A SERVICE OF nrc HEALTH

E-Briefings

Volume 14, No. 4, July 2017

Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute.

In this issue:

The Imperative for Disruptive Leadership in the Boardroom

By Carol Geffner, Ph.D., Newpoint Healthcare Advisors, LLC

Imagine a healthcare system that provides patients with a clinical guarantee, ensuring perfect outcomes and no charge for readmission in the event of an associated problem. Or imagine the design of a "Medical Main Street" where healthcare services representing the continuum of care are integrated into city planning and redesign to build healthy communities for the future.

These are only two examples of innovations within the industry that continue to reshape the delivery of care locally and globally. In the new business paradigm, innovation is becoming a strategic lever for sustainability and growth. Drug therapies will increasingly be based upon genetic profiling. Mobile technology is on its way to becoming the primary communication and education mechanism for patients and medical care teams. Provider teams are already linking information across delivery systems to improve patient outcomes and the overall care experience. The historically staid healthcare industry is being upended by disruptive solutions that are transforming how we think about and deliver the continuum of care.

Moving to Disruptive Leadership

How, then, is this new reality changing the shape of governance? Traditionally, boards of directors have been relatively conservative and risk-adverse in enhancing long-term shareholder value and/or ensuring quality and access of care. More often than not, they have focused on the financial health of the business and have been less concerned with breakthrough thinking at the governance level. Financial and legal expertise often dominate board composition. While these capabilities remain critical, for the sake of future sustainability they must be balanced with expertise in disciplines known for innovation and disruptive thinking.

Research confirms that highly innovative organizations create cultures that nurture experimentation, courage, creativity, and actively seek talent that excels at associative thinking, questioning, and extreme curiosity. These are essential skills for businesses that disrupt the status quo. Such organizations need thinking and action that anticipate marketplace needs and create solutions ahead of customer demand.

While operationalizing an innovative culture is within a management team's purview, the responsibility for providing strategic oversight and policy advice resides in the boardroom. This implies that boards of all healthcare systems and hospitals need not only to understand innovation and disruptive action, they must model this sort of thinking and behavior. Even in small critical access hospitals, long-term sustainability relies on boards that are well-informed about the trends and emerging models of forward-thinking hospitals. While these and other community-based hospitals may not have adequate resources to produce digital innovations, it is their capacity to think broadly and creatively about quality and customer needs that will give

them an edge in a radically changing environment. This may present governing bodies with uncomfortable challenges, such as the need to deeply examine the quality of care delivery while insisting on shaking up the status quo in service to long-term value and sustainability.

Questions for the Board

To build a board that can successfully govern in a rapidly changing ecosystem, there are several categories of questions that boards should be asking and challenging themselves with on a regular basis. Those questions include:

1. **Definition of the business**: What business are we in and does our definition need to change? What alternative perspectives should we entertain to break through insular thinking?
2. **Competitive ecosystem**: Who do we believe are our competitors? Are there any others that could emerge in the next five to 10 years as a competitive force? How are they changing their business models? What can we learn by looking to other industries? What do we know about governance of highly successful and innovative enterprises?
3. **Customer evolution**: Who are our customers of the future? What do they value? Is the organization positioning itself to meet their emerging needs?
4. **Management expertise**: Have we hired the right CEO? Does the CEO have a record of leading rapidly changing businesses that have innovated their products or services? What do we expect from the CEO relative to positioning the business for long-term growth and success? Where does this talent reside on the executive team?
5. **Board culture**: What is the assessment of our board culture? Are we transparent and candid with one another? What kind of innovation is needed in the business to ensure sustainability? What questions or topics should the board address that might be difficult or controversial? What is our capacity to think associatively and challenge our existing business model? What do we do when confronted with uncomfortable issues? How do we get information on the impact we have on the organization's culture and capacity to innovate?
6. **Board leadership**: Does the chair set a tone of openness and ensure that sidebar discussions are proscribed? Does the chair proactively facilitate conversations that force us to deal with difficult, new, and unfamiliar ideas that support organizational growth and sustainability? Does the board chair have an open and trusting relationship with the CEO that fosters conversations that are critical but uncomfortable?
7. **Board agenda**: When will the board have time to discuss possible innovations and emerging business models? How much do we know about innovation strategies and plans? How frequently should we have extended meetings in which detailed discussions occur about our performance as a board, developmental and learning needs, and our impact on the organization?

In summary, boards must not underestimate the influence they exert on a business' capacity to continuously improve, transform, and position for the future. The dynamics and leadership practiced by the board channel through the organization in ways that may be invisible to them, but have a significant impact on the culture, operations, and success of the business. As a result, boards must exert leadership that not only demonstrates vigilance about the financial health of the organization, but also pushes an agenda of change, innovation, and creation of value in emerging markets. This means boards must become comfortable with shaking up the status quo and challenging themselves and the organization's management team to think and act as leaders of an emerging future.

The Governance Institute thanks Carol J. Geffner, Ph.D., President of Newpoint Healthcare Advisors, LLC, for contributing this article. She is also Professor of the Practice of Governance, Management, and Policy and Director of the Executive Master of Leadership program at the University of Southern California Sol Price School of Public Policy. She can be reached at cgeffner@usc.edu.

■■■

2018 Alert: Essential Governance Considerations for MACRA and the Quality Payment Program

By Seth Edwards and Guy M. Masters, Premier, Inc.

On January 1, 2017, CMS began implementing the Quality Payment Program (QPP), the regulatory vehicle that enacts the physician payment reforms required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The QPP is the system designed to move physician reimbursement for Medicare beneficiaries away from traditional fee-for-service toward a model that incents high-quality, cost-efficient care.

During the past six months there has been significant debate related to the future of healthcare. What is clear is that MACRA and QPP are not part of the debate surrounding the Affordable Care Act and the American Health Care Act. MACRA and the payment models it enacts has strong bipartisan support and is already in effect.

Key Questions for the Board

- Does your hospital/health system have a clear strategy to address MACRA physician payment changes for services provided to Medicare beneficiaries that are mandated by law?
- If so, does your strategy embrace both independent and employed physicians?
- Is your organization willing to take action now to mitigate potential negative impacts on Medicare payment rates to physicians in the very near future?

Shifting Financial Risk to Providers: Two Tracks

The QPP creates two tracks designed to place Medicare payments to clinicians at stake and incent a movement toward the assumption of actuarial risk through alternative payment models:

- **Track 1: MIPS**: The Merit-Based Incentive Payment System (MIPS) places eligible clinicians' payments at risk based on their performance in comparison to their peers. This can result in an upward or downward Medicare payment adjustment based on their performance in four domains: cost, quality, clinical improvement activities, and advancing care information.
- **Track 2: AAPM**: The Advanced Alternative Payment Models (AAPMs) requires assuming downside actuarial risk. In exchange, eligible clinicians may be rewarded with up to a 5 percent bonus if a significant percentage of their revenue or patient volumes flow through these models, as well as higher annual pay increases than MIPS participants.

CMS estimates that most (85 percent, or over 418,000) eligible clinicians (ECs) will participate in the MIPS track. MIPS gradually increases the amount of Part B reimbursement a clinician has at risk. Starting with payment year 2019 (based on 2017 performance), ECs have 4 percent at risk. By payment year 2022 (performance year 2020), this amount increases to 9 percent at risk. Moreover, MIPS is a budget neutral program, which means that in order for one EC (e.g., physician) to receive an upward adjustment, other ECs will have to receive a downward adjustment. This dynamic will create competition among ECs, and will also incent continuous improvement.

Bonus or Penalty? Follow the Money

To qualify for an AAPM bonus, clinicians must participate in a program that meets three statutory requirements:

1. The utilization of certified electronic health record technology (CEHRT)
2. Makes payments based on MIPS-comparable quality measures
3. The participants must bear more than nominal risk for losses

In addition, participants in qualifying models must meet threshold requirements related to payment or numbers of beneficiaries they see through the model. (Note: CMS projects that only 70,000 to 120,000 clinicians will be able to qualify under the AAPM requirements.)

Many healthcare organizations and clinicians are struggling to determine the best option for success under these tracks. Within the final rule CMS indicated that they received large amounts of feedback from stakeholders

indicating concern related to the challenges clinicians were experiencing planning for MIPS. CMS decided to alter the implementation plan, and created a "transition year" for performance year 2017 (payment year 2019). During the transition year, CMS lowered the participation threshold required to avoid a downward payment adjustment, and are encouraging clinicians to "pick your pace." Specifically, the final rule created four options for participation in MIPS in 2017:

Action	Financial Payment Impact
Do not submit data	• Automatically receive a -4 percent payment adjustment
Submit minimal data	• Submit a minimum level of data for a single measure across any of the categories to remain neutral (for example, one quality measure or one improvement activity)
Submit partial data	• Submit at least 90 days of data and receive a possible positive payment adjustment
Submit full data	• Submit a full year of data and receive a positive payment adjustment

Incentives to Move Toward Population Health Models

The QPP program creates significant financial incentives for providers to move toward population health through participation in alternative payment models. This is achieved by making fee-for-services as uncomfortable as possible by creating the risk of substantial payment cuts. QPP simultaneously makes the alternative payment models attractive through beneficial scoring under MIPS or through the AAPM 5 percent guaranteed Medicare payment bonus for qualifying practitioners. Success under MIPS requires clinicians to make and demonstrate improvements in quality and cost, use technology to improve care, and redesign the way they are providing care. Conveniently, these are the capabilities that also facilitate success under a population health model.

A New Option: MIPS-APM Track

There is a middle ground that many clinicians are exploring called the MIPS-APM track. This track provides incentives to move toward alternative payment models. It's an attractive option because it does not require downside actuarial risk for participation, but reduces the administrative burden, utilizes the capabilities necessary for success under MIPS, and provides beneficial scoring. The Medicare Shared Savings Program (MSSP) Track 1 is an example of a MIPS-APM. MSSP Track 1 ACOs enjoy the following benefits:

- The ACO provides an opportunity to assist many different provider types under a single program—including primary care physicians, specialists, and non-physician clinicians.
- The ACO is able to report together as a group under the MIPS-APM scoring standard, which reduces the administrative burden on the participating clinicians.
- MSSP ACOs qualify for beneficial scoring:
  - Quality (50 percent of composite score) is measured based on 11 of the group practice reporting option (GPRO) measures that comprise the 31 MSSP quality metrics. This reduces the administrative burden of reporting for individuals or multiple groups under MIPS.
  - Cost is not assessed for MSSP ACOs in MIPS. CMS believes that the ACO is already judged on cost by attempting to generate shared savings.
  - Improvement activities are designed to move providers to population health. As such, participants in a MSSP ACO automatically receive full credit for this category (20 percent of composite score).
  - Advancing care information is reported by each ACO participant tax identification number (TIN), and the ACO receives the aggregated,

weighted average (by number of eligible clinicians) for the composite score (30 percent of composite score).

For the Boardroom

MACRA and the QPP pose challenges and opportunities for Medicare service providers (physicians, hospitals, and health systems) of all sizes and forms across all geographies. Determining a holistic strategy related to the program, clinician integration/alignment, and the movement to population health is critical to ensure that your organization is prepared to be successful. Key questions to consider include:

- How does the QPP align with our strategic plan?
- If we are participating in MIPS, how can we assist both employed and community clinicians?
- Should we develop a clinically integrated network that will embrace and align our clinical and financial incentives with independent and employed physicians?
- Should we consider developing a MIPS-APM to begin the journey to population health and receive value under MIPS?
- Are we prepared to take on downside actuarial risk as an AAPM from a financial and leadership perspective?
- Is there a potential that competitors or disruptors will enter the market and organize clinicians into a MIPS-APM or AAPM? If so, what impact will that have on the organization?

Governing boards must address these questions as part of strategic visioning and planning discussions. It is important to consider which models will match your unique market needs, provider capabilities to take on financial risk, and available resources required to shift to population health management approaches to care delivery. Hospitals, health systems, and physicians across all market sizes, geographies, and competitive landscapes must find ways to create aligned clinical and financial goals and incentives to ensure sustainability and success in a shifting value-based payment environment for not only Medicare, but increasingly for all payers.

The Governance Institute thanks Guy M. Masters, Principal, Premier, Inc., and Governance Institute Advisor, and Seth Edwards, Principal, Population Health Management Collaborative, Premier, Inc., for contributing this article. *They can be reached at guy_masters@premierinc.com and seth_edwards@premierinc.com.*

■■■

Governance Institute Advisor Spotlight: Mark Grube

In this series, we are spotlighting each of The Governance Institute advisors to give you a look into their roles, expertise, and experience in the industry. The advisors are healthcare experts, each with their own areas of focus, who work with members to help them solve their governance challenges—everything from developing leadership skills to building a competency-based board to assuring best-fit strategic plans and partnerships. Our advisory services include:

- Board education and development retreats
- Independent governance review and redesign processes
- BoardCompass® consultation and self-assessment retreats
- Phone and email consultations
- Specialized consultations

In this article, we highlight Mark Grube, Managing Director and National Strategy Leader at Kaufman Hall & Associates, LLC. Watch for future articles in this series to learn more about each of our advisors.

Industry Expertise

Mark Grube leads Kaufman Hall's Strategic Advisory practice, which provides a broad array of strategy-related services to regional and national healthcare systems, academic medical centers, community hospitals, and specialty providers nationwide. He has more than 30 years of experience in the healthcare

industry, as a consultant and as a planning executive with one of the nation's largest healthcare systems.

Mark is a frequent speaker and author on healthcare strategy topics. He has published dozens of articles and white papers, and presented at national meetings of The Governance Institute, the American College of Healthcare Executives (ACHE), The Healthcare Roundtable, HFMA, and the Society for Healthcare Strategy and Market Development (SHSMD). He is a member of ACHE, HFMA, SHSMD, and the Leaders Board for Healthcare Strategy and Public Policy.

His expertise covers many topics of board interest, including:

- **Strategic and financial planning**: helping healthcare boards and executives integrate strategic and financial planning in order to:
    - Gain insight into key dynamics and trends impacting the healthcare provider industry
    - Establish a solid fact base regarding the organization's market and the organization's strategic position related to new core competencies required for sustained success
    - Identify and prioritize alternative repositioning strategies and initiatives
    - Link the organization's strategic mission and vision to measurable financial objectives
- **Managed care strategies**: advising boards and senior leaders on managed care-related concerns including:
    - Managed care positioning strategies
    - Clinical integration network (CIN) formation and development
    - Managed care contracting
- **Partnering**: helping his clients understand the changing landscape and determine:
    - The strategic options available for repositioning the organization for near-term and long-term success
    - How to identify the organization's potential need for a strategic partnership arrangement, including key analyses required for high-quality decision making
    - The optimal partnership exploration process, including the development of partnership goals and a competitive partner evaluation process
- **Governance**: assisting boards with redefining their:
    - Structure
    - Composition
    - Role and function

Work with The Governance Institute

Mark regularly contributes to Governance Institute publications. He recently wrote articles for the Biennial Survey*, BoardRoom Press,* and other newsletters on topics such as consumer-centric healthcare, leadership imperatives for success with value-based care, and strategies for directors around precision medicine. He was a coauthor for the white paper *Strategic Cost Transformation for Post-Reform Success* and the Elements of Governance® publication *Integrated Strategic Direction Setting and Planning, and* presented a Webinar on "Moving Your Organization toward Strategic Cost Transformation."

He also frequently speaks at Governance Institute conferences. This year he presented at the Leadership Conferences on "Strategic Planning 2017: Time to Pivot," where he described the changing expectations of consumers, payers, and employers; how to shape the organization's value proposition to meet those needs; and how to measure and improve performance related to that value proposition.

For more information or to schedule an advisory service, contact The Governance Institute at info@governanceinstitute.com or call (877) 712-8778. A detailed list of our advisory services can also be found on our Web site at www.governanceinstitute.com/AdvisoryServices.

■■■

Upcoming Events

Governance Support Forum
The Westin Copley Place, Boston
Boston, Massachusetts
August 13–15, 2017

Leadership Conference
The Broadmoor
Colorado Springs, Colorado
September 10–13, 2017

Leadership Conference
Four Seasons Resort & Club
Dallas at Las Colinas
Dallas, Texas
October 29–November 1, 2017

Click here to view the complete programs and register for these and other conferences.

■■■

New Publications and Resources

Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards, Second Edition (2017)

The Board's Role in Quality, Second Edition (*Elements of Governance*, June 2017)

Physician Leadership in Hospitals and Health Systems: Advancing a 21st-Century Framework (white paper, Summer 2017)

BoardRoom Press: Volume 28, No. 3 (*BoardRoom Press*, June 2017)

To see more Governance Institute resources and publications, visit our Web site.