

## HEALTH SERVICES FOUNDATION

### 1. Notable Accomplishments

#### Financial Performance

- After five years of bottom line losses through FY00, HSF has had operating surpluses in FY01 and FY02 through FY05, and positive bottom lines from FY02 through FY05. The first six months of FY06 show an operating loss.
- From a high of \$63.3 million in FY95, HSF's net assets had decreased to \$24.1 million by FY02. Since then net assets have been rebuilt to \$61.5 million. Contributing to this increase were \$7.6 million in operating surpluses, a contribution from the Medical Center (MC) of \$15.0 million for medical leadership recruiting, and a significant gain on the sale of VASI to the MC.
- Overall median and average compensation for all HSF physicians employed during the entire period of 2001 through 2004 increased at faster rates than available benchmark figures. On average, HSF physician salaries and incentives are at the 50th percentile of those at other academic medical centers as reported by the AAMC in a report that covers all of the 125 accredited medical schools in the US.
- A sharing agreement was entered into among the MC, School of Medicine (SOM) and HSF under which MC operating surpluses above a five percent margin are shared with the SOM and HSF; an agreement that has resulted in transfers of significant funds.
- Financial relationships with the SOM and the MC have been clarified and aggregated in multi-year agreements.
- The MC worked to enhance, and later protect, governmental funding to HSF physicians for indigent care.
- Days-in-Receivables have dropped from 63.0 days to 43.0 days during the period from FY01 to FY05.

#### Management Performance

- Accomplishments include hiring of talented managers, significant cross-training, and implementation of a pay-for-performance system for all administrative employees.
- An array of payor contracting initiatives have been undertaken that better identify issues, have resulted in improved rates under contracts up for renewal, and involve clinical leadership in contracting decision-making. While it has been noted that there is room for improvement in rates under our two largest commercial contracts, we continue to remind ourselves that negotiations of these contracts was influenced by political pressures from outside of HSF.

#### Areas of Limited or No Action

- There has not been consensus about whether and how HSF should renew its historical pursuit of entrepreneurial opportunities now that HSF's capital base is once again in the position to capitalize such opportunities.
- Implementation of a durable primary care strategy remains a work in progress.

- Improvements in registration, scheduling, documentation, coding and charge capture have lagged due to competition for resources within the departments and within the MC, as well as IT system limitations.
- An integrated patient scheduling and registration system capable of meeting both HSF and MC needs continues to be an unfulfilled hope.

## 2. Two-Year Goals and Metrics for Success

### Models for all of US

#### **Adjust operations to succeed in an environment of increased consumer responsibility**

In collaboration with MC, redesign and rebuild the front-end business functions to identify insurance and payor requirements at first contact, better manage scheduling and registration, collect appropriate payments, triage care, and supply price and quality information to shoppers.

- During the first two years, HSF will provide advice and decision making forums to the MC to enable it to:
  - Reach agreement with the physician community on the operational organization for the front end of the revenue cycle that most effectively and efficiently balances care delivery and financial operation needs.
  - Implement the identified operational organization and install a new scheduling and registration IT system.
  - Assist unsponsored patients in finding funding mechanisms for their care.
  - Develop a detailed plan to supply price and quality information to prospective patients.
  - Develop departmentally based mechanisms to triage care utilizing clinic medical directors.
  - Develop methods to care appropriately for the increasing number of uninsured indigent patients.

Adopt payor-mix goals such that there will be enough paying patients to cover (a) the costs incurred by patients unable to pay, and (b) the costs incurred to fulfill our other missions of research and education.

- During the first two years, HSF will work collaboratively with the MC and the SOM to:
  - Arrive at a consensus understanding of the revenue, cost and mission impacts of patients covered by particular payors on each of the health system entities.
  - Agree on payor-mix goals.

Identify what is needed to remain competitive in the market for patients with good third-party payor coverage.

- During the first two years, HSF will work collaboratively with the MC to:
  - Reach agreement on things needed to remain competitive for patients with third party coverage that reimburses at levels providing a margin sufficient to fund our missions.
  - Establish a plan and timetable for implementation of necessary changes.
  - Identify monitoring mechanisms to verify that actions undertaken are effective.

Develop operational mechanisms to implement if we are not able to achieve the payor-mix goals required to cover (a) the costs incurred by patients unable to pay, and (b) the costs incurred to fulfill our other missions.

**Reevaluate and revamp financial understandings among health system entities to improve response times to anticipated financial dislocations.**

Create “circuit breakers” that mandate automatic reevaluation and readjustment of financial arrangements if certain metrics or environmental events occur. For example, if Medicare changes (and resultant changes in private insurance payment), result in physician payment that is significantly reduced whereas Medical Center payment is not significantly reduced, the overall mechanism for cross-subsidy in the Health System should be examined and potentially changed. This will be done in a spirit of collaboration (“all boats rise”) and not in a way that causes a “borrower – lender” mentality.

**Implement durable primary care and specialty care strategies.**

**Identify drivers motivating retention and recruitment of the best faculty and adjust compensation and benefit policies as appropriate.**

**Improve our operations.**

**Better coordinate demand and capacity, identifying alternative approaches to preserving market share and profitability.**

Coordinate provider employment plans with physical capacity plans.

- During the first two years, HSF will work with the SOM to compare its provider hiring plans and expected physician staffing to existing physical capacity (beds, operating rooms, ambulatory facilities, equipment).
  - If expected physician staffing exceeds expected physical capacity, HSF and the SOM will work with the MC to identify alternative ways of increasing physical capacity.
  - If expected physician staffing exceeds expected physical capacity, and alternative ways of increasing physical capacity within the two-year time frame are not identified, HSF and the SOM will modify their physician hiring plans to bring staffing and capacity into line.

Confirm that current capital expenditure plans will generate physical capacity capable of preserving current market share and, if not, identify alternative approaches to maintaining share.

- During the first two years, HSF will work with the SOM and the MC to:
  - Review future demand growth in our identified markets.
  - Compare our current and projected physical capacity (beds, operating rooms, ambulatory facilities, equipment) to market demand to evaluate whether we will have the physical capacity to preserve our market share.
  - Develop a revised capital expenditure and financing plan that will maintain market share if our current physical capacity plan will not preserve our market share.

Modify evaluation and decision-making structures related to business development projects to assure all parties that a level playing field exists.

- During the first two years, HSF will work with the SOM and the MC to:
  - Clarify that all projects are to be reviewed in a consistent manner.
  - Not waste proponents' time if necessary capital and start-up operating funds are realistically not available.
  - Recognize and accept that political risk is a common factor in all business development projects and not require the absence of political risk before a project will be undertaken.
  - Restructure the capital allocation decision-making process to incorporate leaders of all health system entities.
  - Insure that decision making for entrepreneurial activities is truly spread across the HSF, SOM and MC and that overall benefit to the Health System is considered.
  - Have decision-making processes related to risk and reward apportionment clarified to reassure everyone that they are based on the contributions and risks of all the parties necessary for the project's success.

**Negotiate rates appropriate to our market position in payor contracts during upcoming contract renewal negotiations**

**The Health Services Foundation, School of Medicine and Medical Center will continue to emphasize alignment of their goals.**

### **3. Five-Year Goals and Metrics for Success**

**Models for all of US**

**Work with the Quality Council to systematize care and reduce costs as important elements of quality improvement.**

- Identify ways to initiate a dialogue among faculty leadership concerning how to systematize care.

- Identify and implement change mechanisms based on the ideas generated in the dialogue with providers.

#### **Adjust operations to succeed in an environment of increased consumer responsibility**

- Achieve a patient payor-mix capable of supporting (a) the costs of patients unable to pay, and (b) the costs incurred to fulfill our other missions.
- Demonstrate that initiatives implemented to remain competitive in the market for patients with good third party payor coverage have been successful.

#### **Improve Operations**

##### **Implement IHIMS**

##### **Maintain market share comparable to current market share**

#### **4. Resources Needed and Barriers to Success**

##### **Threats to current revenue flows**

- Loss of income from sharing of MC bottom line.
- Increased numbers of uninsured indigent patients.
- Loss of funding for indigent care.
- Legislated 25 percent cut in Medicare reimbursements to physicians.
- Medicaid reimbursement cuts by Congress.
- Slowdown in collections due to shift of payment responsibility from payors to consumers.

##### **Increased expenses**

- Increased unfunded research expenses because of decreases in research funding and/or expenditure patterns shifting unfunded research expenses to patient care funds.
- Increased bad debts due to increasing deductibles under insurance plans.
- Increased bad debts due to increasing numbers of uninsured and underinsured.
- Increased bad debts due to shifts of uninsured and underinsured from other providers.
- Costs to design, implement, and operate front-end infrastructure needed to handle information demands of consumer-driven health plans.
- Costs to create differentiated service levels to retain patients with good third party payor coverage.

- Increased physician compensation to retain faculty in the face of an increasing shortage of physicians and hiring competition from physician groups that have sources of technical and facility fee revenue.
- Increased costs associated with resident work-hour limitations.
- Higher malpractice insurance premiums.
- Shortage of physicians will lead to greater demand, resulting in higher salary costs,
- Increased costs to appropriately fund HSF's defined benefit retirement plan.

### **Challenges**

- Physical capacity below that required to meet current profitable demand.
- A capital plan that probably constrains infrastructure investment (i.e., beds, ORs, ambulatory facilities, equipment) to levels below that needed to preserve current market share over the long run.
- Weak front-end business functions and infrastructure in ambulatory operations.
- Performance measurement metrics (e.g., tying an evaluation of good performance to an arbitrary bottom line percentage – like 5 percent) that may result in decisions that undercut the long term preservation of market share or delay investments needed to deal with a rapidly evolving environment.
- Limited/no monitoring of quality information from outside sources about our operations.
- Little/no payor-mix management experience and capabilities.
- Need for truly joint decision-making on major initiatives, whether capital or operational.
- Need for improved analysis of entrepreneurial projects in terms of the effect they will have on other regional providers.