# TORCH 2018

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DISCOVERY

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# SLIDES AVAILABLE

- www.dhcg.com/torch2018

# THE PAYMENT PRECIPICE….

- Keeping your facility off the edge.
- What about if we are already off the edge?

# OTHER TOPICS AT TORCH

- Transforming Healthcare…
- Waiver Renewal
- Alternative Payment Models (Means less money, in government speak)
- Start Collaborating, Stop Competing (agree, we have to get over rivalries)
- Rural Strong!  Where is the #?

# POSSIBLE TOPICS WE COULD TALK ABOUT

- Waiver & Medicaid (UHRIP, UCC, DSRIP, Etc.)
- Federal Changes (LVA, MDA, etc.)
- Any other acronym's?
- There are always operational issues
  - Coding
  - Staffing
  - etc.

# BUT….

- Does that move the needle?
  - Does it keep us from falling over the edge?
- Or does that just maintain the status quo?

- Is there anything new?

# SURVIVAL VS THRIVING.

- Is the status quo only survival?
  - Is it simply kicking the can down the road to ultimate failure?
- Are we leapfrogging from government program to government program?
  - And it is critical that they are renewed! LVA, MDH, Waiver, etc.
- Is this survival and is survival on life support the goal?
  - Is survival really acceptance of hospice care for some institutions?
- What does it take for rural hospitals to thrive?
  - We have to serve the population.
    - With comparable service and quality
    - With efficiency

# WHAT DO THESE COMPANIES HAVE IN COMMON

- Uber
- Apple
- AirBNB
- Facebook
- NetFlix
- Amazon
- Toys ‘r us

# COMMON TRAITS

- Entrepreneurial
- Changed the status quo
- Became the status quo

# TOYS ‘R US

- Toys R us – an historic disrupter  (before it was cool)
  - Killed the local toy store, gave us the big box toy store
- Killed by Amazon or killed itself?
  - Lack on engagement with customers – Lego stores going strong
  - Did not embrace technology games – just another isle
  - Lack of imagination
  - Dies due to the inability to move to an internet based platform
    - Notice Walmart’s shift!

# DISRUPTIVE COMPANIES

- Richard Branson said, "Disruption is all about risk-taking, trusting your intuition, and rejecting the way things are supposed to be."
- Disruptive technologies and has been called the most influential business idea of the early 21st century.
- Disruptive innovations tend to be produced by outsiders and entrepreneurs, rather than existing market-leading companies.
    - Existing companies don't want to fail or get fired.

# DISRUPTIVE HEALTHCARE

- Is that an oxymoron?
  - Personable accountant?
  - Good attorney?

# BECKERS LIST OF DISRUPTIVE HEALTHCARE 2017

- FORWARD – Health Membership for wellness
- MDLABS – Individual patient genetic based pharmacy
- MEDALOGIX – Home Health clinical analytics
- MEDXCOM – Answering service integrated to EHR
- NEXT IT Healthcare – Artificial intelligence patient engagement
- Patientory – Facebook for healthcare
- Preocyrion – Heart care
- Solera Health – Chronic Disease
- swyMed – Real time Telemedicine consults
- Twin Sails Technology Group – Tablet EHR
- Welltok – CafeWell Consumer Health Optimization

# ASCENSION HEALTH

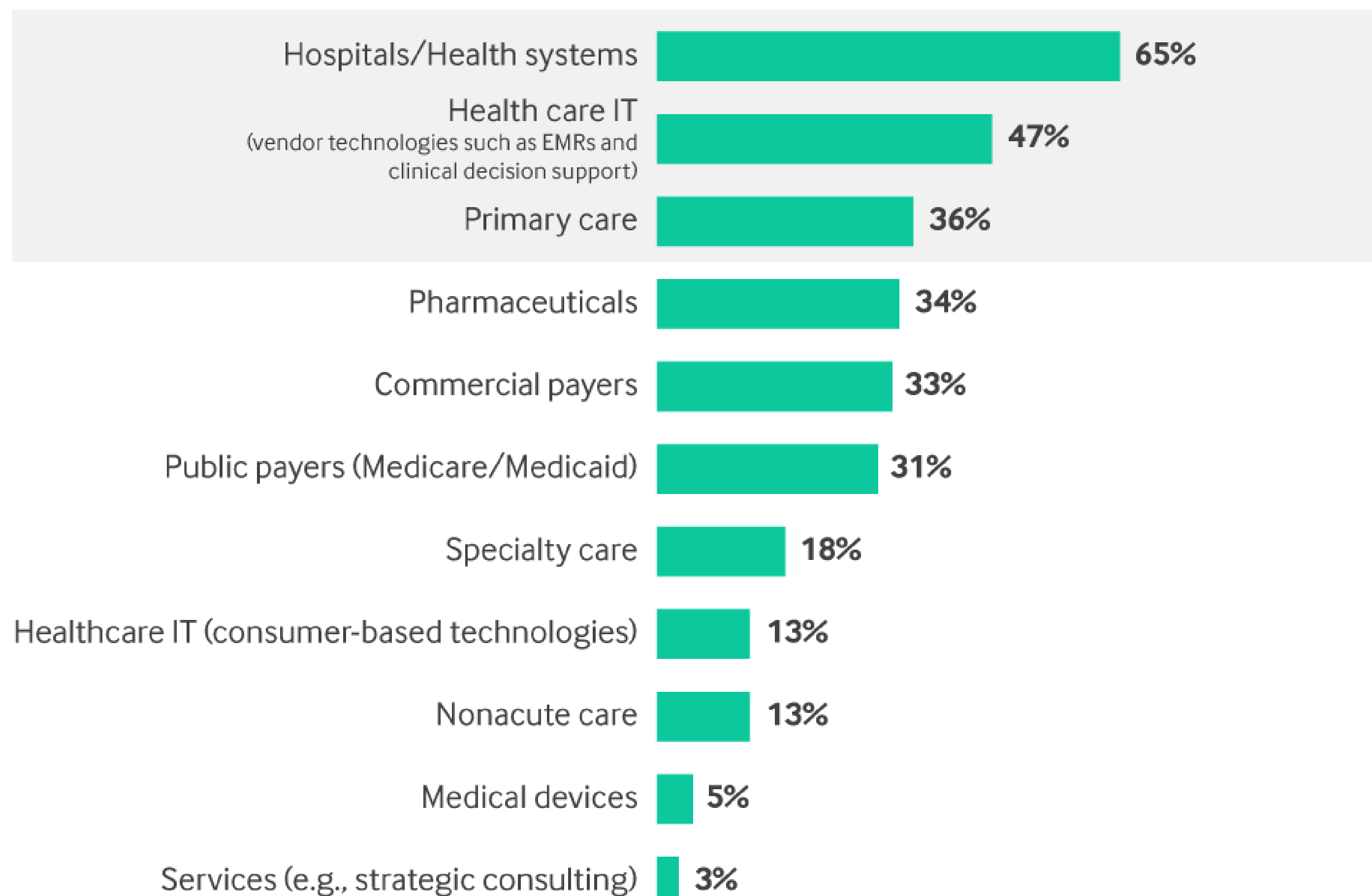
- New Virtual Market Development & Incubations Group
  - Bring outside entrepreneurial talent
  - Create a parallel business
  - Innovate people to innovate business
  - Fall in love with the problem, not the solution – focus on the customer
  - Be your own petri dish

From Inc.com 9/18/17

# DISRUPTIVE TECHNOLOGIES

- Managed Healthcare
  - 3-D Bioprinting
  - Remote care by smartphone
  - Big data & genomics
  - Telehealth – on demand & convenience
  - Consumer facing tools – informed consumers on quality convenience & cost
- Forbes – By 2020
  - Artificial Intelligence – in 90% of all hospitals by 2025
  - Immunotherapies
  - Liquid Biopsies – DNA based  - Cologuard
  - CRISPER – Gene  editing
  - 3D Printing

# NEJM - WHERE IS DISRUPTION NEEDED?



# DISRUPTION IN RURAL HEALTHCARE – FEW ARTICLES / STUDIES

- Physician assistant primary care
- Telehealth for specialty consults – benefit proportional to the hours of travel
- Patient Centered Medical Home

# WE NEED DISRUPTION

- But what does this have to do with accounting & reimbursement?

# DISRUPTION IN THE PAST

- How many hospitals that are in QIPP/MPAP thought they would ever own nursing homes 5 years ago?
- Had anybody ever heard of a service organization 12 years ago?
- Who thought DSRIP was a….
- Who thought we would partner with managed care for UHRIP?
- The Waiver was disruptive
  - Public and private hospitals partnering and collaborating
- CAH legislation was disruptive
  - We need the NextGen version of CAH

- and we need more….

# DISRUPTIVE IDEAS FOR THE FUTURE

- Make some noise in Austin & Washington
  - Focused on long term solutions, not handouts or exceptions
- Initiate programs to recapture out migration
- Look at vertical integration & Cooperatives
- Vendors with disruptive products
- Actually negotiate managed care contracts – What about an IPA on a collaborative or Coop basis?

# LOBBY EFFORTS

- Federal level – Save my hospital Act HR 2957
- State Level – Various issues
  - Telehealth – What about a NAIP like program for rural only?
  - Government / LPPF
  - UHRIP / Waiver

# STATE ISSUES - UHRIP

- Waiver renewal
  - Exec. Comm. Smith has already covered most of this…
  - 3 TORCH Tele meetings in January
- UCC - Medicaid shortfall will be made up by UHRIP
- UHRIP is growing from the current year $600M to $1.25B next year.
- UHRIP does not have significant benefit for rural providers under the current UCC program
  - Rider 38 hold harmless is the reason
- UCC is paying about 80% of the Medicaid shortfall at an IGT rate of 43.12% vs. UPRIP at 100% of the shortfall at an IGT cost (including all the MCO cost) of about 50%.
- Basically UCC is offset almost 100% for the UHRIP gain, with no incremental dollars.

# UHRIP IN DY 9 (FYE 2020)

- That all changes in DY9 with the charity based UCC.
- There is no offset of UCC for UHRIP, thus rural will gain.
  - The problem is that rural has been silent and overlooked in many markets for UHRIP
    - Not participating or funding their IGT's
    - Not returning documents
  - Next year (DY8), many of the regions are proposing a reduction to rural UHRIP, which is not costing rural now, but this is not a precedent that needs to continue. This actually helps the total state funding.
- We need rural facilities to become participatory.
- HHSC has discussed a UHRIP solution for rural facilities to help offset losses under the charity rules
  - We need the limits and percentages increased over the UHRIP concept paper levels
  - We need support from HHSC for higher rural UHRIP rates in 2020.

# UCC FOR CHARITY CARE

- There have been several presentations on this subject
- The rules are set, and as much as well looked for some solutions from HHSC or CMS those are probably not going to occur.
- The issue is that the future pool size is based on data from the 2017 Year and the DY 9 payments will be based on the reported data from FFY 2018 cost reports S-10 data.
- Rural hospitals have never had an incentive to really report charity, thus it is materially underreported.
- So how do we fix this?

# FIXING THE S-10

- We are working on a solution with TORCH – Missed having it done for this meeting….
- Data screening tools for "presumptive charity" that have already been used in in Texas.
  - Christus, CHI, Providence, Covenant, Seton.
- Using non credit based data (Legal issues with credit files)
- Would like to do on a regional basis – maybe by RHP to reduce cost.
- It will be based on a per uninsured person screen, and will relatively modest cost. Hopefully less than 1% of the UCC… and much less in future years. Goal is that the gain in 10 to 20X the cost.
- If we don't do it is a group basis, the cost may be too high for the smaller rural facilities.
- Provider groups would need to agree on a percent of FPL.
  - 200% or 300% of FPL.

# STATE ISSUES

- It has been clear that rural is less represented in Austin than it was in the past…
  - True in Congress also
- Many rules such as Rider 38 payments, Medicaid cost based reimbursement, etc. are gone.
  - Why ?
    - Loss of volume
    - Loss of population
    - Loss of visibility
- We need participation…
- We need a little disruption…

# HARVARD STUDY ON RURAL HEALTH DISRUPTION

- **The Decline of the Rural American Hospital and How to Reverse It**
- There are two kinds of health-care innovation:
  - more-for-more – Typical of the American Healthcare system
  - more-for-less
  - "These [rural] hospitals are caught in a vicious cycle: Rural patients with serious health problems are traveling to cities to seek care from medical specialists, causing revenue declines at rural hospitals and clinics, which respond by downsizing and offering fewer services, causing more patients to seek care in major urban centers."
- **If your cutting services…. WE MUST RECAPTURE OUTMIGRATION**
- **Harvard focuses on Telehealth**

# TELEHEALTH

- Two distinct types of programs – usually based on who is paying
  - Urban outreach – Non disruptive
    - Taking the patient to the urban market
    - Protecting the urban market
  - Rural based – Disruptive
    - Keeping the patient local by providing the services locally
    - Designed to grow rural business
    - May need collaboration of cooperative joint ventures

# REVENUE GROWTH RECLAMATION

- Many of the revenue enhancement programs such as the one on CBS News will hurt rural hospitals favorable payment rates in the future.
  - Bad actors hurt all the compliant hospitals
    - Blue Cross
  - That type of revenue is not sustainable in the long term.
  - The old school practices of churning patients and pushing test is not sustainable.
- I prefer to call this "reclaimed revenue" from urban centers that has out migrated.
- This is also called "leakage" from the primary service area.
- Succinctly - "the goal is to increase the cars in the parking lot and the butts in beds".

# PATIENT EXPERIENCE IS KEY

- Offering the service is not enough
  - The perceived quality must be comparable
  - This also means the patient's family experience.
  - The patient portals, EMR, etc. may not be important to the elderly patient, but it will be to the distant son or daughter.
- Is there a portal for all your hospital and clinic patients?
- What about all your private physicians?

# EXAMPLE – COMMUNITY INFUSION SOLUTIONS

| | Outpatient IV / Injectable Drug Leakage | | |
|---|---|---|---|
| Facility | M/C Payments | Billed Charges | Leakage Facility |
| A | 317,171 | 1,132,754 | Panhandle Regional |
| B | 348,679 | 1,452,829 | Panhandle Regional |
| C | 166,302 | 639,623 | Central Texas Regional |
| D | 777,643 | 3,703,062 | Big System |

The opportunity is to disrupt these markets by scaling up their programs into Regional Centers of Excellence by engaging greater structure, marketing, and contracting. The dollars above note only patients engaging in care and not the pent-up demand which exist where comprehensive, boots on the ground marketing and community engagement will uncover to serve.

# COOPERATIVES & VERTICAL INTEGRATION

- Cooperatives can replace the traditional contracted services
  - Better Transparency, Less Cost, Better service
  - Does not have to eliminate the vendor, it could be a partnership, JV, or other arrangement.
  - Has to keep the entrepreneurial focus.
  - As a board the focus has to be on the cooperative, not the individual.
- Possibilities are more than just for GPO
  - Mid Level Management Specialist
  - Contracted Services - Laundry
  - Staffing
  - Physician Services – ER, etc.
  - HR & Benefits
- Recapture your profits

# EXAMPLE – MATERIALS MANAGEMENT

- What will happen if Amazon enters the supply business?
- It is easy to verify that we get the best price. (True or False)
- Transparency is non existent.
- Every big system will give you their GPO….They get the rebate,
  - But is the rebate giver the best price?
  - How can you know?

# EXAMPLE – BROADJUMP

- Broadlane was created as a Transparent GPO.
  - Passed all rebates down, but charged a fee
  - Sold for $850M
- BroadJump is based on transparent pricing comparisons on a real time, and always updated
- **“Introducing Disruptive Technology to the Healthcare Supply Chain”**
  - **Example is a pacemaker. Prices ranged from $2400 to $6000 for the same medical device.**
  - **Lets you focus on where the potential dollars and savings are.**
- Augments the GPO and compares the various GPO’s. But this requires detailed midlevel management compliance in order to achieve results.
- Working on a database on comparable contracted services

# MANAGED CARE CONTRACTING

- We are creating a database of every managed care contract that we have.
  - Data is available to assist in contact evaluation and negotiation – messenger model for anti trust
- Working with UHRIP also identified contract issues
  - Missing contracts
  - Missing updates
  - Some contracts not updated for years
  - Many not updated with current rates
  - Annual notices required for some CAH's not filed.
  - Rates and forms are not consistent
- Needs to looked at regionally
- On Medicaid, HHSC has made it clear that it is the providers responsibility to negotiate.

# MANAGED CARE

- SETH has performed the IPA type function
  - Outsourced the contracting – may not be directly accountable
- Multiplan - This is not your IPA. This is for the convenience of the MCO.
- Umbrella providers and systems – yes they have better contracts
  - High compliance level is required.
  - They are focused on surgical cases, not primary care. Disparate agendas.
- Cancel the contract. If you lose money why do you accept the contract?
  - Have to do it strategically. If Medicaid, we have to report for lack of network adequacy.

# HEALTHCARE OF THE PAST

# HEALTHCARE OF THE FUTURE

Questions?

Thank You!