the ability to tell employers that they are reducing the increasing cost trend rate so that it more closely mirrors the rate of inflation.
- ❖ **Consumers need to trust that quality payments are different from cost-based performance payments.** Tringale argued that this lack of trust spelled the demise in the 1990s of early versions of capitation. Hospitals can't be seen as gatekeepers.
- ❖ **Hospitals will need analytic support**, a skill set that is currently not available in most community hospitals. Hospitals should request infrastructure support in the contract from insurers, who have performed such analyses for years. The funds need to flow directly to the sponsoring organization (or population health management entity) so that the hospital isn't required to pay it back.

The Blue Cross Blue Shield Massachusetts' Alternative Quality Contract (AQC) illustrates the market tipping point mentioned earlier, with a large growth in beneficiaries under global payment.

- ❖ **There are many different types of groups in the AQC**, including an independent practice association (IPA), a multi-specialty group, an integrated system, and a physician-hospital organization. As early adopters, the IPA survived independently because it is so integrated with the hospital that an outsider couldn't tell them apart. They have done joint contracting because of the clinical integration. Challenged by some of the biggest academic medical centers in the U.S., they've been able to stay independent.
- ❖ **The AQC 2.0 links quality to shared savings.** It is also a risk mitigation tool — such that a practice with a higher quality score will get a greater portion of the shared savings. The approach also limits downside risks.

- The medical group strategy is to drive up quality scores, control network leakage (to capture volume *and* quality scores), manage high-cost/high-risk patients (to keep down avoidable admissions and readmissions, and ED use), link physician compensation to performance, and support PCPs with appropriate practice design.
- There is a big incentive to maintain the largest primary care population possible. Most of these physician groups lose money in the beginning. You need to know what it means to run an efficient practice. Results through year 4 [from four cohorts]:
 - Reduced spending relative to a control group, from 5.8% to 9.1%.
 - Savings primarily came from outpatient facilities, procedures, and imaging — reduced prices from the use of lower-cost settings and lower utilization.
 - Statistically significant quality improvement, at rates well above national averages.
 - Blue Cross Blue Shield incentive payment exceeded claims savings during 2009–2011, but it earned savings in 2012, a trend that continues.

DISCUSSION

- ❖ **Non-merger models also work in low-cost markets:** When challenged by the assertion that care costs in Massachusetts are extraordinarily expensive, Tringale pointed out that the non-merger model also works in relatively low-cost markets like Rochester, New York, where he helped to develop a 130,000-person global budget model.
 - He noted that they made money in the first year, but attributed this to the Hawthorne Effect (changing behavior based on being observed). Years 3 through 5 can be a lot harder. Physicians will then start seeing their performance dashboard, and, after challenging the data, they will start to perform. A PCP who is respected by his/her peers and is committed to working with the hospital (it's better if s/he doesn't hold a formal title in the hospital) can have real impact in "grinding through the data" and convincing peers that there is no reason for the observed variation. This is actually harder to do in high-cost markets like Massachusetts, which have always had more resources and fewer incentives to closely examine work patterns.
- ❖ **Physicians will respond.** When asked whether physicians need more education about value in health care, Tringale responded that physician resistance is largely a myth — for the most part, physicians respond well to a logical presentation of information and data. It's also important for hospitals to listen to physicians. Together, hospitals and physicians can develop solutions tailored to a particular marketplace.
- ❖ **What are the best measures in a global budget program?** Tringale noted that the subject is a source of pushback and is constantly evolving. It's important to have clinical support at the negotiating table with insurers — so working with the hospital's clinical team in advance to select measures is a good idea. It is also important to avoid having different sets of clinical standards for different payers.

Speaker **Jennifer Perloff, PhD**
Deputy Director, Institute on Healthcare Systems
The Heller School of Brandeis University
Payment Reform Options for Community Hospitals in Western Pennsylvania

KEY POINTS

Applications for episodes go beyond current bundled payment models in important ways.

- ❖ Model features include direct participation, risk-sharing with partner hospitals under global capitation, evaluating/rewarding network performance, and accepting risk for hospitalized patients not attributed to the ACO.
- ❖ Opportunities to improve margins for participating hospitals include reducing supply costs, errors and complications, post-acute care costs, readmissions, and length of stay.
- ❖ Similarly, opportunities to improve margins for participating physician groups include reducing supply costs, errors and complications (where gainsharing can occur), post-acute care costs, and readmissions.

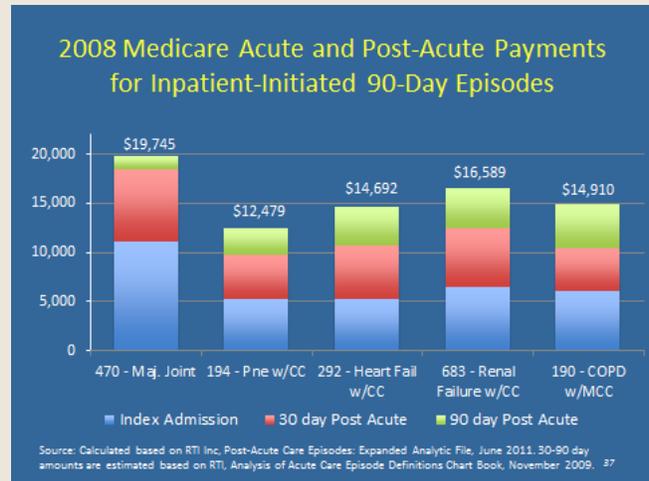
| | | | | |
|----------------|--------|---------|----------|-----------|
| | Part B | \$1,143 | \$417 | (\$725) |
| SNF | Part A | | \$4,271 | (\$4,975) |
| | Part B | | \$294 | (\$73) |
| Home Health | Part | | \$75 | (\$368) |
| | Part | | \$33 | (\$24) |
| Post-discharge | Total | 73 | \$12,232 | (\$8,440) |
| Total Episode | Total | 1 | \$19,100 | (\$8,541) |

Executive Track Session, with Jennifer Perloff, PhD

Bundled payment models can take many forms. Perloff described the CMS Innovation Center’s Bundled Payment for Care Improvement (BPCI) Pilot, in which four different models are being tested by 467 awardees.

- ❖ **Models**
 - **Model 1:** Bundle applies *only* to inpatient professional services and index hospitalization (retrospective).
 - **Model 2:** Bundle applies to the inpatient stay and follows a patient for 30 or 90 days (“look-forward”) post-discharge (including SNF and readmission). Physicians “own” what happens during the look-forward period.
 - **Model 3:** Bundle applies only to the outpatient period in a 30-day look-forward, including all outpatient professional services, SNFs, and readmissions.
 - **Model 4:** Bundle is a prospective payment model that includes the index hospitalization, inpatient professional services, and any 30-day readmissions.
- ❖ **Participants can select the most appropriate bundle.** Selection features include:
 - **Bundle design:** length (30, 60, or 90 days); volume (between one and 48 possible bundles — some of which include multiple, related DRGs)

There are options around risk. It's important to know that up to 70% of costs can be in the post-discharge period. For this reason, I'd advise first starting with 30-day, rather than 90-day, bundles.
— Jennifer Perloff



- **Exclusions:** There are limited exclusions for readmissions and for unrelated conditions that occur in the post-discharge period.
- **Severity adjustment:** There is no risk adjustment except at the DRG level.
- **Stop-loss:** Participants can select a threshold for losses, charging a percentage of the loss above that threshold.
- CMS allows participants to shift their choices over time.

CMS calculates prices under the Medicare BP Pilot using the historical cost per episode (2009–2011).

- ❖ The historical cost is added to an update factor and a CMS discount for a target price. The difference between the two prices is the settlement. Perloff noted that most of the hospitals initially lost money. CMS responded by making the first five quarters “no risk.” It also allowed hospitals to opt for annual rather than quarterly reconciliation, which helps account for variation over time.
- ❖ CMS gets the first 2% of savings (for 90-day episodes). Additional savings can be shared among the facility, physicians, and post-acute providers, although physician gainsharing is capped.
- ❖ Useful principals for gainsharing include setting up quality gates to ensure clinical performance, and distributing savings based on contribution and performance.

Important lessons have been learned from the BPCI pilot.

- ❖ **Medicare spends a tremendous amount in the 30–90 days after patients are discharged from the hospital** (see image).
- ❖ There is **significant variation in post-acute spending** across hospitals.
- ❖ **Hospitals face significant risk of random variation in year-to-year spending per episode** (due to low volumes) — and require program features that mitigate risk.
 - **Meaningful care redesign** can help address the potential loss of net income (arising, for example, from long length of stay or limited discharge planning).
 - **Building risk mitigation into the BP design** can help address potential losses (from outlier hospitalizations, for instance). Strategies include episode selection, episode length, exclusions, risk adjustment, stop-loss protection, and clinical process improvement and care coordination interventions.

Bundled payments can give hospitals the space and time to engage in care redesign.

- ❖ **In the geographic areas in which community hospitals often serve, there may be limited post-discharge providers.** For example, SNF stays may be extra-long and expensive. BPs give providers a chance to have a conversation to figure out how to deal with such an issue. These hospital/post-acute-care relationships become even more important within a 90-day post-discharge time frame.

DISCUSSION

- ➔ Asked to describe how a chronic care bundle would work (e.g., for heart failure), Perloff noted that there is a CHF bundle in the demo. Patients discharged with one of three DRGs are assigned to the bundle. They are seeing aggressive attempts to stay in touch with patients in the post-discharge period, where the bulk of spending occurs.
 - Harty talked about the chronic care bundle with which he is familiar. Taking responsibility for the post-discharge period has introduced new kinds of care concerns, like paying for patients' food and medications and getting a handle on post-acute costs (SNFs). Some are insisting on specific SNF length of stay. Others are more collaborative, asking that SNFs call the hospital before sending a patient to the ED. Capital investment is so far limited to additional staff and some auxiliary care (e.g., food). He described the bundle as particularly challenging over a 90-day period because patients with comorbidities are likely to have an exacerbation of one of their conditions. Connecting medical patients to physicians within the first seven days post-discharge has been a challenge. Especially challenging is the information flow needed to track a patient once they are discharged; it's very difficult to know whether they are doing well.
 - Working with durable medical equipment suppliers is also a challenge.
- ➔ A former CFO for a large SNF noted the value of communicating with hospital CFOs. Initially, the SNF didn't know where the costs were. With the changes in reimbursement and penalties for readmissions, the SNF had to start caring about readmissions. Putting the SNF and hospital costs together was valuable. Perloff responded that this is an important part of the opportunity: "Hospitals are profiling and getting to know their community providers."
- ➔ What happens with therapy cap? Perloff noted that a typical knee replacement would not hit the therapy cap.

But if the cap falls into place and you are stuck, you would need a waiver. Right now, the only waiver that bundled payment hospitals have received is a three-day SNF waive.

— Jennifer Perloff

- ➔ McGowan said that CMMI did have influence on the gain sharing. It was a very painful and intense process that required them to redo it. She noted that the prospective model has been very challenging, although they don't regret what they've learned.

We have had very competitive specialists come to the table and share data that they've never shared before — and make decisions jointly. We worked with nine bundles, even though our costs were lower going in, so higher risk.

— Marion McGowan

- ➔ Feinstein expressed dissatisfaction with the CMS Bundled Payment demo and asked whether other countries have more effective bundled payment methods. She asked, “Should we not just go to capitation and stop worrying about all of these finite charges?” Perloff responded that BP is a transitional payment model — in between FFS and global capitation.

It is very useful to think about the total complement of care around an episode. It can become a care design and monitoring tool. I think it’s a useful intermediate step — although very frustrating as a result of changing CMS design rule changes. Every aspect of the design has changed multiple times. CMS is starting to get their stride, and get stable.
— Jennifer Perloff

- ➔ Kanel: Is there a bundle starting point? Perloff remarked that it really depends on the circumstance.

A lot of people go for joint replacements, where there is less variation. Chronic medical bundles have a lot of variation, but a lot more room for improvement. It really depends on your context, but procedures are usually less risky. I like 90 days because there is more opportunity for upside.
— Jennifer Perloff

- Horty responded that he would do 30 days, because the hospital would have more control over patient outcomes in that period. He is bothered by the fact that providers will have a share of the savings, even though the decisions on care in the post-acute period are being made by others. He views this as a misplaced reward.
- An executive who has four years of experience with a shared savings program said that he gets grief about the distribution of money. Given this turmoil, he asked how gainsharing can be done, especially among all of the providers over a 90-day period. Horty noted that his group made a very strong rule that nobody would gainshare in the first year; Perloff said that they haven’t had a lot of hospitals trying to gainshare.

GOVERNANCE TRACK SESSION

The Role of the Board in Payment Reform

Speaker **John Horty, AB, LLB**
Horty, Springer, and Mattern, Estes Park Institute

Co-Facilitators **Edward J. Roth III** *President and CEO, Aultman Health Foundation, Canton, Ohio*
Steven Tringale, CEO *Tringale Health Strategies, LLC*

OVERVIEW

The role of a community hospital’s governance board in payment reform discussions is critical. The board must balance risk versus reward in guiding its organization into an uncertain future. With many current payment reform models being voluntary, the board must be an active partner with the executive team and medical staff

in the planning process. In this session, the speakers shared decades of experience in advising community hospital trustees, as well as approaches used in the renowned Estes Park Institute curriculum that has trained healthcare leaders since 1974.

KEY POINTS

Trustees need to be sure that they are making the right decision if they merge with a larger system.

- ❖ **Community hospitals are critical to community health.** Horty said that there are few examples of communities that were better off after their hospital lost its independence.
- ❖ The **two major problems** that community hospital boards think of when they consider changes such as acquisition include a lack of capital and a concern that “if we don’t do it now, we’ll get left out of the game.” But the real problem is that community hospitals are changing and that trustees will have to engage in new thinking about their future role. By definition, community hospitals have to care about community and business costs. Unlike tertiary care and academic medical centers (which rely on referrals and FFS payments), community hospitals won’t get business and would likely have to close if they price themselves too high. Boards must consider how to restructure the payment system so that community hospitals are viable.
- ❖ **The main reason that hospital acquisitions occur is to make a profit off of the purchased hospital.** But that is the worst reason to acquire a hospital. The purchasing hospital often doesn’t consider whether its own culture meshes with that of the purchased hospital.
 - Horty shared his personal experience with selling a hospital in Johnstown to a large medical group, but a lower-than-anticipated volume of surgeries performed by the acquiring group’s physicians contributed to the hospital closing.



Governance Breakout Session, led by John Horty and Edward Roth

Community hospitals need to reduce beds and increase outpatient care options.

- ❖ **Community hospitals of the future:** In 15–20 years, community hospitals will handle chronic diseases and pneumonia and other conditions that can be handled locally. As such, hospital trustees should invest in those services, as opposed to building. Reducing beds and increasing outpatient care options is a sound strategy.
- ❖ **Competing with hospital systems:** One of the major problems with community hospitals in the future is how to pay off the doctors that you will no longer need (since they will be getting less patients). Horty suggests that three to four community hospitals come together to jointly provide telemedicine services — or other models of reaching patients outside the hospital — which would enable them to compete against large hospital systems.

Trustees must work to change the culture of the hospital.

❖ Recommendations for Trustees:

- Boards are hesitant to try different models because they can't predict definite savings in advance, but they may have no choice.
- Establishing trust is the first step toward changing culture.
- It is important to keep some decision-making power in the community. An effective board should not be larger than 12 people. Harty even prefers that boards not have an executive committee. Roth countered that the Aultman Health Foundation has a 44-member board that functions well, so it varies based on the organization.

DISCUSSION

- When asked whether a trustee's responsibility is to the community hospital or to the community, Harty replied that community hospitals must think deeply about their patient population, regardless of size. This is different from tertiary hospitals, which usually see themselves more as regional or statewide institutions.

A community hospital trustee is accountable to the community, not just the community hospital. In order to justify staying in a community, a hospital needs a way of demonstrating that the money spent there stays there and creates value.

— John Harty

- Roth described the strategy employed by Aultman Hospital when it acquired a neighboring community hospital.
- When Aultman acquired Dunlap Hospital in Orrville, Ohio, it let the other hospital keep its own board and largely keep its staff intact at first. At around the same time, a competing system purchased a different hospital down the road but decided to eliminate that hospital's board. Roth noted that the latter hospital has since closed, while Dunlap Hospital is still around.
 - Aultman employed a three-stage acquisition process. Year one was strategic initiatives (align HR, get finance systems communicating, get service lines embedded, adopt the same quality measures, create integrated legal and risk teams). No jobs were eliminated in year one, nor were wages or benefits changed. An integration specialist worked at the new hospital to ensure a smooth integration. In year two, they merged cost initiatives (supply chain, standardized products, etc.). In year three, they worked on more difficult issues (e.g., taking Dunlap Hospital's laboratory down to a stat library and processing the more complex lab orders through the purchasing hospital). Aultman was methodical in its acquisition, rolling out changes gradually.

Sometimes hospitals just want to dump the "nuclear bomb" on a place and force the purchased hospital to change overnight. This oftentimes has negative repercussions.

— Edward Roth

- Asked for suggestions for creating an effective, unified board following a merger or acquisition, Roth noted that Dunlap Hospital had a board of 50 people when it was purchased by Aultman. A precondition

of the acquisition was that, although Dunlap would have its own board, it would have to shrink to 10 trustees, with Dunlap and Aultman each selecting five members.

- ➔ An Armstrong Hospital trustee asked whether others were having trouble recently with uncompensated care.
 - The group discussed possible reasons for an increase in uncompensated care, including a growth in high-deductible health plan enrollees (rather than due to an increase in the number of uninsured). Tringale suggested that trustees reach out to the health insurance exchange or state insurance department to relay that uncompensated care claims have climbed due to the bronze health plans they are selling. If uncompensated care rises after a local, large employer switched employees to a high-deductible plan, the hospital CEO can meet with the company CEO or explain the problem in a newspaper editorial. Tringale also suggested that the hospital CEO can propose to the company that they take 25% of the savings generated by the switch to the high-deductible plan and establish a fund for low-income employees. The fund will help reduce underinsured care.

- ➔ Asked for examples of community hospitals partnering with payers, Roth said that Aultman Hospital started its own health insurance plan in 1994, which has since transformed into 100% of its business. This expansion has been mostly smooth, but there have been some challenges. For example, the health plan didn't want to create a contract with the Aultman integrated network ("They said, 'We already contract directly with our doctors, so why would we give that up?' "). Aultman had to explain that the network could do more.

- ➔ Reflecting on his role as a trustee of Boston Healthcare for the Homeless (which has a 110-bed respite facility), Tringale said that it is important to demand horizontal transformation from all players: "You need a care management team integrated across the board — you need to demand that the post-discharge providers, such as rehab, strive for similar quality as what you provide. Hospitals need to be more conscious of the conditions into which they discharge patients. You can't expect to discharge a patient home to be cared for by an elderly spouse who can't help. There is so much variability between SNFs, not to mention within the SNF — quality can vary by floor or by time of day."

REFLECTIONS AND SUMMIT WRAP-UP

Moderator **Keith T. Kanel, MD, MHCM, FACP**
Chief Medical Officer, Pittsburgh Regional Health Initiative

Panelists **John Horty, AB, LLB** *Horty, Springer, and Mattern, Estes Park Institute*
Steven Tringale, CEO *Tringale Health Strategies, LLC*

Observations and advice for the region's community hospitals:

- ❖ Horty related his strong conviction that community hospitals can survive in the future. It will require change, but change is required in sectors throughout the U.S. economy. He believes that, in the future, although community hospitals will not be full-service institutions, they will be just as valuable as other components of the healthcare system. **It is crucial, Horty said, for hospital governing boards to understand that the payment system is changing.** The western Pennsylvania region is probably heading toward bundled payments, because this will allow for some FFS payments, but it is difficult to predict what the landscape will look like in 10 years. Assessing that future landscape is especially important, as physicians will stay connected only if the governing board is strong. They must believe that they have a future with the institution.
- ❖ **Tringale argued that, no matter where the region's healthcare system ends up, the change is going to be based on creating value in a different way.** He described the region's hospitals as being at the pivot point between value-based clinical care and valued-based reimbursement. Tringale believes that, while there will be some holding companies that provide services such as analytics, value is going to be created at the local (clinical) level. **There are real opportunities for the region's community hospitals — opportunities that include retaining their independence.** He further asserted that, moving forward, there will be broader collaboration at all levels (e.g., between inpatient and post-acute providers, between hospitals and medical staff), but that there are as many ways to respond to the current challenges as there are communities. Each hospital and each community is unique. Finally, he urged community hospitals to recognize that not only can they improve the health status of their communities, but that doing so *also* has an economic value outside the pure healthcare setting. Community hospitals are the natural place to organize this care. Even in the very large systems, we see a tremendous amount of variation at the local sites that those systems control. That's because the value is generated in these locally contained, community-based, primary care-focused delivery systems.



How hospitals not currently engaged in an ACO or in bundled payments can get started.

- ❖ Tringale argued that **hospitals should manage expectations and start small** — aiming not to make money, but to learn. He suggested that if the hospital wants to do bundles, it might work with PCPs or specialists, and use that model to learn and grow: *“Use the experience as a learning tool and an*

investment in where you are going to be in the long term. Focus on starting to change the culture, building a cohort that will be more accepting of the system in which these changes become the norm, rather than the exception. Don't look at it as a threat, but take the first step — on a strong foundation of core operational excellence, buttressed by a strategic direction.”

- ❖ Horthy indicated that, because they are more likely to be able to affect population health, **it will be easier for community hospitals to move toward bundled payments than it will be for big healthcare systems.** He noted that CMS is really looking to the community hospital to test this: *“This is a learning experience for all of us. Too few of us have tried to give care in our community, especially chronic care. I've been as guilty of this as any of us. In the future, the responsibility that community hospitals will have for the patients with chronic disease won't end at discharge; they will be ours until they die. But we are going to have to get paid for it.”*
- ❖ Tringale concurred, and noted that this is why it's important to align the incentives on the payment side. **It is critical that the reward systems support the hospital's goals and culture.** He also suggested that sending workers into the community is the best way to extend a hospital's brand. This might be done by co-branding certain specialty services with an academic site. The risk is that if the hospital does this for 10% of its patients, the other 90% will want the same level of care. He cautioned, further, against doing this as a demo.

What community hospitals will look like in five years?

- ❖ **Horthy envisioned arrangements in which community hospitals come together, without joining their assets, and without competing with each other.** Telemedicine, for example, can help make this possible. The future may require returning to an older model in which hospitals raised money from — and were accountable to — their local communities. He suggested that updating the Hill-Burton Act (in which hospitals were placed in underserved areas) would be beneficial in making the current transformation.
- ❖ Tringale agreed with Horthy that **community hospitals will need a new capital strategy.** Hospital management will have to be looking at *real* ROI — defined not just as bricks and mortar or IT capacity, but also as intellectual capacity, ability to link to post-acute providers, and ability to perform the analytics necessary to improve population health. **Management teams will need to be restructured to focus on post-acute care, going well beyond hospital-physician relationships.** He emphasized that this change doesn't mean that the hospital takes ownership of post-acute providers, but that it develops different kinds of relationships with them. These relationships should also include more direct links to the social service providers in the community.
- ❖ Tringale also **anticipates that there will be a strong and growing emphasis on geriatrics.** “It's going to be one of the hallmarks of the evolving system. Hospitals will have an incentive to slow down how fast its older population dies off.” And he pointed out that population health management will provide an overall economic value to the community and its workforce.

SPEAKER BIOGRAPHIES

John Bluford III, MBA, FACHE

President Emeritus, Truman Medical Centers; President, Bluford Healthcare Leadership Institute

John Bluford is a nationally renowned visionary leader who has spent his entire career building and shaping talented teams of healthcare professionals focused on developing a positive innovative culture that has transformed public sector and safety net institutions to create “quality net” assets for their respective communities. Bluford has been recognized by *Modern Healthcare* as one of the Most Influential People in Health Care. In 2011, he served as chair of the American Hospital Association. He is also past chairman of the National Association of Public Hospitals, the Missouri Hospital Association, and the Greater Kansas City Chamber of Commerce. In 2013, Bluford was the recipient of the National Center for Healthcare Leadership — Gail Warden Leadership Excellence Award.

Michael Wolf

Secretary, Department of Health, Commonwealth of Pennsylvania

Michael Wolf was confirmed as Secretary of the Pennsylvania Department of Health in May 2013. As the Commonwealth’s top health regulator, Secretary Wolf heads one of the nation’s leading public health agencies with a budget of more than \$800 million. Under his leadership, the Department of Health is committed to modernizing the Commonwealth’s healthcare system and improving access to essential health services for all Pennsylvanians. Secretary Wolf has worked to bring additional medical services to rural and underserved communities, increased funding for community health centers, improved telemedicine services, and expanded programs that attract and retain healthcare practitioners. He is a graduate of Slippery Rock University, where he earned a Bachelor of Arts in Political Science. He also holds a master’s degree in Business Administration, with a focus on Global Management, from the University of Phoenix. Secretary Wolf’s vision for Pennsylvania is one in which every resident has access to affordable, high-quality health care.

Tony G. Farah, MD, FACC, FSCAI

Chief Medical Officer, Allegheny Health Network; President, Allegheny Clinic

Tony Farah is the chief medical officer (CMO) for Allegheny Health Network, a nationally recognized integrated healthcare system that serves the greater western Pennsylvania region as the provider arm of Highmark Health. As CMO, Dr. Farah is the network’s senior-most medical officer and is responsible for ensuring that the highest standards of patient care, quality, safety, and service excellence are achieved across the system’s eight hospitals and more than 2,100 employed and affiliated physician practices. He also serves as president of Allegheny Health Network’s physician organization, the Allegheny Clinic; leads one of the region’s premier interventional cardiology practices based at the network’s flagship Allegheny General Hospital (AGH); and served as a trustee of one of his field’s most prestigious scientific organizations, the Society for Cardiovascular Angiography and Interventions. Prior roles for Dr. Farah include CMO of AGH from 2009 to 2011 and medical director of AGH’s Cardiac Catheterization Laboratories from 1997 to 2011. In this latter capacity, he played a prominent role in many innovations that have dramatically improved the treatment of patients with coronary artery disease — from new disease-fighting medications to procedures such as balloon angioplasty and stent implantation. Throughout his career, Dr. Farah has been the principal investigator or co-investigator of well over 100 clinical trials, and his work has been featured in many of the industry’s premier, peer-reviewed scientific journals. *Pittsburgh Magazine* has recognized Dr. Farah annually since 1998 as one of Pittsburgh’s “Best Doctors” in the field of cardiology, and in 2014 he was named *the Pittsburgh Business Times’* Healthcare Hero Award recipient in the category of healthcare executive.

Martin S. Gaynor, PhD

E. J. Barone Professor of Economics and Health Policy, and Chair of Governing Board, Health Care Cost Institute, Carnegie Mellon University

Martin Gaynor is the E. J. Barone Professor of Economics and Public Policy at Carnegie Mellon University, and former director of the Bureau of Economics at the Federal Trade Commission. His research focuses on competition and antitrust policy in healthcare markets. He has written extensively on this topic, testified before congress, and advised the governments of the Netherlands and the United Kingdom on competition issues in health care. Dr. Gaynor received his bachelor of arts degree from the University of California, San Diego in 1977 and his doctorate from Northwestern University in 1983.

John Harty, AB, LLB

Harty, Springer & Mattern, Estes Park Institute

John Harty is one of the founders of the law firm Harty, Springer & Mattern, PC. He now serves as managing partner of the firm, which is located in Pittsburgh. Through Harty Springer seminars, Harty has educated board and medical staff leaders for decades on topics such as governance, medical staff leadership, compliance, quality, and strategic planning for hospitals. He has promoted healthcare leadership through his service as the chair and a faculty member of the Estes Park Institute of Englewood, Colorado, a nonprofit corporation that presents educational programs for healthcare executives, physician leaders, and trustees. Harty is the past chair of the boards of directors of St. Francis Central Hospital and St. Francis Hospital, both in Pittsburgh. In addition, he has served on the boards of Mercy Hospital and Mercy Health Care System, also in Pittsburgh. His reputation in the healthcare industry — especially his support of community hospitals — is well established. Harty is a past board member of the Hospital Council of Western Pennsylvania and the Hospital Association of Pennsylvania, an honorary fellow of the American College of Healthcare Executives, and a recipient of the Award of Honor of the American Hospital Association, and he holds an Honorary Life Membership in the American Hospital Association.

Joseph Martin

Executive Director, Pennsylvania Health Care Cost Containment Council (PHC4)

Joseph Martin joined the Pennsylvania Health Care Cost Containment Council in 1991, and he was appointed to the executive director position in November 2009. In this role, Martin provides leadership to a professional and technical staff of 28 and is responsible for overseeing all agency operations, including the planning, directing, coordinating, and executing of all PHC4 initiatives. Martin also works with a 25-member council to set policy and work priorities, as well as to plan and implement the future direction for PHC4. He has more than 30 years of experience in the public relations field, including public, government, and media relations, policy development, and nonprofit fundraising for various organizations. Previously, Martin served as PHC4's director of communications, and was responsible for the dissemination of PHC4's reports, developing strategies for communicating the agency's information and reports to its key customer groups, providing editorial oversight for all PHC4 publications, including the PHC4 website, and responding to all media requests for information. He supervised the Council's Special Requests Unit, which provides standard and customized datasets to a variety of data users, and the Financial Unit, which collects, analyzes, and publishes financial data for Pennsylvania's general acute and specialty hospitals, as well as outpatient surgery centers. Martin has been widely quoted in the academic, healthcare, and popular press internationally, in the U.S. and throughout Pennsylvania regarding PHC4's findings and reports.

Marion McGowan, RN

EVP & Chief Population Health Officer, Lancaster General Health

President, Lancaster General Health Innovative Solutions, Inc.

President, Lancaster General Health Community Care Collaborative, LLC

Marion McGowan is a healthcare executive with over 20 years of experience in leading healthcare delivery organizations across the spectrum of the care continuum. Her past experiences include serving as the president of large and small acute-care hospitals, chief operating officer of a large community health system, and executive leader for home healthcare, physician medical groups, a skilled care facility, and other post-acute care services. Presently, she serves as the executive vice president and chief population health officer at Lancaster General Health, the president of Lancaster General Health Community Care Collaborative, an ACO located in Lancaster County, Pennsylvania, and president of the Lancaster General Innovative Solutions company. McGowan has a bachelor's degree in nursing and a master's degree in public health management, and is a doctoral candidate in the philosophy of leadership.

Harold D. Miller

President and CEO, Center for Healthcare Quality and Payment Reform

Harold Miller is the president and CEO of the Center for Healthcare Quality and Payment Reform. He is a nationally recognized expert on healthcare payment and delivery reform, and has worked with physicians, hospitals, employers, health plans, and government agencies in more than 30 states and regions. He has given testimony to Congress on how to reform healthcare payment, and has authored a number of papers and reports on payment and delivery reform. Miller also serves as adjunct professor of Public Policy and Management at Carnegie Mellon University, and he serves on the board of directors of the National Quality Forum.

Jennifer Perloff, PhD

Scientist, Deputy Director, Institute on Healthcare Systems, The Heller School, Brandeis University

Jennifer Perloff is a scientist and deputy director at the Institute on Healthcare Systems within the Schneider Institutes for Health Policy. She has over 15 years of experience in evaluation and health services research. She currently co-leads a team that has developed analytics to support hospitals participating in the Center for Medicare and Medicare Innovation (CMMI) Bundled Payment for Care Improvement demonstration, including ongoing monthly and quarterly reports. Dr. Perloff has worked with numerous hospitals to identify opportunities and understand risk within the context of the CMMI demonstration. She is also co-leading a project to develop behavioral health bundles for a managed behavioral health company in New England, and has looked at other specialty bundles as well. Dr. Perloff is involved in a number of other projects focused on the analysis of large claims data sets, including a project to design episodes of care within Medicare, developing a method to assess value of Medicare Advantage plans, and comparing the cost and quality of nurse practitioner versus physician delivered primary care.

Hoangmai H. Pham, MD, MPH

Director, Seamless Care Models Group (SCMG), CMS Innovation Center, Centers for Medicare & Medicaid Services

Hoangmai Pham is a general internist and director of the Seamless Care Models Group at the CMS Innovation Center, where she oversees demonstrations on accountable care organizations and advanced primary care. SCMG currently sponsors the Pioneer ACO Model, Comprehensive Primary Care Initiative, Advance Payment and ACO Investment Models, and Comprehensive ESRD Care Initiative, and actively develops new models. Previously, Dr. Pham was senior health researcher and co-director of research at the Center for Studying Health System Change and Mathematica Inc. in Washington, D.C. She has published extensively on care fragmentation and coordination, quality reporting and improvement, health disparities and provider market trends, and the intersection of each of these with payment policy. Dr. Pham provided primary care at safety net organizations for many years. She was named the Alice S. Hersch Young Investigator by Academy Health, was awarded the

Donabedian Health Care Quality Award by the American Public Health Association, and was a Robert Wood Johnson Clinical Scholar at Johns Hopkins.

Edward J. Roth III

President and CEO, Aultman Health Foundation, Canton, Ohio

For over 30 years, Edward Roth has been part of a team dedicated to providing excellence and affordability in health care. He began his career with Aultman in 1981 and was named president and chief executive officer in 2001. Since that time, he has led Aultman with a spirit of compassion and a true belief in the power of each individual to make a difference. Roth is responsible for more than 5,000 employees and all corporate entities within Aultman Health Foundation. He is a graduate of the University of Akron.

Steven Tringale

CEO, Tringale Health Strategies, LLC

Steven J. Tringale is the president and chief executive officer of Tringale Health Strategies, LLC (THS). Prior to the establishment of THS, he was the managing director of Hinckley, Allen & Tringale, LLP, a healthcare consultancy affiliated with the law firm of Hinckley, Allen & Snyder, LLP. Tringale has also held a number of senior executive positions in large healthcare companies, including the position of president of the senior division of Blue Cross & Blue Shield of Massachusetts (BCBS). In that role, he managed a division, which encompassed almost 400,000 subscribers to private health insurance products, and he administered the Medicare benefits for 1.8 million seniors in the region. Prior to his appointment as president of the senior division, Tringale joined the company as the senior vice president for external affairs. In this role, he was the founding incorporator and executive in charge of the Massachusetts Caring for Children Program, an insurance product created to assist low- and moderate-income families to insure their children. Tringale was responsible for all of the external strategic relationships of the corporation, including legislative affairs, regulatory affairs, public relations, labor relations, communications, advertising, and public policy development. Prior to his experience at BCBS, he was the senior vice president for health policy for the Life Insurance Association of Massachusetts (LIAM), an association of major commercial insurers. It was in this role that Tringale was responsible for the development of public policy for commercial health insurers, as well as the creation of reimbursement and product strategies for LIAM member companies. His earlier experiences also include positions at the Massachusetts Rate Setting Commission and the Joint Committee on Health Care in the Massachusetts Legislature. Tringale is currently a senior fellow of the Estes Park Institute and speaks throughout the year to hospital senior leadership teams, medical staff, and board members, from across the country, on a variety of topics. He has presented to numerous groups and has testified in front of many state legislatures and congressional committees.

Keith T. Kanel, MD, MHCM, FACP

Chief Medical Officer, Pittsburgh Regional Health Initiative

Keith Kanel is the chief medical officer for the Jewish Healthcare Foundation and its supporting organizations. He oversees relationships with regional health systems, community primary care groups, and clinical and academic physician organizations. He is director of the multistate Primary Care Resource Center Project (PCRC), funded by the CMS Innovation Center, as well as principle investigator for initiatives funded by the Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation. Dr. Kanel's focus areas include quality improvement, health delivery systems, and payment policy. He is also medical advisor to the CMS Qualified Entity Project for public reporting in the state of Pennsylvania, and led a joint effort by PRHI and the Allegheny County Health Department to issue updated guidelines for preventing, testing, and treating *Legionella bacteria*. He is an internal medicine physician with over 20 years of clinical and administrative experience in prominent academic medical centers and progressive integrated delivery systems. He was previously chief of general internal medicine at Allegheny General Hospital, where he co-founded one of the region's first hospitalist services and was director of its primary care training program. Dr. Kanel later led successful quality and patient

safety initiatives at the UPMC Health System. He has served on the faculties of the University of Pittsburgh School of Medicine, the Drexel University College of Medicine, and the Carnegie Mellon University H. John Heinz III School of Public Policy and Management. He has been named to the Best Doctors in America list, and has been cited multiple times as a “Top Doctor” by *Pittsburgh Magazine*.

Karen Wolk Feinstein, PhD

President and Chief Executive Officer, Jewish Healthcare Foundation, Pittsburgh Regional Health Initiative, and Health Careers Futures

Karen Wolk Feinstein is president and chief executive officer of the Jewish Healthcare Foundation (JHF) and its two supporting organizations, the Pittsburgh Regional Health Initiative (PRHI) and Health Careers Futures (HCF). Appointed the Foundation’s first president, Dr. Feinstein has made JHF and PRHI a leading voice in patient safety, healthcare quality, and workforce issues. When Dr. Feinstein founded PRHI, it was among the nation’s first regional multi-stakeholder quality coalitions devoted simultaneously to advancing efficiency, best practices, and safety in health care through the use of industrial engineering principles. Dr. Feinstein also founded Health Careers Futures to assist the region’s healthcare industry in attracting, preparing, and retaining employees, and was a leader in the formation of the Network for Regional Healthcare Improvement (NRHI), a national coalition of Regional Health Improvement Collaboratives that supports national policy efforts to improve healthcare quality and value. Dr. Feinstein is widely regarded as a national leader in healthcare quality improvement and often presents at national and international conferences. She is the author of numerous regional and national publications on quality and safety; she was the editor of the *Urban & Social Change Review*; and she is the editor of the book *Moving Beyond Repair: Perfecting Health Care*. Additionally, she has served on the faculties of Boston College and Carnegie Mellon University, and taught at the University of Pittsburgh. Dr. Feinstein has previously held executive posts at other nonprofits, including the United Way, and is a past president of Grantmakers In Health. She serves on a number of nonprofit and for-profit boards, including the board of directors and executive committee of NRHI; the board of directors of the Allegheny Conference on Community Development, United Way of Allegheny County, Allegheny County Parks Foundation, and Institute of Politics; and as co-chair of the board of directors for the Pennsylvania Health Funders Collaborative. Dr. Feinstein earned her bachelor’s degree at Brown University, her master’s degree at Boston College, and her doctorate at Brandeis University.



Centre City Towers
Suite 2400
650 Smithfield Street
Pittsburgh, PA 15222
412-594-2550