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# For Board Members Only: Trends and Strategic Implications for 2010

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The year 2010 is about the recovering economy, continued high unemployment, and healthcare reform. There are fundamental priority areas that require focus and attention during these changing times. Changes in payment structure, the economy, and delivery system changes are a catalyst to accelerate action and there will be winners and losers. The following ten trends and their impacts are The Camden Group's best advice to board members and senior leadership to preserve and enhance your organization's financial and clinical success in this evolving environment.

## 1. Healthcare Reform: Payment and Payer Mix Changes

The true picture and details of healthcare reform will take shape as approved legislation is translated from concept into functional policies, programs, and regulations. **The implementation will take months and, in some cases, years.** The most profound impact will be felt in reimbursement change, impacting Medicaid, Medicare, disproportionate share hospital payments, and even commercial payment rates. We anticipate that the majority of provider services will be reimbursed at or near Medicare rates over the next three to five years. Due to competition and market forces, it is very likely that within the next few years, commercial health plans will lower their premiums to match government and co-op health insurance options. It follows that payments to providers also will be reduced. Hospitals with a good payer mix should be most concerned, as they will be most affected by these changes.

*Key questions to consider:* Will you be able to maintain a positive operating margin if commercial insurance payment rates are adjusted to Medicare reimbursement levels? Although approximately 30 million additional people are targeted to eventually have some form of health insurance, if payment rates for these currently uninsured/indigent patients are at or below Medicare levels, can you lower your costs enough to make up the difference on volume?

***In the Boardroom***

- *Model the financial impact of declining reimbursement rates and your performance.*
- *Assess the potential impact on financial performance if reimbursement for commercial health plans declines by 10 or 20 percent, or more.*
- *Identify ways to significantly reduce clinical resource consumption per patient. What would it take to reduce operating expenses by 10 or 20 percent or more?*
- *Consider economic alignment with physicians through incentives to enhance clinical effectiveness and cost.*

## 2. The Economy: Expect the Worst, Hope for the Best

As we begin our recovery from the recession, unemployment will likely remain high through 2010. Demand for healthcare services will remain low, and bad debt will persist at current levels or go up. Many laid-off employees cannot afford to pay for COBRA health benefits, even with subsidies. Charity and indigent care levels will remain high, as PPO enrollment increases and volume softens. Enrollment in Medicare Advantage will remain constant until changes to premiums and benefits kick-in. Medicare Advantage providers will feel the impact of reimbursement reductions this year (hierarchical condition category [HCC] and risk adjustment factor [RAF] improvements are good for one year).

***In the Boardroom***

- *Monitor utilization and financial performance indicators for the hospital; drive throughput higher; monitor elective procedures and payer mix.*
- *Monitor key bond rating indicators for signs of strength or deterioration. Don't fall into the trap of thinking that the organization is back on stable financial footing because the investment portfolio has rebounded with stock market gains. EBIDA, days cash on hand, and operating margin are still the best financial health barometers to watch.*
- *As always, track days in accounts receivable, bad debt, and charity care levels; be vigilant about good revenue cycle practices.*

### 3. Physician–Hospital Alignment

Physicians have felt the impact of the recession as acutely as hospitals. Patient volume and revenues generally have fallen for many primary care physicians and specialists. Healthcare reform initiatives will favor primary care and will be tough on specialists and sub-specialists. Physician supply will be recalibrated through the economics of reimbursement, from educational subsidies to payment levels for procedures. As medical home and Accountable Care Organization (ACO) models take root, primary care physicians are once again headed to the front of the "food chain!" Hospitals will work closely with specialists as bundled payments, clinical integration, and value-based purchasing (VBP) programs continue to grow. Hospitals will continue to employ more primary care and specialty physicians in order to enhance access and create a platform for better care coordination. Physicians will continue to show preference for employment by hospitals, health plans, and large medical groups to find safety in numbers, ease of practice, and more balanced lifestyles.

***In the Boardroom***

- *Review your organization's medical staff/community needs assessment plan very carefully. Look for looming shortages in primary care and key specialty areas. How will you attract high quality, culture-compatible physicians to your medical staff?*
- *Ensure that you have structures and vehicles available to easily assimilate new physicians into practice as well as retiring physicians looking for part-time work/practice.*
- *Closely monitor physician satisfaction scores to ensure responsiveness to concerns. Do not neglect your core supporters as you pursue new recruits.*
- *Work with specialist physicians to reduce costs in your "bundled service lines."*

### 4. Clinical Integration and Changing Delivery Models

Hand-in-glove with physician–hospital alignment is the movement toward clinical integration. Hospitals and physicians will further align clinical and financial incentives patterned after entities that have created models that meet federal and health plan guidelines and rigorous standards of integration. Payment reform and pilot initiatives support and financially reward clinical and financial integration. Bundled payment structures (e.g., acute care episodes, VBP) for selected cardiac and orthopedic procedures are being piloted currently, and will likely expand to other providers and procedures. ACOs will be introduced with the objective of allowing qualified providers to assume responsibility for overall costs and quality of care for defined populations. 2010 is the year to prepare for clinical integration and coordinated care delivery.

***In the Boardroom***

- *Assure that evidence-based protocols that include cost factors are being established and used effectively.*
- *Partner with physicians to examine current status and capabilities to integrate financially and clinically, including the ability to accept and manage bundled payments for specific services.*
- *Coordinate clinical integration initiatives with overall cost control strategies required to make money at Medicare reimbursement rates.*
- *Consider using multi-disciplinary task forces or other methods to assess care delivery processes and to increase throughput, right-size under-performing services, streamline care, expand access, and reduce all-but-essential overhead costs.*
- *Begin to access the quality and cost of your continuum of care (e.g., home health, SNF, ambulatory)*

### 5. Consolidations and Closures

The evolving healthcare delivery environment will create opportunities for some and catastrophe for others. Hospitals that cannot survive will be acquired, converted to alternative use, or closed. We do expect to see a number of hospitals close during the next five years. Hospitals that survive will generate sufficient patient volume (e.g., operate at 90 to 95 percent occupancy), manage payer mix, significantly reduce overhead, and achieve high throughput. Market forces will drive consolidations where there is financial and competitive rationale to combine resources and correct for size based on market need.

***In the Boardroom***

- *Assess your market to determine if there are opportunities to acquire or merge with another institution to consolidate services, achieve economies of scale, eliminate duplication, capture market share, and improve financial performance.*
- *Assess your risk for becoming a take-over target or for insolvency under reform payment levels. Is it appropriate to develop an exit strategy as a contingency?*
- *Evaluate your portfolio of services and other assets—what tough decisions need to be made to chart the right course?*

### 6. Organized Labor and Workforce Supply

Organized labor was very supportive of the healthcare reform agenda of President Obama. Expect unions to aggressively continue to organize healthcare workers in order to build membership. Their top priority thereafter is to push for mandated staffing ratios among nurses and allied professionals. The demand for allied health professionals will mean greater need to support advanced nursing training, programs, and recruitment.

***In the Boardroom***

- *Monitor employee satisfaction survey results and other morale indicators.*
- *Cross-train allied professionals to perform other duties (e.g., nurses doing respiratory therapy).*
- *Keep an eye on turnover rates overall and in key departments and service-line areas. Look for root causes, as higher than normal turnover rates can be symptoms of poor leadership or other problems to address.*
- *Support clinical care redesign initiatives that address more efficient utilization of clinicians.*

### 7. Capital Access and Expenditures

Access to capital will be difficult in 2010. Strategic planning will have to focus on resource allocation, net income generation, and preparation for the new era in healthcare delivery. Capital expenditures should be focused on essential projects that reinforce core competencies, critical information technology infrastructure, revenue generating equipment and services, and streamlining care processes.

***In the Boardroom***

- *Building projects will be the exception rather than the norm for most.*
- *Follow strict criteria for assessing and prioritizing capital projects—there must be clear return-on-investment thresholds and other qualifying criteria for approving expenditures.*
- *Evaluate underperforming assets and sell or divest if prudent.*
- *Focus on operating performance improvement and optimize revenue management.*

### 8. Information Technology

Healthcare reform notwithstanding, investments in appropriate IT resources are essential. Clinical information systems, CPOE, and EMR (both physician office and hospital) are all key components of ensuring high quality, efficient standard-of-care service. Financial rewards as well as penalties are tied to IT adoption under reform guidelines. New delivery models and payment reform require EMR.

***In the Boardroom***

- *Assess IT plans to assure progress is being made to develop integrated EMRs, linking ambulatory, office, and inpatient EMR systems to facilitate real-time reports and patient access.*
- *Assure that "meaningful use" criteria are being met in order to access federal subsidies for both the hospital and physicians.*
- *Look for partnerships with vendors, pharmaceutical companies, and other clinical/research entities that may offer grants, discounts, or subsidies.*
- *Monitor IT integration to ensure that technology streamlines and enhances care, decision making, and ease of access, rather than complicating it.*
- *Involve physicians, patients, and other users in the evaluation and adoption process.*

### 9. Clinical Quality/Patient Outcomes

Typical pay-for-performance (P4P) programs will evolve to include both quality metrics and cost. Reporting on quality will continue to be of increasing importance and will have significant impact on whether you receive full payment for services rendered. Payments will be affected positively (gainsharing under bundled payment and ACO programs; P4P; and value-based purchasing) and negatively (e.g., reduced payment for readmissions, hospital-acquired infections, and others.) Public posting (transparency) of quality and patient safety data and indicators will require internal vigilance to ensure performance levels are achieved.

***In the Boardroom***

- *Monitor key quality indicators and benchmark against national standards, as well as your organization's own historical performance.*
- *Ensure that systems are in place to maximize P4P, gainsharing, and other financial incentives available that reward demonstrated high quality.*
- *Consider discontinuing low-volume, non-essential programs that fail to meet quality standards.*

**10. Value**

Patients will have more choice in 2010 and beyond. Over time, healthcare reform will level the "paying" field. Choice will be made based on value, benefit design, provider network, accessibility, and perceptions of quality. Physicians, hospitals, and other providers will need to focus on brand identity and demonstrating quantifiable indicators of value.

***In the Boardroom***

- *Focus on lower-cost, high-volume, superior service.*
- *Evaluate each service line against what the best in the industry are doing, and set a standard to meet or exceed their results—in quality, financial return, community service, or other criteria you have set.*
- *Spend time in each board meeting discussion "strategic value" in terms of brand identity, patient preference, physician choice, and market position.*

**Last Word**

2010 may well be remembered as the defining inflection point of the U.S. healthcare industry. The status quo has been re-established at a higher plateau of performance equilibrium. This is and will be a decade of opportunity, challenge, and reinvention, which will require leadership that can adapt, advance, and perform. Ask many questions and be willing to explore new strategies and ideas to keep your organization healthy, growing, and successful in these changing times.

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