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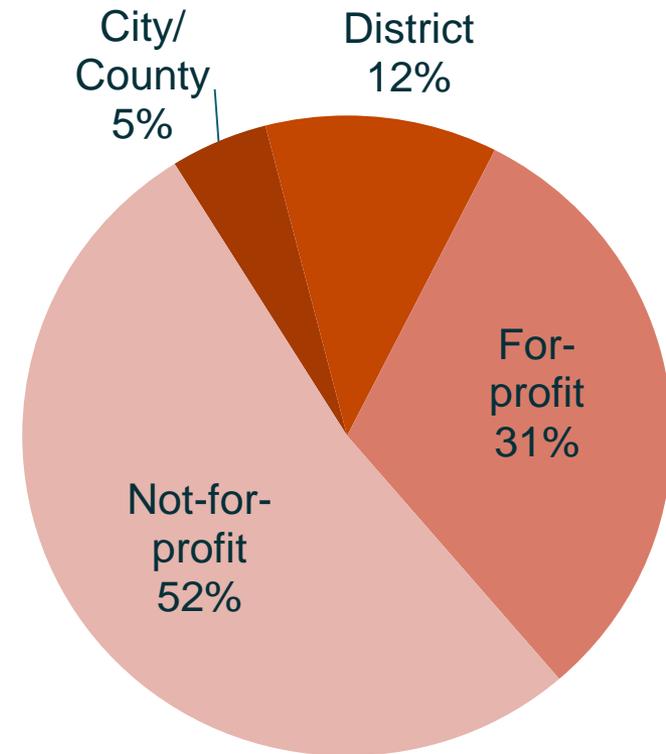
# Challenges in Hospital Management

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# Hospitals: Central to the Health System

- **32% of national health spending**
- **372 California non-federal hospitals in 2012**
  - 321 General acute care
  - 26 Psychiatric
  - 25 specialty (children's, heart, orthopedic)

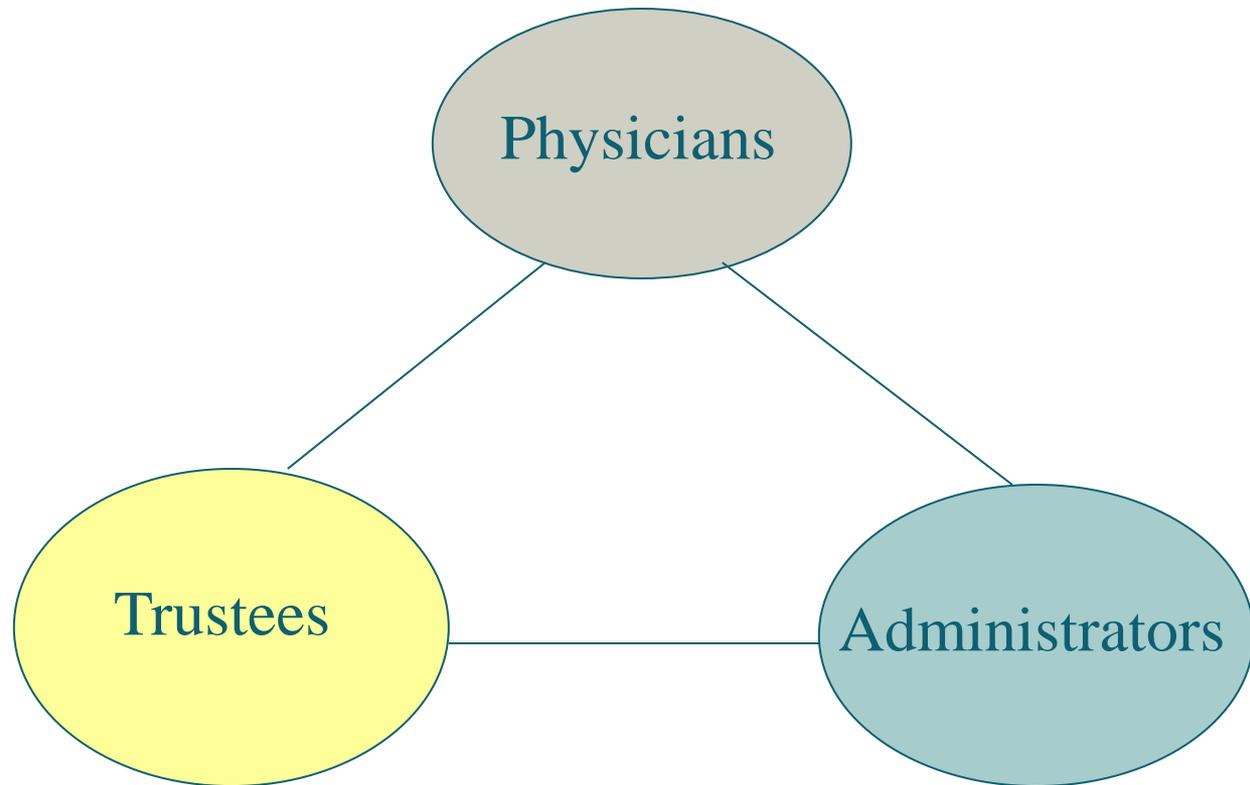
## Ownership



# What drives a hospital?

- **Economic theory of for-profit companies**
  - Maximize profit
- **Economic theory of not-for-profit organizations**
  - Maximize \*something\* under a budget constraint
  - What is a hospital maximizing?
  - Theories and models:
    - Physician incomes
    - Community service
    - Quality
    - Market position/power/prestige
    - Whatever the Board of Directors wants

# Decision-making and Power in the Modern Hospital



# Implications of this theory

- **Hospitals care about money and costs**
  - If for-profit, they want profit
  - If not-for-profit, they still must stay within the budget
- **Hospitals probably care about other things**
  - These other things will vary across hospitals

# We assume not-for-profits provide more community benefits

- **Nonprofit hospitals have advantages**
  - Tax-exempt
  - Issuance of tax-exempt bonds
- **In exchange for tax advantage, they are supposed to provide benefits to the community**
  - Charity care
  - Losses on medical research
  - Unbilled public services (screening, classes)
- **For-profits spend less on charity and uncompensated care**
  - Nonprofits admit more Medicaid and uninsured
- **But... For-profits tend to locate where the need for charity care is low**

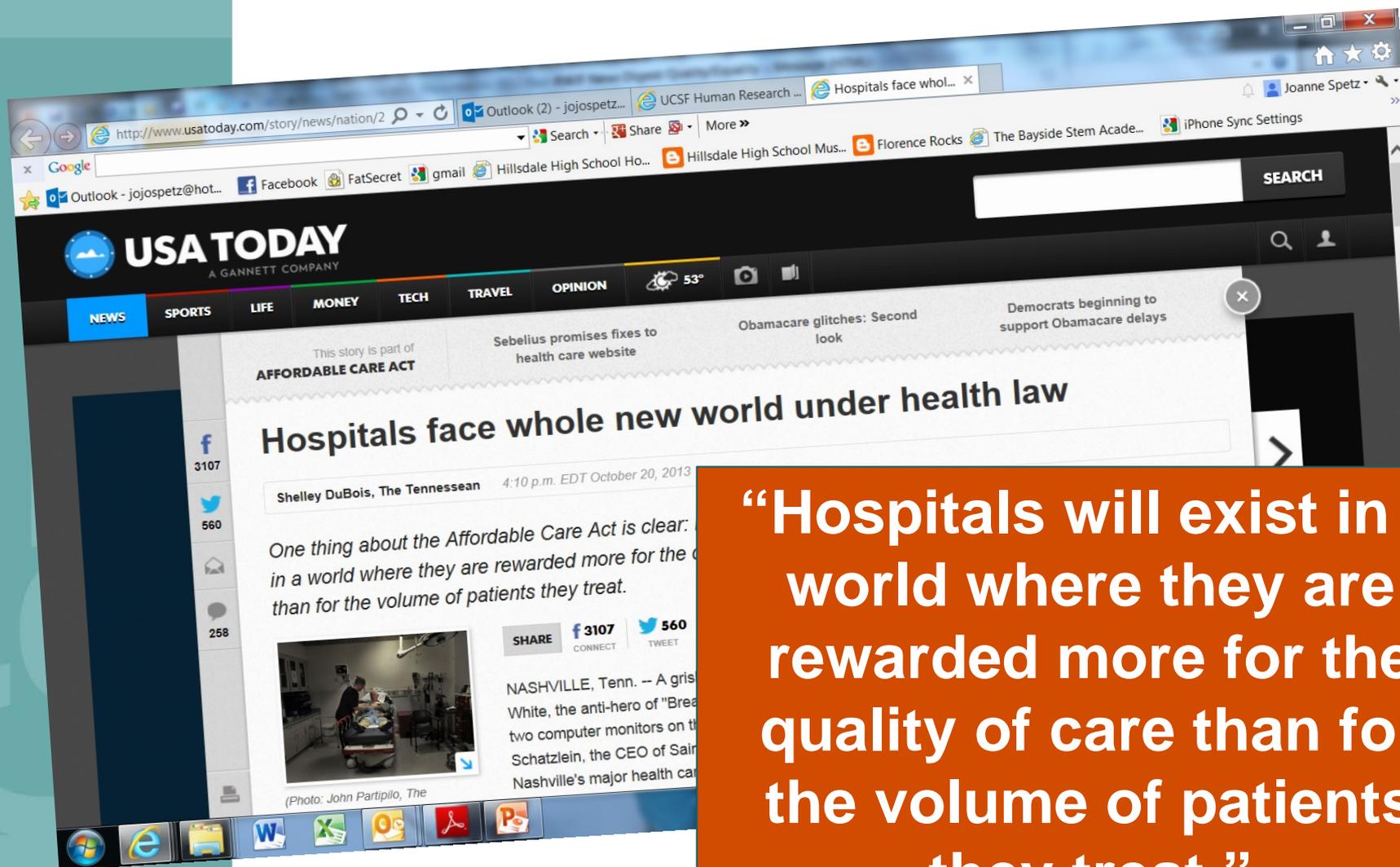
# Issues Hospitals Face Today

- **Quality and Patient Safety**
  - Information technology
- **Capacity issues**
  - Emergency Departments
  - Inpatient setting
  - Staffing changes and shortages
- **Financing**
  - Medicare & Medi-Cal payments
  - Uncompensated care
- **Competition**
  - Specialty hospitals
  - Consumer-driven health care

# Quality and Patient Safety

- **Quality**
  - Clinical quality (structure, process, outcomes)
  - Consumer satisfaction
- **Patient Safety**
  - Avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care
- **Errors**
  - “wrong patient, wrong medication, wrong dose, wrong route, wrong time, errors of omission”
- **Should we pay for good quality, punish bad quality, or do both?**

# Performance-based payment



**“Hospitals will exist in a world where they are rewarded more for the quality of care than for the volume of patients they treat.”**

Medicare

Medicaid/CHIP

Medicare-Medicaid  
CoordinationPrivate  
InsuranceInnovation  
CenterRegulations  
and GuidanceResearch, Statistics,  
Data and SystemsOutreach and  
Education[Home](#) > [Medicare](#) > [Hospital Quality Initiative](#) > [Hospital Inpatient Quality Reporting Program](#)**Hospital Quality Initiative**[Highlights](#)[Hospital Inpatient Quality Reporting Program](#)[Hospital Outpatient Quality Reporting Program](#)[Hospital Compare](#)[Hospital Compare Ads](#)[Inpatient Measures](#)[Process of Care Measures](#)[Outcome Measures](#)[HCAHPS: Patients' Perspectives of Care Survey](#)[Medicare Payment and Volume Information for Consumers](#)[Premier Hospital Quality Incentive Demonstration](#)**Hospital Inpatient Quality Reporting Program**

The Hospital Inpatient Quality Reporting (Hospital IQR) program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points.

In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care. Some of the hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website at: [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

Additional information on the Hospital IQR Program can be found at the links or downloads listed below.

**Downloads**

[Reporting Hospital Quality Data for Annual Payment Update Fact Sheet \[PDF, 38KB\]](#) 

[DRA Section 5001\(a\) \[PDF, 16KB\]](#) 

[MMA Section 501\(b\) \[PDF, 12KB\]](#) 

# Hospital Inpatient Quality Reporting

- **CMS Program launched in 2005**
- **Intended to help consumers get quality of care information**
- **Hospitals given financial incentive to report 10 quality measures for each FY 2005-2007**
- **Non-submission resulted in a 0.04 percentage point reduction in annual payment update**
  - Reduction of 2.0 points starting in FY 2007
- **No CMS reimbursement for some complications of care, started 2008**

# The ACA and Payment Reforms

- **Value-based purchasing (VBP) for all hospitals**
  - Initiated by CMS
- **Reporting is now mandatory**
- **Percentage of Medicare reimbursement tied directly to quality**
  - Incentive payments to meet or exceed performance benchmarks
- **Clinical measures include metrics related to**
  - Heart failure
  - Pneumonia
  - Hospital-related infection

# Payment bundles

- **Hospitals will receive bundled payments that cover:**
  - The hospitalization
  - Post-acute providers the 30 days after
- **Hospitals with high rates of readmission will be paid less if patients are re-admitted to the hospital within the same 30-day period**

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# Increasing numbers of insured people

- **46 million uninsured in 2009**
  - About 80% work in low-wage jobs
- **People with insurance demand more care**
- **In Massachusetts...**
  - In one year, 340,000 people gained insurance
  - Widespread shortages of primary care providers
  - In 2009, 60% of family-medicine doctors' offices were accepting new patients, down from 70% in 2006
    - Only 44% of internal medicine practices

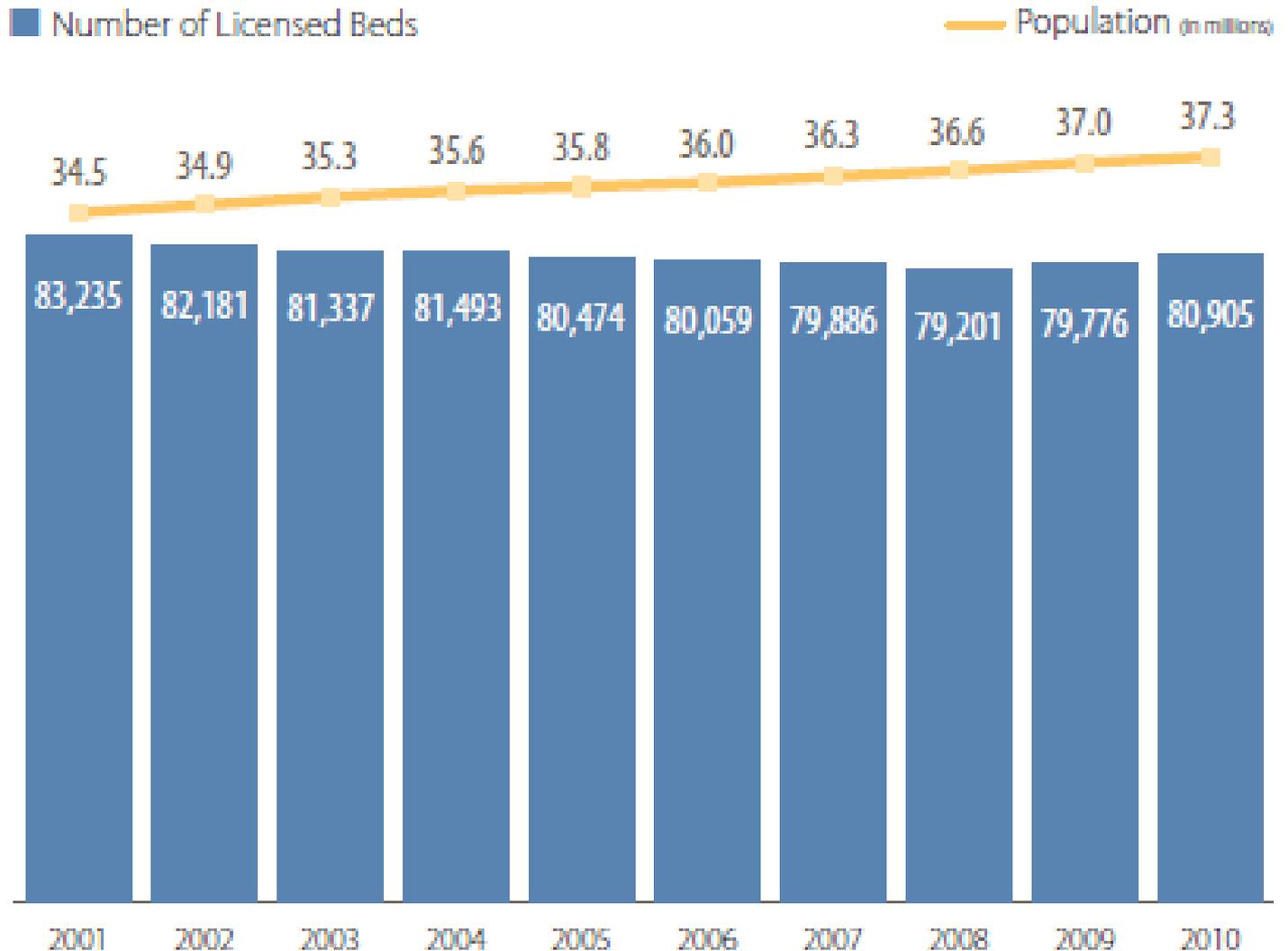
# Increasing numbers of insured people

- **In Oregon...**
  - Health Insurance Experiment found increase in ED visits in year following new enrollment
- **In California...**
  - Health Care Coverage Initiative found decrease in ED visits

# California's situation

- **Up to 2.7 million Californians are expected to gain health insurance due to the ACA**
- **More insurance coverage will lead to greater demand for health care services**
- **Greater demand for health services will lead to greater need for health workers**

# Bed capacity has not kept up with population growth



Source: California HealthCare Foundation

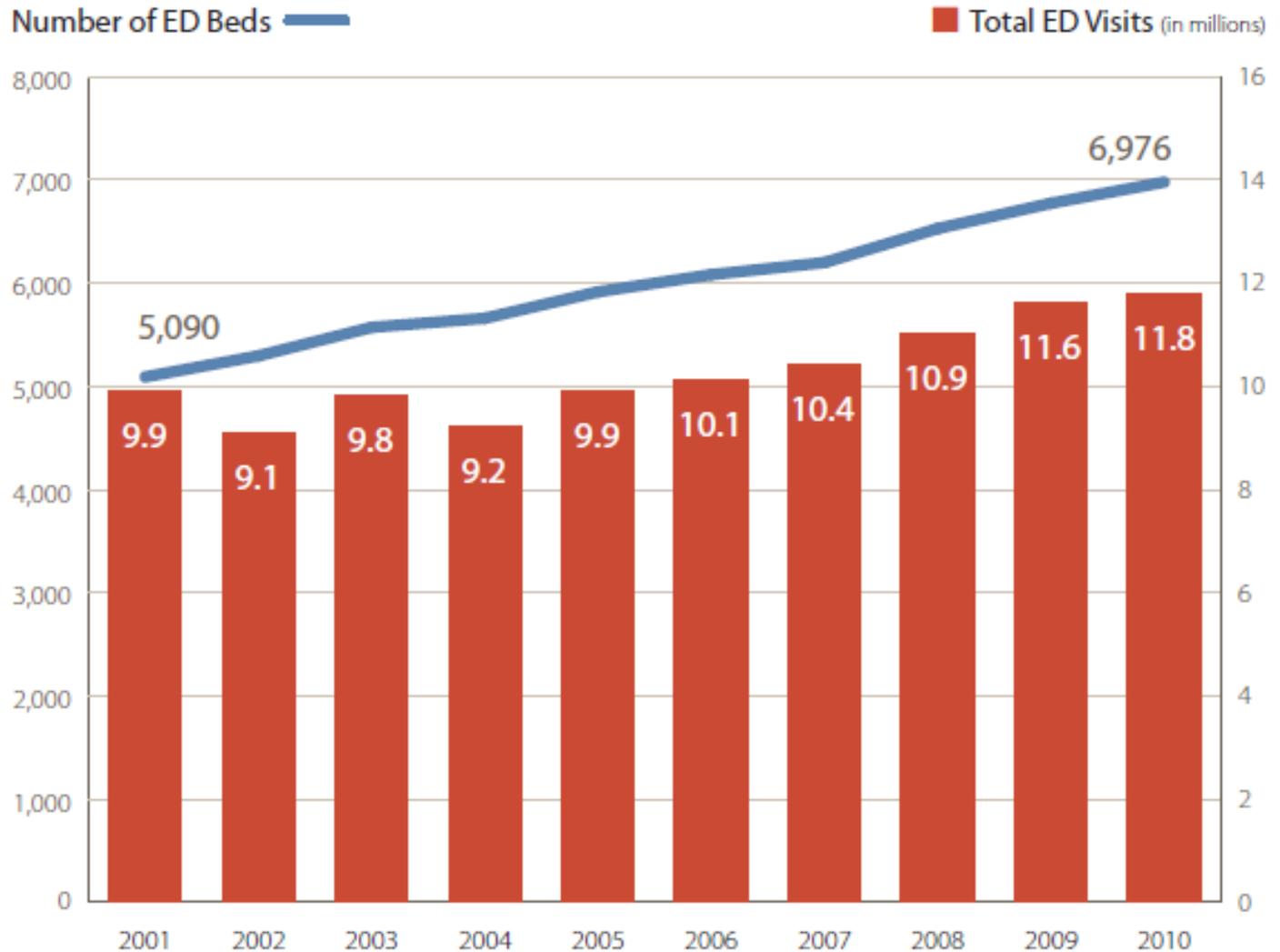
# Some hospitals have closed

- **2011-2010: 37 hospitals closed**
  - 10 general acute care
  - 15 total in LA County
  - 8 total in San Joaquin County
- **Loss of 4,698 beds**
  - Drops in perinatal, pediatric acute, rehab center, coronary care, burn center, acute respiratory care
  - 2.4% growth in medical-surgical acute beds
  - 18.4% increase in ICU beds
  - 15.1% increase in NICU beds

# Are closures good or bad?

- **Good:**
  - Increase efficiency by consolidating services
  - Increase quality by focusing on expertise
    - Example: NICU proliferation harmed babies
  - Eliminate excess capacity
- **Bad:**
  - Closures of low-profit departments leaves gap in access
    - Burn centers
    - Emergency departments
  - Some regions hit harder than others

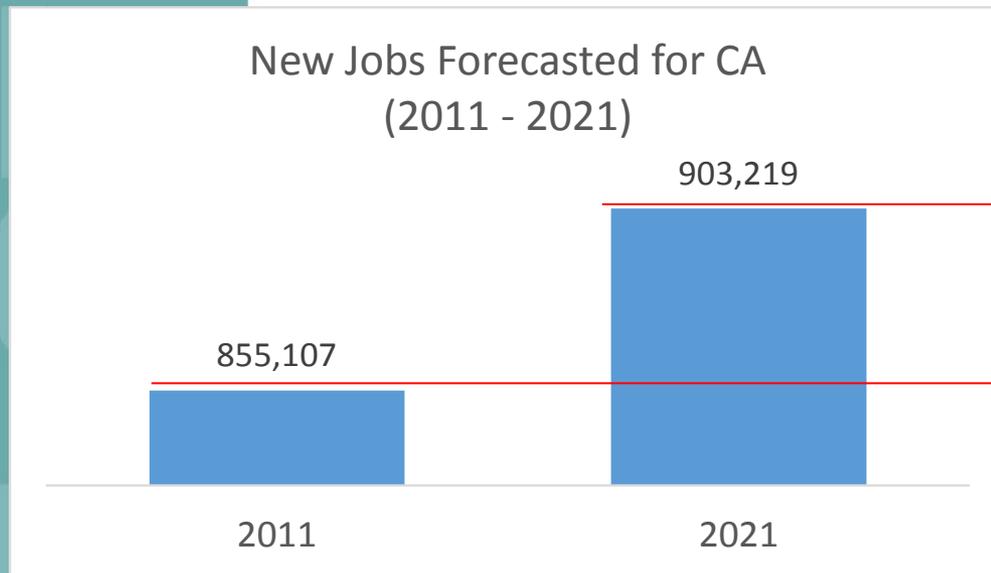
# Some key services are growing: Emergency Dept. beds & visits



Source: California HealthCare Foundation

# CA New Job Growth due to ACA

- The ACA will drive the need for 48,112 new health care and select support care jobs in California by 2021
  - About 6% increase in jobs over ten years as a direct result of ACA



48,112

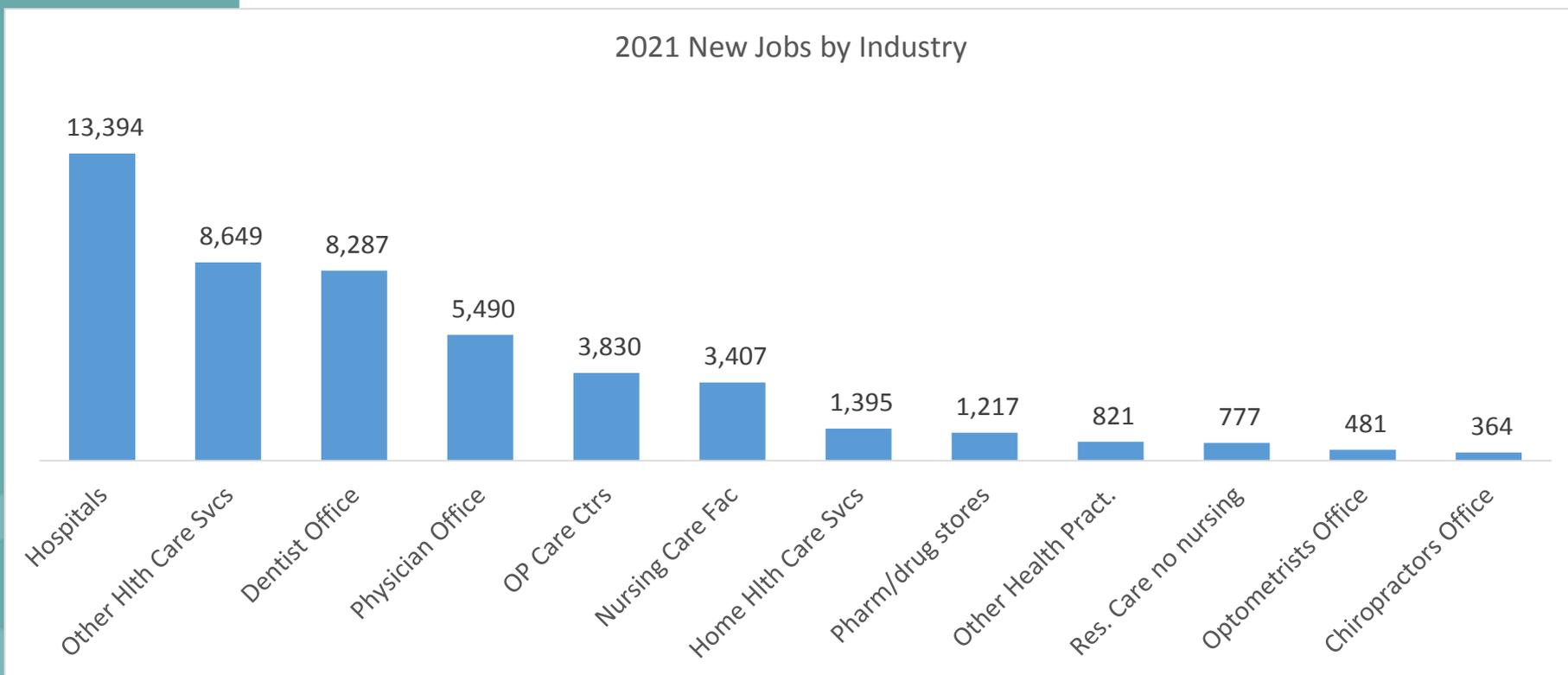
Only a fraction of jobs needed

Does not factor in:

- Aging of the population
- Long-term Care
- Changes to care delivery

# New Jobs by Industry

- Despite projected drop in admissions, hospitals show highest demand for new jobs due to ACA

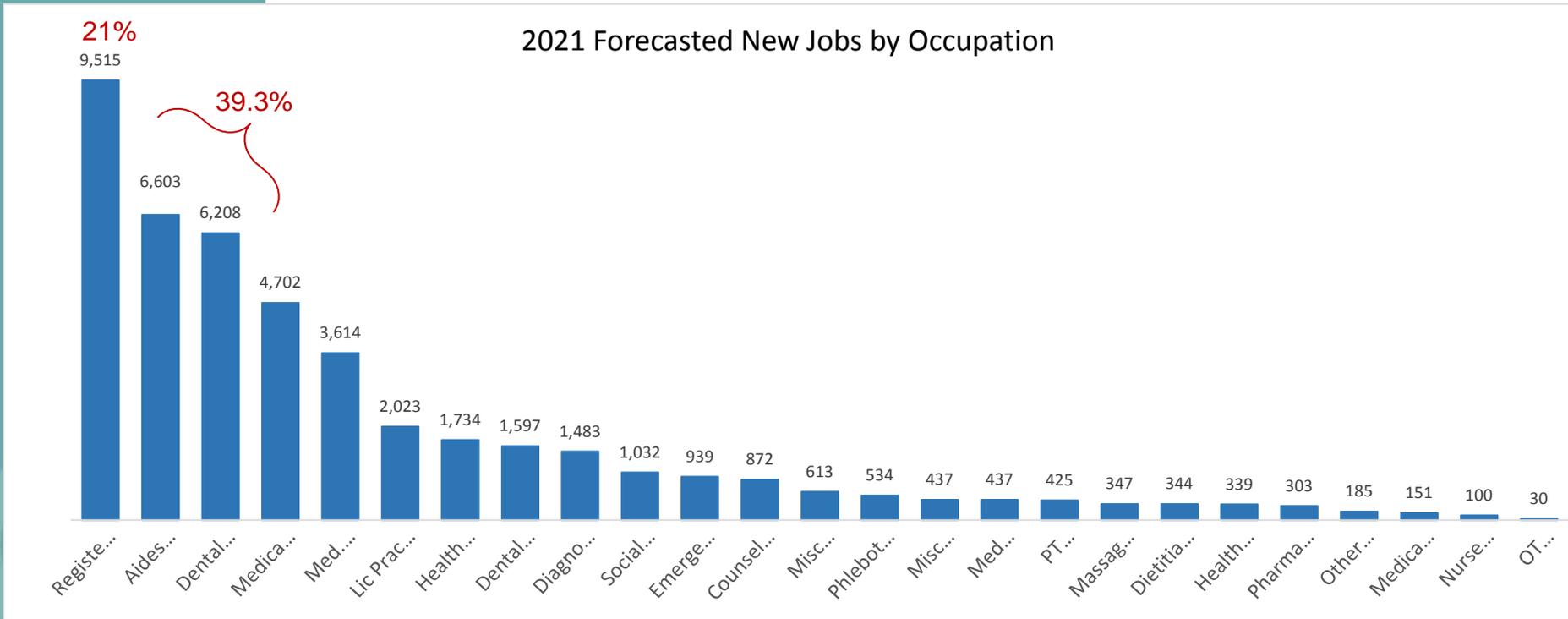


\* Other Health Care Services includes mental health practitioners excluding physicians; physical, occupational, and speech therapists and audiologists; podiatrists; other miscellaneous health practitioners

Source: American Community Survey, HSI Analysis

# New Jobs by Occupation

- Demand for RN jobs among the highest (~9,500)
  - Growth rate among the lowest (~4.3%)
  - 21% of new jobs will go to RNs



Source: HSI Analysis

Health practitioner support techs include dietetic techs, pharmacy techs, psych techs, respiratory techs, surgical techs.

Diagnostic related techs include cardiovascular techs, diagnostic medical sonographers, nuclear medicine techs, and radiologic techs

# Regional Job Growth due to ACA

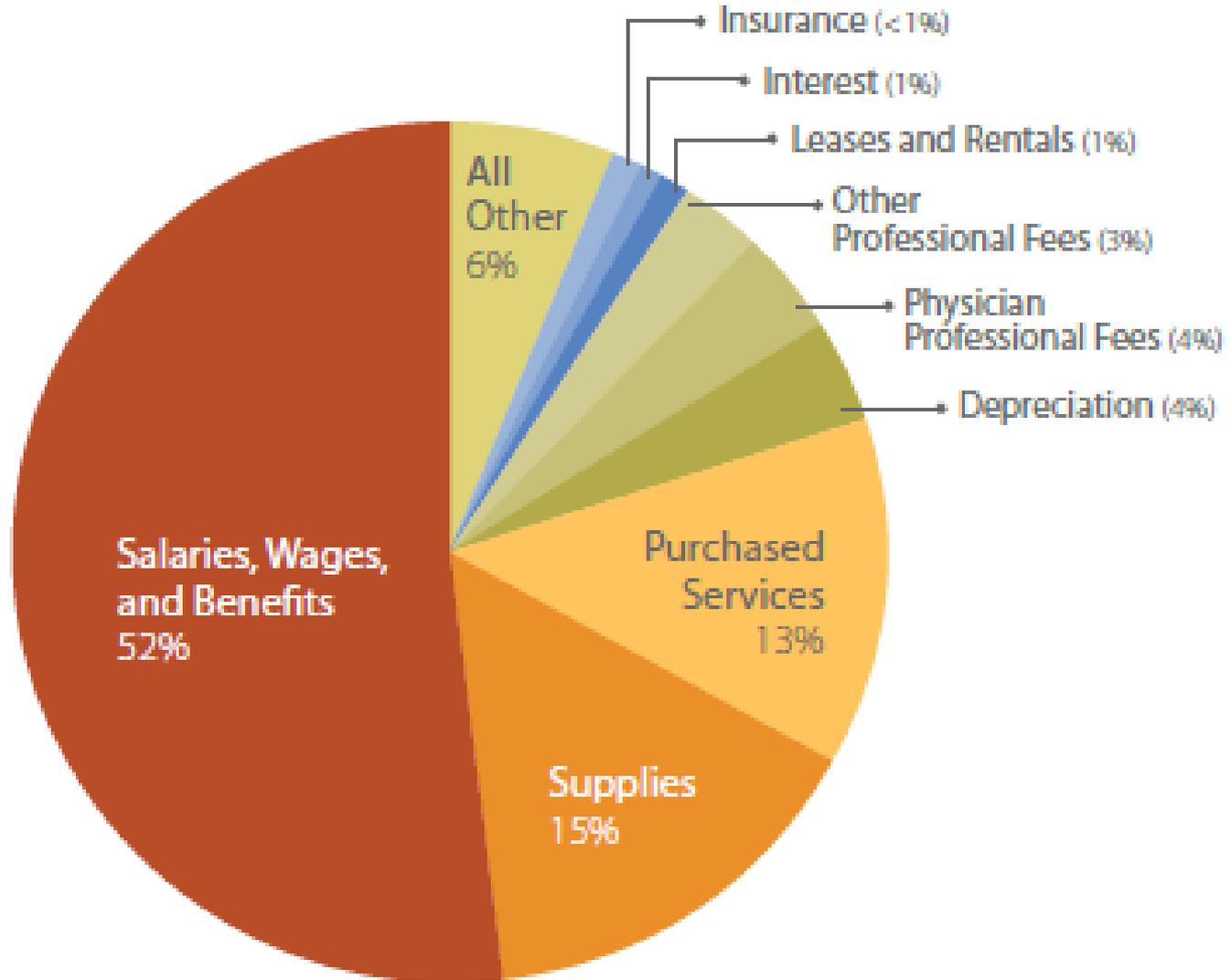
- **Fastest growth rate estimated for San Joaquin Valley**
- **Largest numbers of new jobs estimated for Los Angeles and other Southern California**

	2011	2021 Range		New Jobs		10 Year Growth	
	Baseline	Occup	Industry	Low	High	Low	High
N.CA & Sierra Cntys	14,373	15,078	15,088	705	715	4.90%	4.97%
Greater Bay Area	180,824	189,925	190,286	9,101	9,462	5.03%	5.23%
Sacramento Area	51,484	54,404	54,609	2,920	3,125	5.67%	6.07%
San Joaquin Valley	82,902	87,828	88,106	4,926	5,204	5.94%	6.28%
Central Coast	35,858	37,836	37,928	1,978	2,070	5.52%	5.77%
Los Angeles	221,927	233,556	234,063	11,629	12,136	5.24%	5.47%
Other S. CA	240,378	253,685	254,425	13,307	14,047	5.54%	5.84%
<b>Subtotal</b>	<b>827,746</b>	<b>872,312</b>	<b>874,506</b>	<b>44,566</b>	<b>46,760</b>	<b>5.38%</b>	<b>5.65%</b>

\* Regional total slightly less than CA due to data limitations by county and rounding errors when analyzing Occupation and Industry (see appendix for details)

Source: American Community Survey, <http://healthpolicy.ucla.edu/health-profiles/Pages/HealthProfiles2011AR.aspx>, HSI Analysis

# Hospital Expenses, 2010

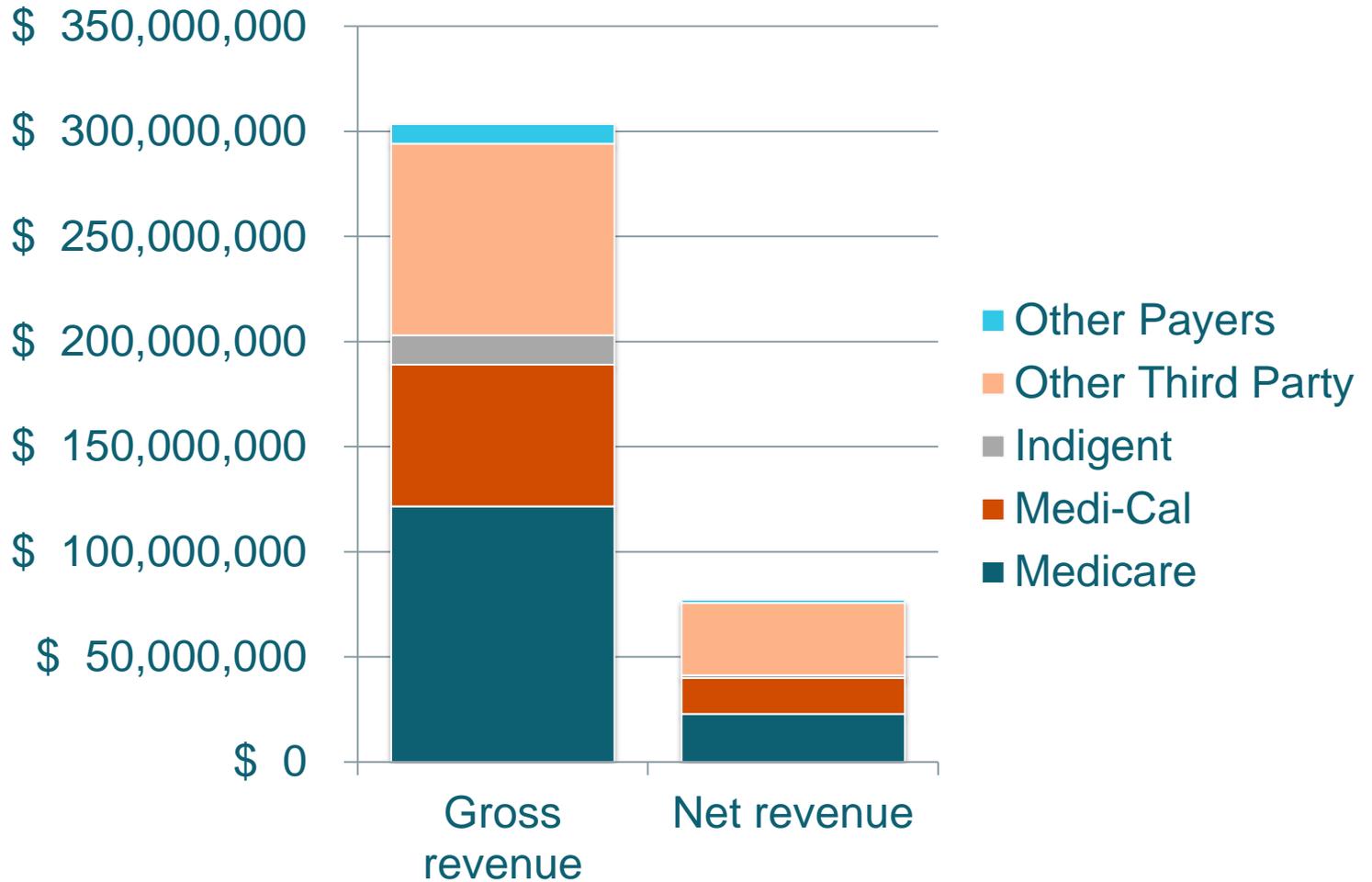


Source: California HealthCare Foundation, 2013

# Issues Hospitals Face Today

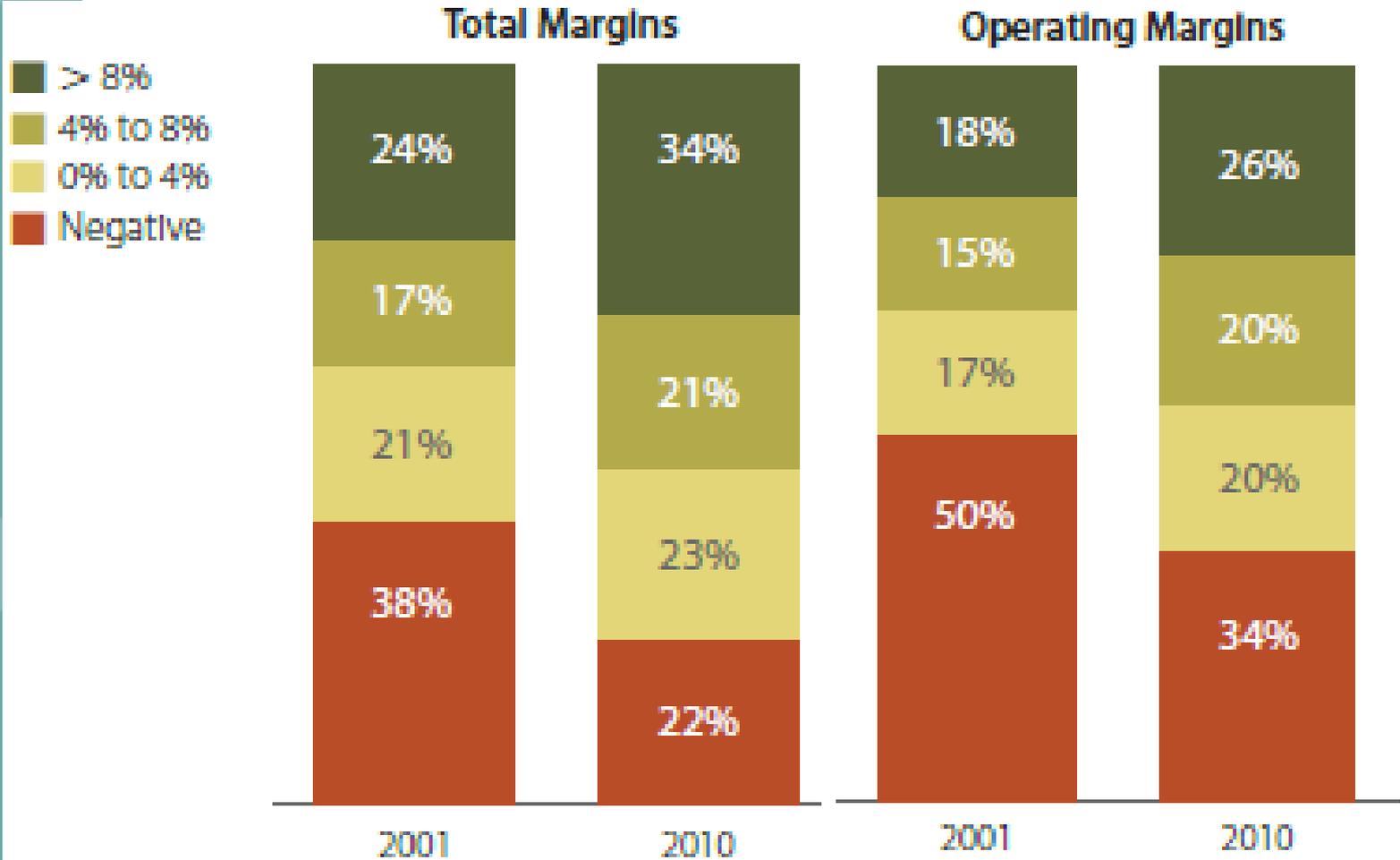
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# Gross & Net Revenue of California Hospitals (Thousands), 2012



Source: California HealthCare Foundation

# Hospital Operating Margins, 2010

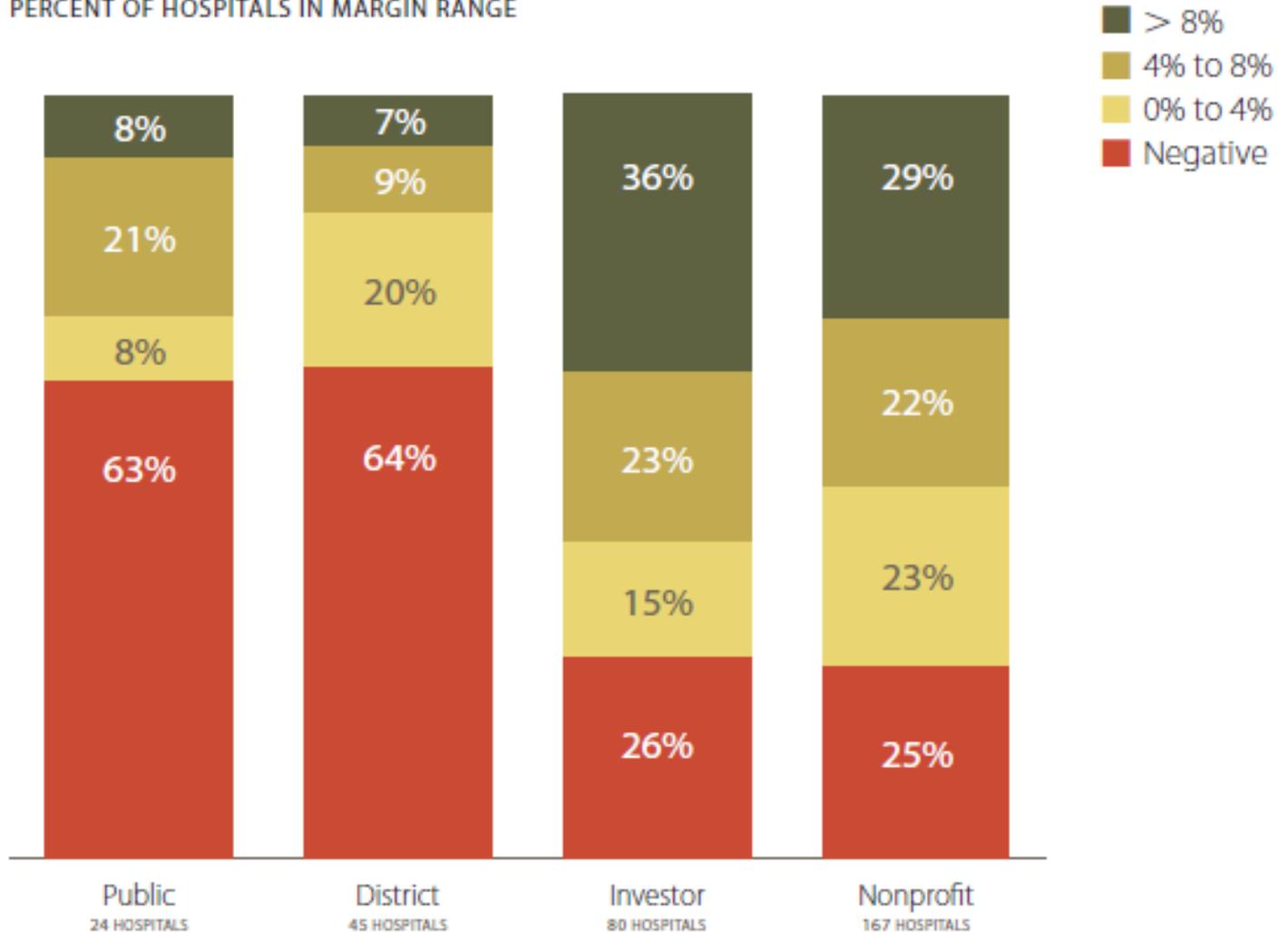


2012:  
Average total margin = 5.8%  
Average operating margin = 3.0%

Source: California HealthCare  
Foundation, 2013, & OSHPD

# Operating Margins, by Ownership Type

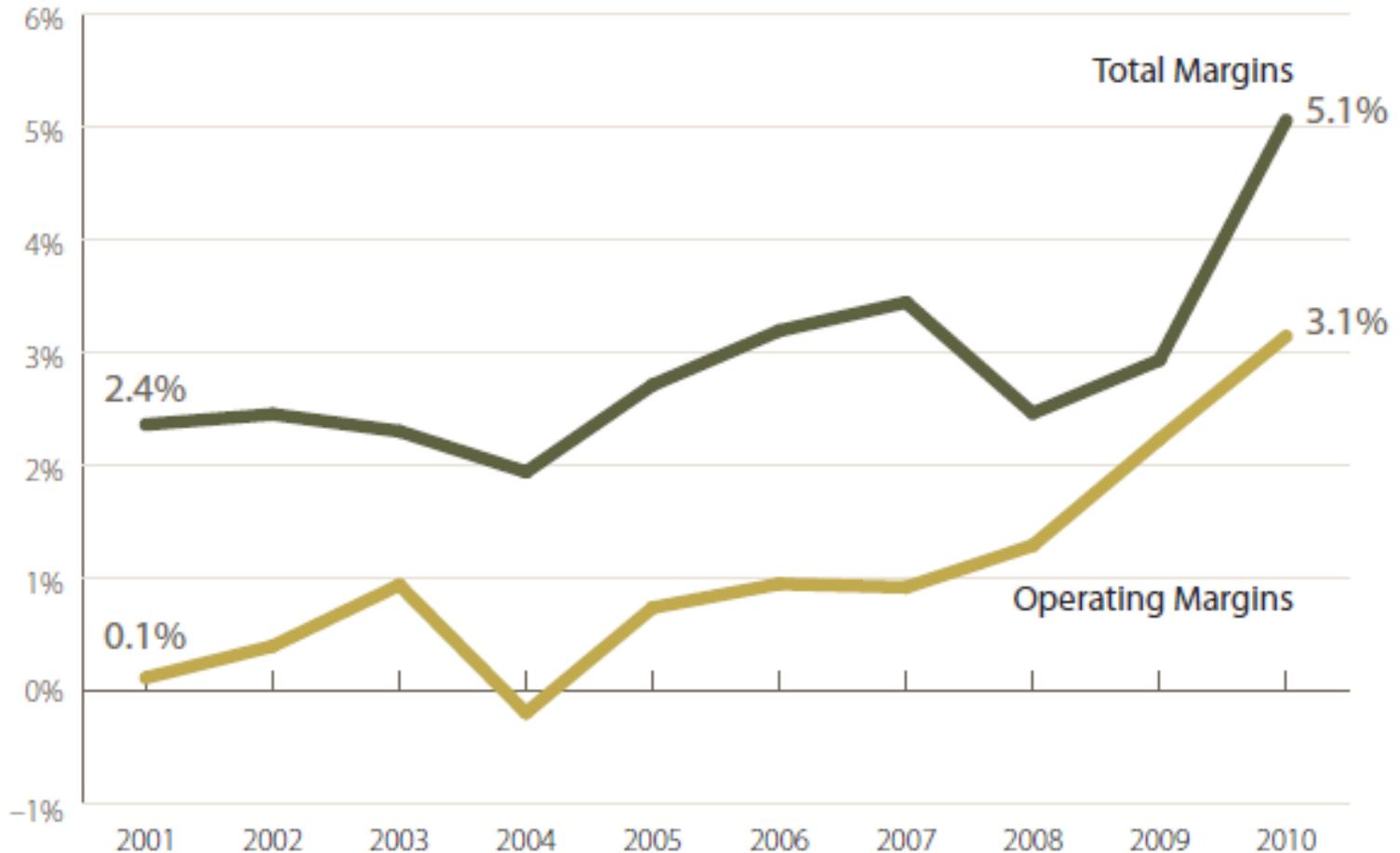
PERCENT OF HOSPITALS IN MARGIN RANGE



Source: California HealthCare Foundation

# Total & Operating Margin Trends, 2001-2010

MEDIAN MARGIN



Source: California HealthCare Foundation

# Financial Outlook

- **What affects the “bottom line”?**
  - Negotiated rates and Medicare payment rates
  - Overhead
- **Medi-Cal**
  - More enrollees
  - Low payments
- **Uncompensated care**
  - Sum of charity care and bad debt
  - Hill-Burton requirement: Up to 3% of operating costs for 20 years
  - Elimination of Disproportionate Share payments
  - Legal obligations to keep not-for-profit status

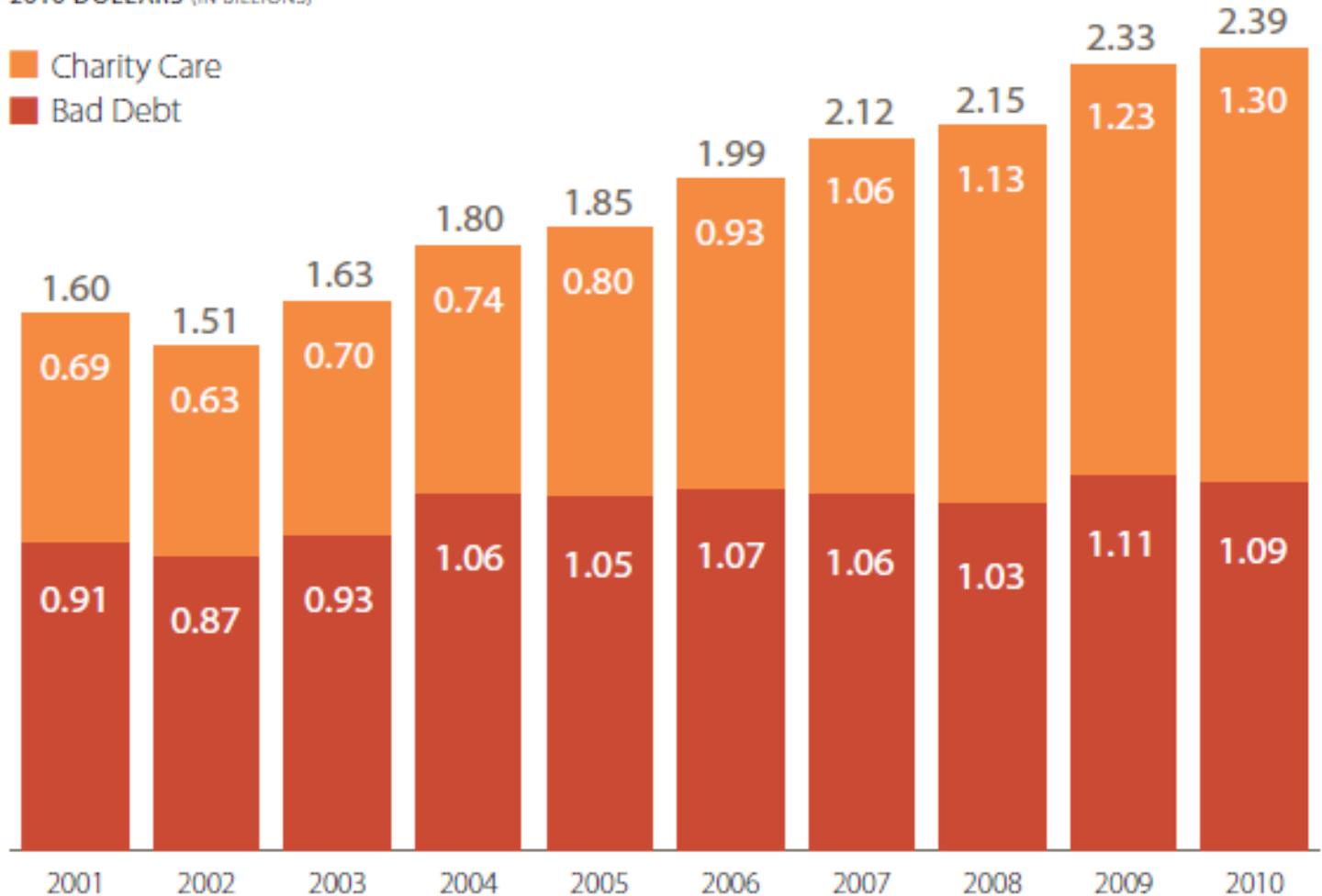
# Medi-Cal and Medicare payment demonstrations

- **Medicaid Global Payment Demonstration - capitation for safety net hospitals**
- **Medicaid “medical home” for those with chronic conditions.**
- **Medicaid Bundled Payment Demonstration**
- **Value-Based Purchasing with percent of payment tied to quality**
- **Medicare payment incentives/penalties to reduce hospital readmissions**
- **Medicare Bundled Payment Pilot**
- **Accountable Care Organizations: paid on a fixed price ‘per member per month’ (PMPM)**

# Charity care & bad debt, 2001-2010

2010 DOLLARS (IN BILLIONS)

Charity Care  
Bad Debt



Source: California HealthCare Foundation

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# Competitive factors

- **Specialty hospitals**
  - Seek the high-margin care
  - Orthopedics
  - Cardiac (?)
- **Consumer-driven health care**
  - Price transparency
  - Need to compete on price & quality at the same time

# Horizontal Integration

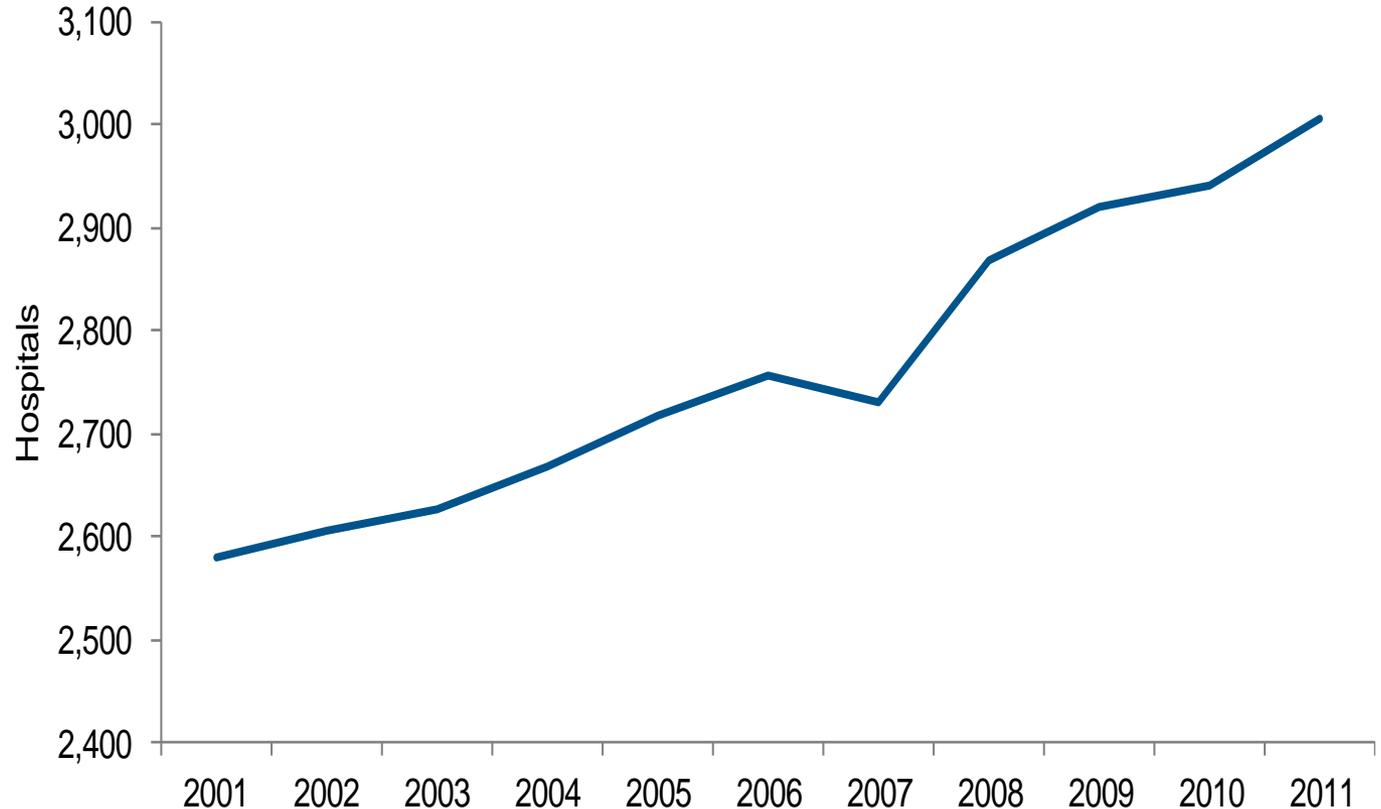
- **Hospitals are increasingly part of multi-hospital arrangements:**
  - 30.8% of US hospitals were in systems in 1979
  - 60% in systems in 2012
- **8 largest systems in California**
  - Kaiser, Dignity, Sutter, UC, Prime, Tenet, Adventist, St. Joseph
  - 38% of beds & hospitals in 2010

# Monopoly 101: Key Features of a Monopoly

- **No Close Substitutes**
  - water supplied by local public utility
  - cable television companies
- **Barriers to Entry**
  - DeBeers and diamond mines
- **Impact**
  - Can control prices & charge more for the same product



# Number of US Hospitals in Health Systems, 2001 – 2011



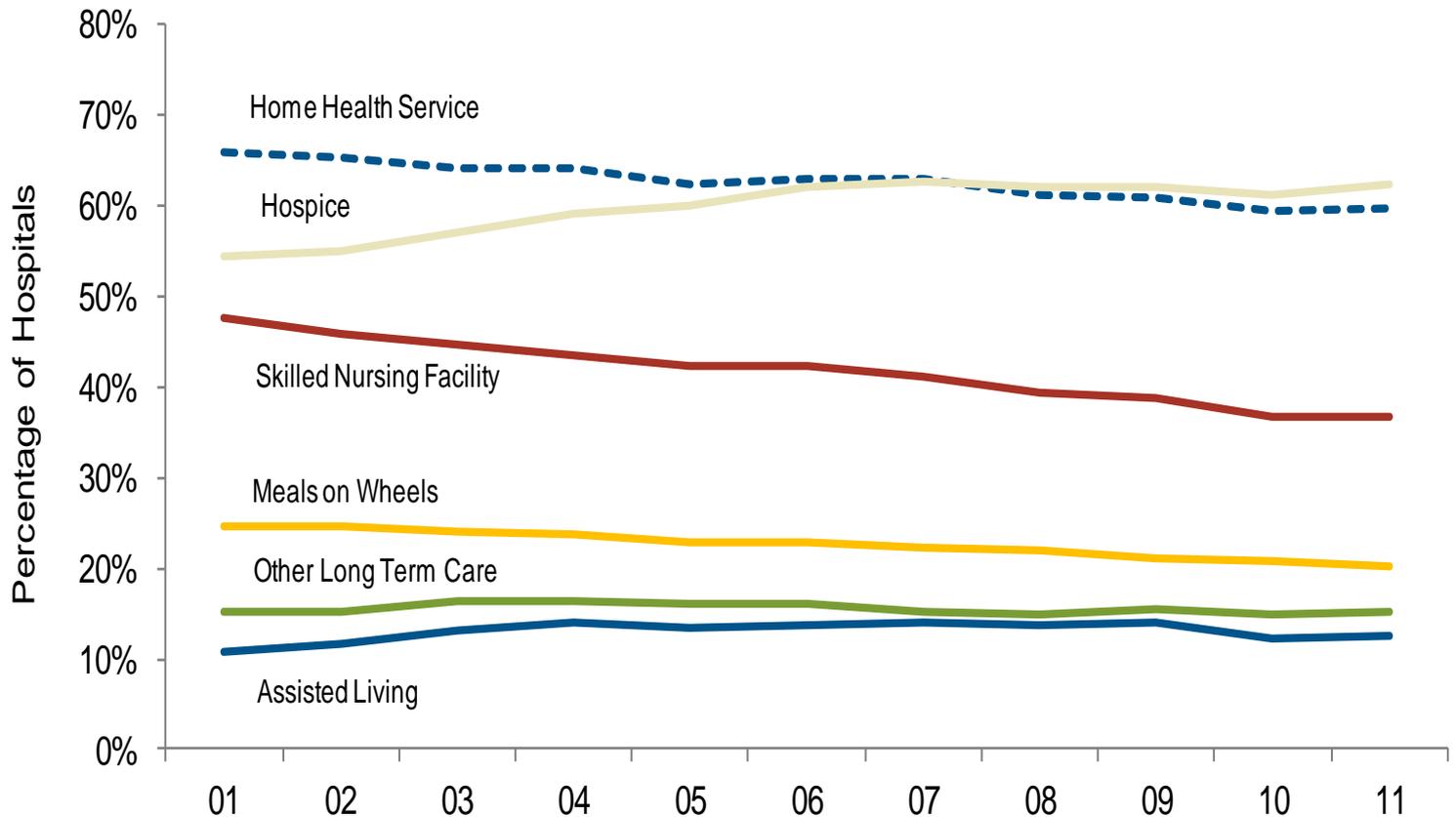
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals.

<sup>(1)</sup> Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.

# Vertical Integration

- **Linking organizations at different stages of the production process**
  - Hospitals need a “supply” of patients to generate revenues.
- **Accountable Care Organizations (ACOs)**
  - Provide and manage the continuum of care across different institutional settings
  - Including at least ambulatory and inpatient hospital care and possibly post acute care
  - ACOs receive a percentage of the cost savings that they have realized

# Share of US Hospitals Offering “Non-hospital” Services, 2001 – 2011



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals.

<sup>(1)</sup> Includes services offered in hospital, health system, network or joint venture.

Previously Chart 2.9 in 2009 and earlier years' Chartbooks.

# What to watch

- **Impact of growth of Medi-Cal and loss of disproportionate share patients**
- **CMS payment reforms**
  - Increasing quality
  - Losing money
  - Integration and ACOs
- **Increasing consolidation in some markets**
  - SF Bay Area
  - Los Angeles?
- **Labor shortages and rising wages**
  - Nursing unions