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Closing the Meaningful Use Gap for Small/Rural Hospitals

By Lauren Phillips

Small and rural hospitals have the advantage of being nimble and having to corral fewer people to consensus than large hospitals, but finding IT skills and funds is often a constant struggle. The non-traditional financing approaches highlighted in this article may help shrink the IT disparity between small/rural and large/urban hospitals. ➜ ➜

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Given the high cost and complexity of electronic health record (EHR) implementation, it is not surprising that small and rural hospitals continue to lag behind: Only 13.9 percent of small hospitals and 12.9 percent of rural hospitals were in a position to qualify for Stage 1 meaningful use incentives at the end of 2011, according to a May 2012 *Health Affairs* study.[a] In comparison, 29.7 percent of large hospitals and 20.3 percent of urban hospitals qualified.

In fact, this EHR gap grew from 2010 to 2011: Small and rural hospitals that had some form of EHR jumped about 10 percent in that time, compared with 17.3 percent and 12.1 percent growth for large and urban hospitals, respectively.

Yet, says Tracey Mayberry, partner, CSC Healthcare Group, most organizations understand that, even if they can't move fast enough to meet the deadlines for meaningful use incentive payments, they must act in time to avoid the penalties for noncompliance that go into effect in 2015. To do otherwise "is really almost an admission that you're done as a hospital."

The problem, of course, is resources—or rather, the lack of them. "Hospitals in the rural market find it difficult to make the significant investment in EHRs due to constraints in available financing, competing priorities for limited capital dollars, and thin operating margins," says HFMA's Todd Nelson, technical director for senior financial executives/accounting.

While bank loans and other traditional financing options may be an option for some well-positioned small/rural facilities, others may find better luck with philanthropy and nontraditional financing approaches, such as the ones highlighted in this article.

a. DesRoches, CM, et al, "Small, Nonteaching, and Rural Hospitals Continue to Be Slow in Adopting Electronic Health Record Systems," *Health Affairs*, April 2012, vol. 31, no. 7.

Government Funding Opportunities

Small and rural hospitals have a number of government-sponsored funding options to explore, says Aaron Fischbach, public health analyst, Federal Office of Rural Health Policy.

Community Facility Direct and Guaranteed Loan Program. Under the auspices of the U.S. Department of Agriculture's (USDA's) Rural Development offices, the Community Facility program covers health IT and is intended to foster compliance with meaningful use in not-for-profit and public hospitals and clinics in communities of less than 10,000 people.

The Community Facility program has little grant money, says Fischbach. However, hospitals can use anticipated meaningful use incentive funds as collateral to borrow funds from the Community Facility program. The terms on these loans give hospitals enough time to implement an EHR, attest to meaningful use, and then use the incentive payments to repay at least a major portion of the loan.

Clinics need to take a more circuitous route. Unlike hospitals, clinics do not qualify for direct EHR incentive payments; instead, the Centers for Medicare and Medicaid Services (CMS) program pays their clinicians, who typically reassign the payments to the clinic under their employment agreements.

USDA and Small Business Administration loans. To the extent that for-profit hospitals can prove that job retention and/or creation is involved, they can apply for loans or loan guarantees to cover IT improvements from the USDA Rural Development's Business & Industry Program or from the Small Business Administration's capital loan programs.

USDA Rural Development also sponsors three other programs where hospitals can look for funding assistance with telecommunications software, hardware, and connectivity:

Government IT Assistance: Looking for Guidance?

A good place to turn is the 70+ Regional Extension Centers, funded by the Office of the National Coordinator, which offer technical assistance, guidance, and information on best practices to support and accelerate providers' efforts to achieve meaningful use. This includes on-site technical assistance to "priority primary care providers" that have not yet adopted an electronic health record (EHR) or that have certified EHR technology but need help meeting meaningful use criteria.

Find the extension center that serves your region at www.regionalextensioncenters.com.

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> The Rural Utilities Service Telecommunications Infrastructure Loan Program
> The RUS Broadband Initiatives Program
> The Distance Learning and Telemedicine Loan and Grant Program

HUD block grants. Hospitals in counties or cities that are Entitlement Communities and, thus, eligible for monies under The U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant Program, may qualify for funds for equipment designed to provide improved community facilities and services—including hardware to improve health services.

CAH-specific programs. Critical access hospitals (CAHs) and other hospitals with fewer than 49 beds can apply to their states for funds to help with activities related to quality improvement and the effective use of IT, which are available from the Health Resources and Administration's Small Hospital Improvement Program (SHIP) and Medicare Rural Hospital Flexibility Grant (Flex) Program. Fischbach explains that these programs grant money to the states for assistance to hospitals to provide, for example, technical or training help—rather than funds to purchase hardware or software.

Rural Health Care Program. One program that Fischbach says is "very under-subscribed" is the Rural Health Care Program, run by the Universal Service Administrative Company under the oversight of the FCC. "Every monthly bill for phone service includes a universal service fee. Those fees are used to subsidize the costs of telecommunications for public and not-for-profit healthcare providers in rural areas, which may pay four or five times as much as their nearby metro counterparts for the same services. The subsidies can be significant—and there is a lot of money that isn't being spent right now."

Meaningful Use 101: Medicare Versus Medicaid

Medicare	Medicaid
Federal government will implement (will be an option nationally).	Voluntary for states to implement (may not be an option in every state).
Fee schedule reductions begin in 2015 for providers that are not "meaningful users" by 2015.	No Medicaid fee schedule reductions.
Must be a "meaningful user" in year one.	There is an adopt/implement/upgrade option for first participation year.
Maximum incentive is $44,000 for eligible providers.	Maximum incentive is $63,750 for eligible providers.
Meaningful use definition will be common for Medicare.	States can adopt a more rigorous definition (based on common definition).
Medicare Advantage eligible providers have special eligibility accommodations.	Medicare Advantage Care providers must meet regular eligibility requirements.
Last year an eligible provider may initiate program is 2014.	Last year an eligible provider may initiate program is 2015.
Last payment year in program is 2016; payment adjustments begin in 2015.	Last payment year in program is 2021.
Only physicians, subsection (d) acute care hospitals, and critical access hospitals are eligible.	Five types of eligible providers and two types of hospitals are eligible.

Source: Mike Allen, Winona Health Services, tailored this exhibit based on information pulled together by Cerner.

Networking Opens Other Doors

One way small hospitals can obtain IT resources is by joining networks and consortia that take advantage of discounted pricing and economies of scale. Mayberry has seen a number of community hospitals leverage strategic partnerships—either by affiliating or by joining large, mature independent delivery networks—to gain access to solutions, products, and talent they might not otherwise be able to afford.

"Smaller organizations with non-overlapping geographies can form collaboratives to work on IT initiatives, especially if they have a common vendor. For example, they might start a shared service organization, essentially combining their IT operations," he says.

Fischbach cites another advantage of affiliation. "Small, independent hospitals tend to be the last priority for vendors that can make more money working with a big health system like Mayo or Kaiser Permanente. So if the small hospitals can group together, they can not only save on hardware purchases but they can also probably get the attention of a vendor sooner."

To encourage collaboration among rural providers, HHS allocated $12 million in 2011 for grants to networks of rural healthcare organizations in support of IT adoption and and meaningful use. The money must be used for purchasing technology, installing broadband networks, and training staff.

In 2011, when 25-bed Jersey Shore Hospital in north central Pennsylvania decided to team up with 21-bed Fulton County Medical Center in McConnelsburg, 2.5 hours away, the two CAHs didn't even know about the availability of these HHS grants. They were just looking for a means to share IT resources needed to achieve

meaningful use, including joint installation of an EHR that would otherwise have cost each organization an estimated $2.3 million, according to Carey Plummer, Jersey Shore's CEO.

Thanks to the Pennsylvania Mountains Healthcare Alliance, a 19-hospital collaborative to which both belong, they found each other, a partnership that has saved each some $300,000 on EHR implementation—and provided grant money, too. Both hospitals expect to attest to stage 1 meaningful use criteria by Sep. 1, 2013. (For more details, see the case study on page 6 of this newsletter.)

Vendor Relationships

Not all small and rural healthcare organizations are struggling to find IT dollars and meet meaningful use deadlines; some of them were close to the finish line when the American Recovery and Reinvestment Act was enacted. Winona Health Services, a Minnesota system consisting of one 99-bed hospital, a nursing home, an assisted living community, and 45 employed physicians, started its EHR journey more than 10 years ago and was ready to attest in November 2011, says CFO and treasurer Michael M. Allen, FHFMA, CPA.

"We really just needed to go the last mile. There were a few small pieces of functionality to put in place, and there was still work to do with the medical staff to bring a few operational processes in line with meaningful use criteria."

Central to Winona's success, according to Allen, is something he recommends that every small hospital pursue: a close, strategic, integrated relationship with its EHR provider.

"As a small, independent system that wanted to accomplish big things, we knew we'd get lost in the shuffle with any vendor if the relationship was simply based on a transaction. The EHR is so critical to the goals of the organization and of the community. You need to feel comfortable with your partner, and be able to work together over the long haul."

Despite due diligence, Allen cautions that hospitals are not going to fully understand what they're getting from a vendor at proposal time; it's just too complex.

"Increasingly, however, EHR systems are going to cost about the same and have about the same functionality. If you have a strong, give-and-take relationship, the cost and other issues will fall into line."

What does a give-and-take relationship look like from the provider side? Feedback plays a prominent role. Allen himself sits on the vendor's client care council with 35 or 40 other hospitals and systems.

"We get together at least twice a year and at other times on the phone, and work on improvements and solutions to problems in the delivery or use of software or the billing for software—whatever it might be. It's rewarding from my perspective because I've got colleagues from all these other places in the room, and we learn from each other."

Likewise, Winona physicians sit on the vendor's physician council, which focuses on how physicians use the software to improve patient care and workflows, and how changes could enhance and accelerate those improvements.

"We also open ourselves up for site visits by other small hospitals that want to see how the system is working," says Allen. "The vendor organizes the visits, but it still takes a day of our time every time."

In return, Allen explains, the vendor helps Winona mature its software. "Maybe they need a beta partner for some new software, which is exciting and interesting but also very time intensive. So, typically, they will end up giving us that functionality or discounting it significantly."

Sometimes there are gray areas in the agreement, things the provider and vendor don't see eye to eye on. Because Winona has been generous in working with the vendor, "they're going to be more flexible and understanding," says Allen.

"If all you do is take, at some point the relationship is just not going to be there when you need it most," he continues. "You need to make investments of money and effort both. Structure the contract in a way that you can manage financially, then roll up your sleeves and put in the time."

Maximum Value

Once a hospital has an EHR in place that will allow it to qualify for meaningful use

Leasing Now an Option for CAHs

Many critical access hospitals (CAHs) breathed a sigh of relief in July when the Centers for Medicare & Medicaid Services (CMS) changed its policy to allow CAH's meaningful use incentive payments to include the cost of capital leases for certified electronic health record (EHR) technology.

Previously, while a CAH could include lease costs on its cost report, only reasonable costs to which purchase depreciation would apply were allowable for incentive payments. But in July, CMS decided that a capital lease is essentially the same as a virtual purchase agreement and meets the intent of the statute and regulation to qualify the leased asset as a purchased asset. The cost must be based on the fair market value of the asset at the date the lease was initiated. For more information about this reversal, visit www.cms.gov/EHRIncentivePrograms.

incentives, how can the hospital be sure it is getting maximum value from that system? The trick, says Jim D'Itri, partner, CSC Healthcare Group, is to not stop there.

"In a small way, meaningful use is pushing the effective application of automation to make the hospital more efficient, but it doesn't go far enough in terms of safety and quality. The hospital has to engrain the meaningful use values into its culture, into its normal workflows. For example, meaningful use requires 30 percent of medical orders to be done through computerized provider order entry. But it makes no sense to stop at 30 percent."

Meaningful use, like the EHR, is part of a much bigger agenda, says D'Itri. "In the end, it's about harmonizing investments to foster accountability, assuming responsibility for the health of a population, and managing consumption wisely."

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A commentary by Jeffrey C. Bauer

Reform at Half-Time: ACA Versus the Economy

The Supreme Court's ruling on the Affordable Care Act is not the end of the reform game. It's half-time. Here's my color commentary on what we've seen so far, and what we might expect as play continues.

The Affordable Care Act (ACA) was enacted at the end of a bruising first quarter. Nothing much happened in the second as everyone waited for judges to decide if the game was being played according to the rules. Assuming the same teams return after half-time elections, lobbyists playing for both sides will dominate the third period. An underrated player—the economy—will determine the outcome in the final quarter.

Why? The 2012 Roberts decision upheld a 2010 law built on unrealistic projections that the economy would recover before the mandate goes into effect in 2014. The economy has not rebounded as hoped, and today's consensus forecast suggests neither governments nor patients will be able to meet their financial obligations under the law. If lobbyists don't neutralize key provisions over the next two years, economic stagnation will likely defeat the ACA.

Economic Forces at Play

Two economic forces make it difficult for ObamaCare to win, even though the referees decided the game can continue. First, ACA makes mandatory insurance "affordable" by dramatically cutting the covered portion of care. Today's average health plan pays approximately 80 percent of a patient's health costs, leaving 20 percent to be billed to the beneficiary. Mandated coverage in 2014 will be priced on an actuarial assumption that basic insurance pays only 60 percent—leaving the insured patient with a 40 percent out-of-pocket obligation. Many ACA fans will cry foul when they discover this unpleasant play in the game plan. (As Chief Justice Roberts noted, the Supreme Court only decides whether a law is constitutional, not whether it is viable.)

As an economist unabashedly committed to reinventing the way we deliver health care, I simply cannot see how consumers will be able to hold up their end of the reform bargain when the mandate goes into play.

The second trend is ongoing decline in spending capacity. Personal wealth, employment income, consumer confidence, and other key components of purchasing power have fallen dramatically since 2008 and are unlikely to rebound by 2014. The student loan bubble will probably burst in the meantime, the banking system is digging itself into a deeper hole, and the global economic outlook is depressing (literally). Taxes are also likely to rise over the next two years because austerity is not re-igniting economic growth.

Hence, as an economist unabashedly committed to reinventing the way we deliver health care, I simply cannot see how consumers will be able to hold up their end of the reform bargain when the mandate goes into play. The ACA will not generate more money for healthcare providers because there won't be more money in government coffers or consumers' pocketbooks. Odds are that economics will defeat ObamaCare.

The Providers' Card

Can providers survive under such dismal circumstances? Yes, as long as strategic financial leaders work relentlessly to harness the abundant waste in current operations and redirect recovered resources to creating an efficient and effective delivery system—doing health care right all the time, as inexpensively as possible. Some innovative American health systems have already proven that it can be done without the ACA.

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By Lauren Phillips

Two CAHs Team Up to Achieve Meaningful Use

Two Pennsylvania CAHs are sharing EHR resources and expenses—and even a CIO.

Like many resource-strapped small and rural hospitals, 25-bed Jersey Shore Hospital and 88-bed Fulton County Medical Center—located 2.5 hours away from each other in Pennsylvania—felt that attesting to meaningful use in time to reap any incentive money might be an unreachable goal.

It was the beginning of 2011, and the U.S. Department of Health and Human Services (HHS) was about to allocate $12 million for grants to rural health networks to support IT adoption and help them meet meaningful use requirements. The money is slated for purchasing technology, installing broadband networks, and training staff.

The two critical access hospitals (CAHs) didn't know about the new HHS grants. They were just looking for a means to share IT resources needed to achieve meaningful use, including joint installation of an EHR that would otherwise have cost each organization an estimated $2.3 million, according to Carey Plummer, Jersey Shore's CEO.

Thanks to the Pennsylvania Mountains Healthcare Alliance, a 19-hospital collaborative to which both belong, Jersey Shore and Fulton County found each other. Over the last year, the partnership has saved each facility about $300,000 on EHR implementation—and provided needed grant money, too. Both CAHs expect to attest to Stage 1 meaningful use by Sep. 1, 2013.

Shared Resources and Expenses

Today, Jersey Shore and Fulton County share CIO, Christine Haas, as well as IT resources across the board, including:

- A healthcare information system
- A cloud-based hosted server facility
- New physician practice management software
- Clinical and financial IT specialists
- A help desk for IT support

The Pennsylvania Mountains Healthcare Alliance has played a multifaceted role in the arrangement:

- It negotiated and holds the master contract with the two hospitals' vendor of choice, capitalizing on the larger group's ability to get a better price for equipment.
- It has provided IT consulting services to the partnership.
- It serves as a funding mechanism for a three-year, $900,000 grant from the Health Resources and Services Administration: The two hospitals are the primary recipients of the $600,000 available in the first two years and will share in the last $300,000 in the third year.
- It allows the partners to use its private wide-area network to connect to their server facility.

When third-party vendors were needed—for example, for voice recognition software—Jersey Shore and Fulton County negotiated the contracts together. In some cases, each signed a separate contract in what is still considered a joint pricing venture. In addition to a lower price, the partners saved an estimated $40,000 in legal fees.

A Collaborative Structure

So how did the two hospitals manage to bring their clinicians and staff into sync while still maintaining their independence? With a lot of planning, work, and travel between the two facilities, says Haas. The hospitals created cross-functional core teams for each of the 16 areas of implementation (e.g., pharmacy, operating room, payroll). These teams reached consensus on all the specifics around installing the hospitals' shared infrastructures, such as establishing naming conventions for data elements.

"Each team has co-leaders representing the two hospitals, and one of these co-leaders was chosen as the single point of contact with the vendor," she says. "We also held joint core team leader meetings to discuss logistics every week. In addition, we have an executive oversight committee that also met weekly."

The collaborative effort, Haas says, has been "amazing. The progress we made together is so much more than if we had done this alone."

Hospital leaders were warned that getting their physicians involved would be difficult: It wasn't. "The two hospital teams collaborated on clinical decisions and documentation," says Haas, "working through a physician champion selected for the project and the core team leaders in charge of the physician care manager system. In addition to one-on-one training, there were one-hour lunch-and-learn sessions for physicians in the weeks leading up to the go-live date in July."

Plummer attributes the smooth physician collaboration to the fact that "the physicians viewed the venture as two hospitals working together rather than some big system wanting to take over their practices; nobody was trying to be king of the hill." As a result, employed physicians will be able to attest for meaningful use on schedule, although

only one independent physician accepted the invitation to join the physician practice management system and pay a monthly service charge.

Future Plans

The IT project has gone so well, says Plummer, that the two hospitals are considering joining forces in other ways, such as payroll, marketing, and public relations.

The key, he believes, is the similarities between the hospitals—both CAHs, both rural, both very community-minded—and a leadership commitment to honesty and integrity. If you're open and honest on everything, Plummer says, the financial savings will come along.

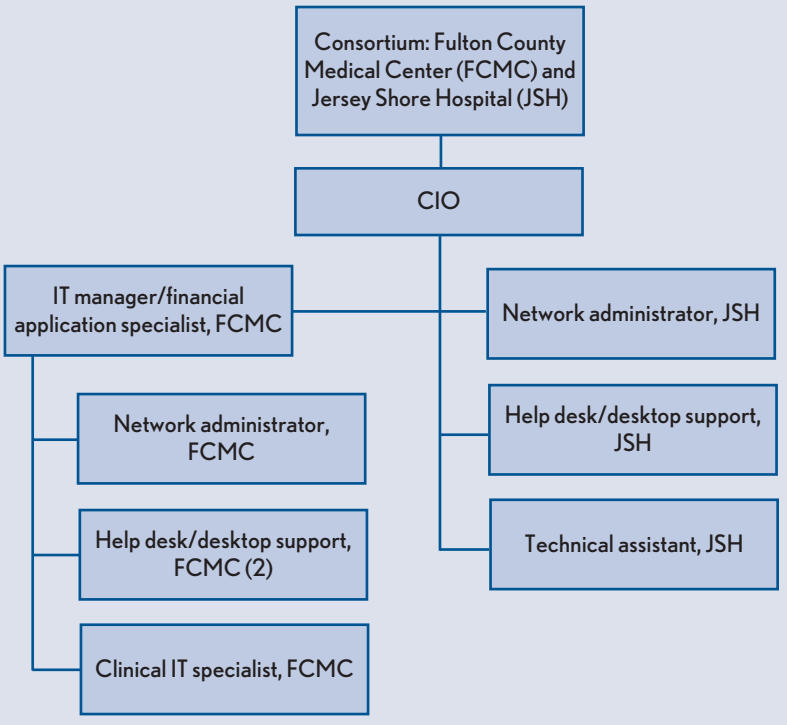
Meanwhile, word of the partnership has spread, and another hospital would like to make it a threesome. That's fine with Jersey Shore and Fulton County. Plummer says they have the potential to develop into a partnership of 10 or twelve small and rural hospitals around the country—all of which would benefit from those third-party contracts the two hospitals already negotiated.

"The way we set things up, the hardware is not sitting in either of our hospitals; it's off-site, so it would be easy to bring in other organizations, as long as we could extend that same trust and honesty," he says. "We wouldn't necessarily gain any further advantage by expanding, but that's not why we did this in the beginning. We did it to save rural health care in our communities."

Lauren Phillips is president, Phillips Medical Writers, Ltd., Bellingham, Wash., and a frequent contributor to *Strategic Financial Planning* (philwrite@att.net).

Interviewed for this article (in order of appearance): Carey Plummer is CEO, Jersey Shore Hospital, Jersey Shore, Pa (cplummer@jsh.org). Christine Haas is CIO, Jersey Shore Hospital, Jersey Shore, Pa (chaas@jsh.org).

IT Consortium Structure



Source: Fulton County Medical Center and Jersey Shore Hospital

Hospital Consolidation Leads to Price Increases

Hospital mergers in concentrated markets can lead to dramatic price increases—exceeding 20 percent, according to a June 2012 report from the Robert Wood Johnson Foundation that synthesizes research from the last decade on hospital consolidations.

Hospital consolidation. The report, called *The Impact of Hospital Consolidation—Update*, defines hospital concentration as "the extent to which a market is dominated by a few (or one) hospitals." When hospitals merge, the consolidated hospitals gain more power at the bargaining table with insurers. "The evidence points to differences in hospital bargaining leverage as a principal driver of the difference between relatively expensive and inexpensive hospitals systems within the same hospital market."

The report also examined the effects of hospital competition on quality of care, using the English National Health Service (NHS) as a test sample. A 2006 reform of the NHS, which allowed patients to choose hospitals, created competition in the system. "The studies all show a substantial impact of the introduction of hospital competition in the NHS on reducing mortality rates," write the RWJF researchers. For instance, one study found that heart attack mortality decreased by 10.7 percent when an additional hospital was added to less concentrated markets.

Physician-hospital consolidation. On examining the impact of physician/hospital consolidations, the RWJF researchers conclude that the existing literature "does not find evidence supporting either clinical gains or cost reductions. The most likely reason is that most consolidation did not lead to true integration."

By Jamie Cleverley and Lawrence Baylis

Did Hospital Value Improve with the Economy?

Overall, hospitals' financial structures strengthened after the Great Recession, due primarily to a concentration on cost containment. This is a clear lesson learned for the years ahead, as hospital financial leaders devise ways to keep their organizations viable despite reduced payment streams.

Key Take-Aways

The hospital industry quickly shifted from recession mode in 2009 to value enhancement in 2010:

> Margins improved by almost a full percentage point.
> Both operating and non-operating margins improved.
> Overall debt financing levels increased by 4 percent; however, hospitals depreciated more in fixed assets than was invested in new buildings and equipment.
> Inpatient costs remained steady, and outpatient costs increased a mere 2 percent.
> Charge increases were only about 3 percent.
> Quality scores remained steady.

The 100 top-performing hospitals outperformed average U.S. hospitals on all Community Value measures:

> Nearly 20 percent lower costs for both inpatient and outpatient services
> Eighty-nine percent higher margin levels
> Twenty-two percent less debt financing

While many would argue that the economy is not entirely clear of the challenges brought on by the Great Recession, signs of progress exist. Improvements in consumer confidence, as well as housing and labor markets are a few indicators that we've moved on from the worst of the last storm. "Officially," economists seem to agree that the recovery started somewhere at the beginning of 2010. This proclamation may not have helped your neighbors find new jobs or sell their houses more quickly, but it is encouraging to know that the economic gears are turning once again.

With an economy on the mend, many hospitals have been able to dust off strategic plans that were put on hold in the crisis days of 2008 and 2009. But how quickly were hospitals able to shift away from survival mode to value enhancement? Were some able to recover more quickly? Finally, what were the elements used to help bring some hospitals back from the brink? This article seeks to address these—and related—questions.

How Can Value Be Objectively Measured?

In essence, we believe that a hospital has high value in the community when it is financially viable, is appropriately reinvesting back into the facility, maintains a low cost and charge structure, and provides high-quality patient care. Our national study, known as the Community Value Index®, assesses the value that hospitals provide their communities by evaluating 10 financial, operational, and quality measures in the following four key dimensions. See the sidebar on page 9 for how we calculate these dimensions.

> Financial viability and plant reinvestment
> Cost structure
> Charge structure
> Quality performance

To determine performance in each area, a hospital's value for each of the 10 metrics is compared against all other hospitals with similar size and teaching intensity. The hospital is then assigned a score based on its relative position among its peer group. (For more details, see the article "Assessing Community Value," in the Summer 2010 issue of this newsletter.)

Taken together, financial, cost, charge, and quality performance combine to create the overall Community Value Index® score. We are able to use this composite score to compare one hospital or group of hospitals to another. The composite score does not change much year to year because all hospitals are compared using the same year of data for the study. It is the relative performance of a hospital to the group that creates the hospital's score. If all hospitals are performing worse in that year because the economy deteriorated, the composite score would not show significant change because the bar for the entire industry went down. The individual metrics, however, would show the declines. For this reason, we are focusing more on the individual metrics to address our key questions.

Did Hospital Value Improve with the Economy?

To determine if and how hospitals were able to improve value as the economy

improved, we examined performance in the last year of the recession (2009) and the first year of recovery (2010) using public data sets. We calculated medians for all hospitals in the Community Value Index study for both years (approximately 3,000 in each year). We then structured the data by core area to more easily see what value components had the greatest change from 2009 to 2010 (see the exhibit on page 10).

The results of the research include the following factors:

Margins improved. One thing is immediately evident in reviewing the data: Hospital margins improved significantly by almost a full percentage point, representing a 34 percent increase over the prior year. The 2010 value of 3.81 percent is more consistent with the 4 percent margin levels that have been standard in the hospital industry for years.

What is hidden in this value is the improvement in both operating and non-operating margin areas. Hospitals have relied heavily on non-operating income, and the stock market declines of 2008 and 2009 hit many hospital bottom lines hard. The improvement in the economy led to improved market results and, subsequently, improved overall margin levels. Nonetheless, operating improvement did occur, as well, aided by net patient revenue increases of 6 percent.

Debt financing levels increased. Of note, however, is that hospitals increased overall debt financing levels by 4 percent. This point may be misleading since it appears, on the surface, that hospitals borrowed more during the period. However, it may also be indicative of less aggressive asset growth in relation to debt growth. To that point, the two-year change in net fixed assets shows that hospitals depreciated more in fixed assets than was invested in new buildings and equipment, resulting in a decreased fixed asset value on the balance sheet. This proves what many thought was occurring in the industry as a result of economic uncertainty from 2008 to 2010: Hospitals put the brakes on larger capital projects, whether in response to decreased demand, heightened risk, or tightened capital markets.

Fixed asset efficiency was stable, however, at $2.44 of net revenue production for every dollar invested in fixed assets. This level has been stable for years, highlighting that hospitals are keenly aware of the relationship of fixed asset investment and the need for revenue generation on those invested dollars. If this were not a concern, we certainly would have seen a drop in fixed asset turnover with the deterioration in the general economy.

Cost growth contained. Financial stability and growth was possible because hospitals significantly contained cost growth during the period. Inpatient costs were nearly equal in 2010 as in 2009 (adjusting for case mix and wage index differences), and median outpatient costs increased a mere 2 percent to $81.10, stated at a relative weight and wage index of 1.0.

Effective cost management permitted hospitals to re-establish historic margin levels. Charge increases were also low at approximately 3 percent—again, adjusting for differences in case intensity and cost of living—even with an increase in Medicaid patient days. These points are significant in light of health reform

Community Value Index® Dimensions

Financial viability and plant reinvestment. This dimension is calculated by comparing performance in four metrics:

> Total margin
> Debt financing percentage
> Two-year change in net fixed assets
> Fixed asset turnover

From these four metrics, a "finance" dimension score is derived. High-value hospitals have lower levels of debt and higher values of profit that they use to efficiently reinvest back into the facility.

Cost structure and charge structure. These two dimensions are determined by examining a hospital's costs and charges by inpatient and outpatient encounter. We do not employ cost or charge by adjusted patient day/discharge methodology because of the inherent flaws of these metrics. Instead, Medicare cost (charge) per discharge (case mix and wage-index adjusted) and Medicare cost (charge) per visit (relative weight and wage-index adjusted) are used to benchmark specific inpatient and outpatient areas.

Again, the Community Value Index calculation compares a hospital's performance for these metrics against others in its specific peer group to determine the hospital's relative score. For the charge area, Medicaid Days Percentage is also used to adjust for payer mix. Over the years, we have found that hospitals with a less favorable payer mix often increase charges to recover payment deficiencies from poor payers.

Quality performance. This dimension is measured through the Hospital Quality Index™. This index provides an overall quality score for hospitals by judging performance in mortality, readmission, and process of care areas.

Community Value Index (CVI)*, U.S. Median 2009-2010

CVI Area	Metric	CVI U.S. Median-2009 Data	CVI U.S. Median-2010 Data	% Change
Financial	Net patient revenue	124,478,928	131,922,036	6%
	Total margin	2.85	3.81	34%
	Debt financing %	48.21	49.94	4%
	Two-year change in net fixed assets (%)	3.47	−0.63	n/a
	Fixed asset turnover	2.43	2.44	0%
Cost	Medicare cost per discharge (case mix/wage-index adjusted)	6,619	6,651	0%
	Medicare cost per visit (relative weight/ wage-index adjusted)	79.70	81.10	2%
Charge	Medicare charge per discharge (case mix/ wage-index adjusted)	19,350	19,928	3%
	Medicare charge per visit (relative weight/ wage-index adjusted)	319.32	330.30	3%
	Medicaid days %	16.36	17.14	5%
Quality	Average % of national process of care average	102.30	102.29	0%
	% process areas reported	93.10	93.10	0%
	% process areas reported in top 10th percentile	25.93	28.00	8%
	National mortality score	100.17	100.24	0%
	National readmission score	99.69	99.50	0%
	Hospital Quality Index™±	96.52	96.47	0%

Source: Cleverley & Associates, Inc., using data from the Centers for Medicare and Medicaid's public use files.

*The Community Value Index assesses the value that hospitals provide their communities by evaluating 10 financial, operational, and quality measures in the four dimensions highlighted.
± This Hospital Quality Index provides an overall quality score for hospitals by judging performance in mortality, readmission, and process of care areas.

legislation. Hospitals are being asked to survive in an environment with more Medicaid patients and less Medicare reimbursement on a patient-encounter basis. In this brief period of time, we have seen that hospitals have been able to accomplish the task—in part, through cost control. It is everyone's belief that the coming declines in Medicare reimbursement will necessitate more drastic cost-containment measures for long-term viability.

Quality holds steady. In addition, the cost containment seen in the industry had an interesting outcome on quality, which could be interpreted as "good" or "bad," depending on your perspective. As seen in the quality data metrics, virtually all process of care and outcome of care areas saw no improvement (that is, a decline). So hospitals were able to contain costs without sacrificing patient care. However, they were also not able to make the improvements in quality that so many are demanding.

Again, this will be an interesting issue going forward: Can hospitals improve quality with fewer available resources? As a country, we will need to ask what we are willing to pay to achieve perceived "necessary" levels of care.

Did Some Hospitals Recover More Quickly?

Beyond the peer groups that were used for the study, we also segmented the hospitals by organization structure to determine if certain groups were able to improve more quickly than others. To look at these relative performance levels, we examined the composite Community Value Index scores for 2009 and 2010 and reported the following conclusions:

Investor-owned saw the greatest declines. Investor-owned hospitals had the largest change when comparing movement in median Community Value Index scores for each of the comparison groups to the prior year. Investor-owned hospitals

Community Value Index (CVI)*: Top 100 Versus U.S. Median, 2010

CVI Area	Metric	CVI Top 100 Median	CVI U.S. Median	% Difference
Financial	Net patient revenue	243,732,234	131,922,036	85%
	Total Margin	7.21	3.81	89%
	Debt financing %	38.97	49.94	−22%
	Two-year change in net fixed assets (%)	7.22	−0.63	n/a
	Fixed asset turnover	3.11	2.44	28%
Cost	Medicare cost per discharge (case mix/ wage-index adjusted)	5,514	6,651	−17%
	Medicare cost per visit (relative weight/ wage-index adjusted)	66.52	81.10	−18%
Charge	Medicare charge per discharge (case mix/ wage-index adjusted)	15,198	19,928	−24%
	Medicare charge per visit (relative weight/ wage-index adjusted)	224.29	330.30	−32%
	Medicaid days %	22.83	17.14	33%
Quality	Average % of national process of care average	102.54	102.29	0%
	% process areas reported	93.10	93.10	0%
	% process areas reported in top 10th percentile	23.61	28.00	−16%
	National mortality score	103.01	100.24	3%
	National readmission score	97.67	99.50	−2%
	Hospital Quality Index™±	97.85	96.47	1%

Source: Cleverley & Associates, Inc., using data from the Centers for Medicare and Medicaid's public use files.

*The Community Value Index assesses the value that hospitals provide their communities by evaluating 10 financial, operational, and quality measures in the four dimensions highlighted.
± This Hospital Quality Index provides an overall quality score for hospitals by judging performance in mortality, readmission, and process of care areas.

median score dropped 1.89 percent from the previous year.

This finding is interesting in that many would have expected these hospitals to rebound more quickly given investor demands. The performance area score that affected investor-owned hospitals the most was "financial viability and plant reinvestment," which dropped 6.23 percent compared to the 2009 median score. Contributing to the decline in this area was a decrease in total margin (from 5.7 percent in 2009 to 3.5 percent in 2010) and an increase in debt financing percentage. In addition, investor-owned hospitals experienced the second largest increase in Medicaid days percentage.

Not-for-profit made the biggest gains. The group that made the largest improvement in median Community Value Index score was the not-for-profit hospital/other ategory (which excludes government and church-related hospitals). This group improved by nearly 1 percent.

In general, there was a very narrow spread between all organizational structure groups in composite Community Value Index scores from 2009 to 2010. This highlights the fact that this difficult economic time impacted all hospitals in much the same way—and has led to a rebound that is roughly equal across groups.

How Did the Highest Performers Fare?

One of the central pieces of the Community Value Study is to determine the 100 top-performing hospitals in the country (the top 20 hospitals from each of the five peer groups in the study based on the composite Community Value Study score). The exhibit above shows the relative performance of these high-performing hospitals and the U.S. median. It is interesting to see how much better these facilities are performing—even shortly after the impact of the Great Recession.

Financial performance is significantly better in every metric:

> Eighty-nine percent higher margin levels

> Twenty-two percent less debt financing
> Higher fixed asset growth and efficiency levels

Top 100 hospitals did increase their charges by 9 percent (inpatient) and 7 percent (outpatient) from 2009 to 2010; however, charges are still 24 percent (inpatient) and 32 percent (outpatient) lower than the national level. This is even more remarkable considering these facilities have a less favorable payer mix (23 percent Medicaid patient days, which is 33 percent higher than the study's national median).

How is this possible? These top-performing facilities have a cost structure that is nearly 20 percent lower for both inpatient and outpatient services. In addition, this significantly lower cost position has not resulted in lower quality performance. In fact, the Top 100 hospitals have an overall Hospital Quality Index™ score that is 1 percent higher than the national level. In short, we believe these facilities are models for current and future industry performance as they have weathered the economic storm with strong financial and quality performance built on a sensitive charge structure and low-cost patient encounters.

How Can Hospitals Thrive in the Future?

In sum, we have seen that hospitals have been able to improve their value position with the improving economy. Keeping costs in check has a multiplying effect on other performance areas. If hospitals are able to reduce costs, they will subsequently improve financial viability and reinvestment—and, thus, benefit the community. A low-cost structure also enables hospitals to limit charge increases. Top 100 hospitals in the Community Value Index study were able to limit their cost increases in 2010 to 0.3 percent for both inpatient discharges and outpatient visits—the lowest of any group in the study. While the economy improves, it is clear that greater uncertainty lies ahead. Learning from this latest storm may very well help us address future challenges.

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Business Intelligence

By Ken Perez

Pinpointing Your Hospital's Specific ICD-10 Reimbursement Risks

By isolating the specific codes, physicians, and service lines that will bear the brunt of the ICD-10 transition, hospital leaders can better deploy the necessary resources needed to reduce potential reimbursement risks.

Because of ICD-10's pivotal role in how hospitals and health systems will be reimbursed, it is critically important to analyze the impact of the massive coding change prior to ICD-10's implementation. As one CFO of a small hospital system warned, "The consequences of not getting ICD-10 right are monumental. You could lose a lot of revenue."

While ICD-10 will affect your entire hospital operation, the new coding system will affect some service lines and specific DRGs more dramatically than others in terms of complexity of the transition (e.g., from one code in ICD-9 to many codes in ICD-10). For example, orthopedics will experience many more one-to-many translations than pulmonary.

A type of business intelligence known as impact analytics takes a hospital's existing data and predicts the hospital's specific reimbursement and operational risks from ICD-10—down to individual physicians and diagnosis codes that will be most affected.

Impact Analysis Versus Analytics

A distinction needs to be drawn between the similar-sounding concepts of impact *analysis* and impact analytics. An impact analysis, often conducted by consultants, sizes up the financial impact that the transition to ICD-10 will have on an organization in terms of costs, information systems, technology infrastructure, staffing, and other resources. Detailed estimates and plans for all these areas are common deliverables.

In contrast, impact analytics helps an organization understand the specific operational and financial impacts (e.g., reimbursement decreases/increases, staff training needs) that could take place as a result of the ICD-10 transition. Impact analytics estimates and prioritizes the risk associated with the way payers (Medicare, Medicaid, and commercial) will map ICD-10 codes to DRGs. This detailed level of analysis is important because, while all ICD-10 codes are valid for various reasons, not all ICD-10 codes are of equal value to every hospital (i.e., some account for more business for the hospital than others).

The Benefits of Impact Analytics

The shift from ICD-9 to ICD-10 constitutes a quantum leap. The total ICD-9 to ICD-10 code growth multiple is almost 8x. Correspondingly, ICD-10 codes are much more specific, and the new coding system's structure is more complex. For these reasons, it is not possible to directly crosswalk ICD-10 codes to a DRG grouper.

One unpublished analysis by a major commercial payer yielded the following results after converting ICD-9-based claims into ICD-10-based combinations: 80 percent went to the same DRG, 12 percent went to a single different DRG, and 8 percent went to multiple different DRGs.

Impact analytics allows a hospital to proactively identify areas that will be most impacted by the ICD-10 transition by leveraging a hospital's own data, various algorithms, and general equivalence mappings, which is a way to map one source system code (e.g., ICD-9) to a target source system code (e.g., ICD-10). The resulting business intelligence enables hospitals and health systems to:

- Identify the codes used by the healthcare provider organization that will be most impacted by the ICD-10 conversion
- Prioritize physician and coder education by isolating the populations at greatest risk for missing documentation
- Continuously monitor performance by profiling physicians and service lines on an ongoing basis
- Classify the specific gaps in documentation required for complete ICD-10 diagnoses
- Benchmark case mix index and identify root causes of variances between ICD-9 and ICD-10

For example, a hospital can rank order reimbursement risk areas by using a report that shows the estimated change in reimbursement amount by service line, DRG, medical, surgical, physician, and group of physicians under various cases (e.g., best, worst, likely). One hospital that is an early adopter of impact analytics uses this type of report to focus specifically on the possible effect on its surgical DRG reimbursement, because that is where the organization makes a majority of its profit.

Optimal Use of Resources

By predicting and isolating the specific codes, physicians, and service lines that will be at greatest operational and financial risk, impact analytics allows hospitals to optimize training, education, and change management, resulting in successful navigation of the ICD-10 transition.

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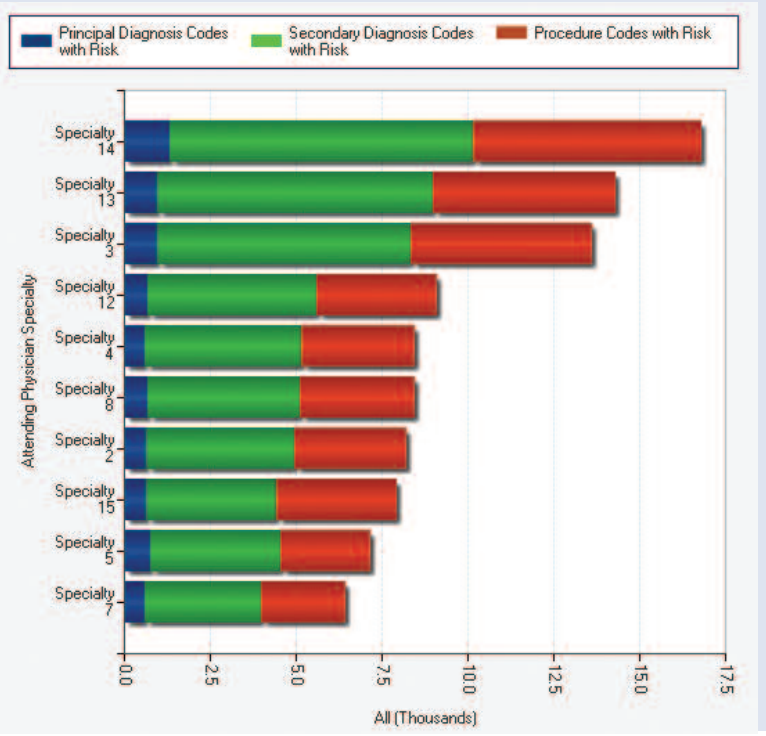
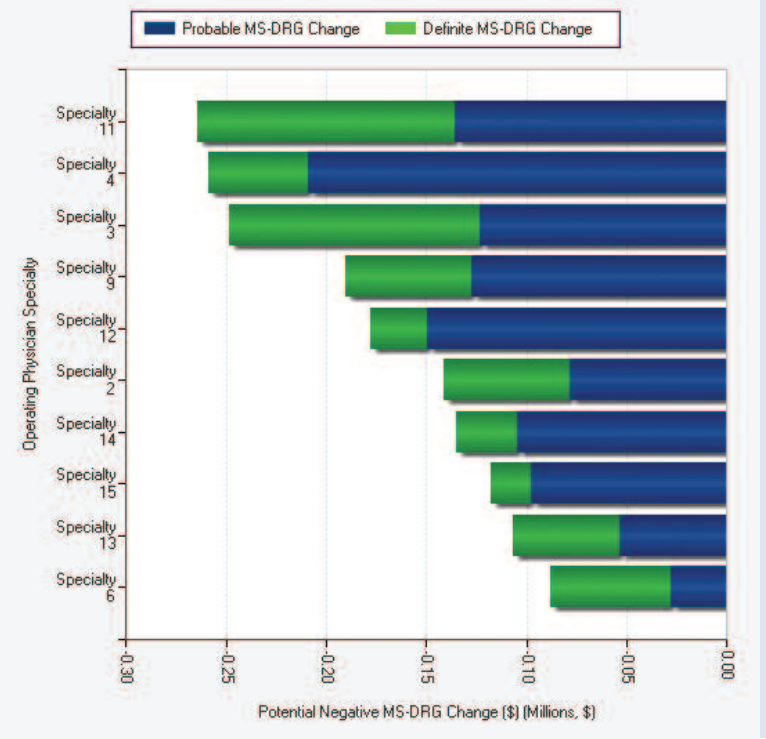
Top Attending Physician Specialties by Codes with Probable Risk



Source: MedeAnalytics; reprinted with permission.

Identification of claims requiring additional documentation specificity under ICD-10.

Top Operating Physician Specialties by Negative Potential Medicare Reimbursement



Source: MedeAnalytics; reprinted with permission.

Estimates of the potential reimbursement impact on a hospital of moving to ICD-10.

By Steven W. Kennedy, Jr.

Happy Endings Are Possible for Small Hospitals in Today's Credit Markets

After a number of starts and stops, an Indiana critical access hospital obtained needed capital from a local bank, securing a combination of tax-exempt, bank-qualified draw bonds and a taxable draw loan.

Remember *The Little Engine That Could*? You know, the children's book where the Little Blue Engine overcame insurmountable odds and pulled the train full of toys over the mountain pass chanting the rallying mantra, "I think I can. I think I can. I think I can." It's one of the greatest allegories on the power of positive thinking and motivation ever told.

The story is reminiscent of many situations that small community hospitals, especially in rural areas, are encountering when trying to finance capital improvements: Resources are limited, financial performance could be better, uncertainty abounds with healthcare reform and reimbursement cuts, and the economy is struggling. For all the aforementioned reasons, access to capital is tight.

Some people in the lending world believe it's too risky providing debt financing to smaller hospitals—just like the tale's big engines refusing to haul the train up the mountain, each one with a different excuse. All the while, the only thing these hospitals have is the gumption to think that they can.

One small hospital, Pulaski Memorial Hospital, is a perfect example. It showed what moving forward with realistic expectations, taking action to improve credit, and finding good financial partners can mean when overcoming the odds of the capital markets.

A Financing Tale Begins

In 2005, Pulaski Memorial, a noninvestment grade, county-owned, critical access hospital in northwestern Indiana, sought to fund a modest expansion and renovation project, just under $6 million. The hospital's financial firm and architect made a presentation to the hospital board, outlining the project scope, debt capacity, and funding options. This led to the board's decision to begin securing financing to fund the hospital's project.

The green-lighted project would encompass the following:

- A $1.35 million expansion of the hospital's medical-surgical unit
- A $1 million upgrade of its surgical suite
- A $450,000 hydro-therapy addition
- A $700,000 renovation of its radiology department, central sterile facility, and laboratory
- A $2.2 million addition, which would house physicians, administration, and a conference center

By expanding and modernizing, Pulaski's leadership felt that the hospital could remain competitive in its market.

Challenges Along the Way

However, shortly afterward, the hospital started to experience operating losses causing its leadership to halt the financing process. Throughout 2006 and 2007, the hospital regained its financial footing and again began to consider accessing the credit markets. In the meantime, management brought in its financial firm in an advisory role to provide a credit profile tutorial to all hospital department heads, so that the hospital's department leaders could understand the importance of controlling costs and maintaining the hospital's fragile profitability margins.

Despite hospital management's continued progress in strengthening operations, the onset of the 2008 financial crisis derailed the project once again as the hospital leadership grew concerned about the future of the hospital. Not willing to give up, Pulaski took additional steps to improve revenues.

Onward and Upward

In 2009, Pulaski brought on a new CFO. After battling through some reimbursement and collections issues in 2010 and 2011, the hospital decided to again move forward with the financing, only this time with a reduced scope totaling $2.7 million, which was more realistic given

Pulaski Memorial Hospital Financing Tale: Lessons Learned

Backstory:

- Critical access hospital in Indiana with noninvestment-grade financial profile
- $2.7-million capital project comprised of a partial renovation ($1.7 million) plus construction of a medical office building ($1 million)
- Combination of tax-exempt, bank-qualified draw bonds and taxable loan

Good News:

- Ability to leverage local bank relationship
- Leveraged bank-qualified tax-exempt bonds to secure interest expense savings
- Construction draw bonds/loan allows capital to be funded as needed, eliminating negative arbitrage associated with traditional tax-exempt bonds

Bad News:

- The closer to home, the smaller the pool of lenders
- Decreased relative benefits with tax-exempt bonds in a low interest-rate environment
- Tax-exempt draw-bond structure traditionally only associated with bank-related financing, not public tax-exempt markets

the tight capital markets and the hospital's financial strength. The revised project included renovations to the hospital's existing physical plant for $1.7 million, as well as the $1 million construction of a medical office building that would house independent physicians.

The financing allows Pulaski to modernize its central sterile facility and surgical suite, providing a safer environment for its patients as well as helping the hospital to attract and retain a high-quality staff and physicians. The new medical office building, adjacent to the hospital, will help to increase hospital referral volumes from the physicians renting space. Overall, the projects will help the hospital remain competitive with the three hospitals also providing inpatient and outpatient primary care services within its market.

Reaching the Summit

Earlier this year, the hospital's financial firm closed the $2.7 million funding, placing tax-exempt, bank-qualified draw bonds with a local bank to fund the renovation and structuring a taxable draw loan with the local bank for the construction of the medical office building. The draw structure of both debt issues eliminates negative arbitrage concerns.

In addition, the taxable financing for the medical office building was necessary because it would house physicians not employed by the hospital.

What made this financing project possible even though the hospital experienced six years of setbacks?

Several factors were important in making the expansion project a reality. Some lenders can be particularly hesitant to lend new construction funds in today's market, so Pulaski's leadership team wisely reduced the project scope—especially in light of the hospital's recovering financial position. They strategically managed the organization's risks by reevaluating the proposed expansion and its capital allocation plans.

Equally crucial to the financing were Pulaski's longstanding relationship with its community bank and articulating the hospital's improved credit strengths and preferred funding structure to the community bank. These combined to provide a low-cost, community-based funding tailored to the needs of Pulaski's credit profile and strategic plan.

Adopting a Can-Do Attitude

Although smaller hospitals today often have problems accessing capital to support expansion/renovation projects to stay competitive, there still can be a happy ending. All it takes to attract capital is an organization's ability to have a plan of action that addresses risk, strong relationships with financial partners, and a can-do attitude.

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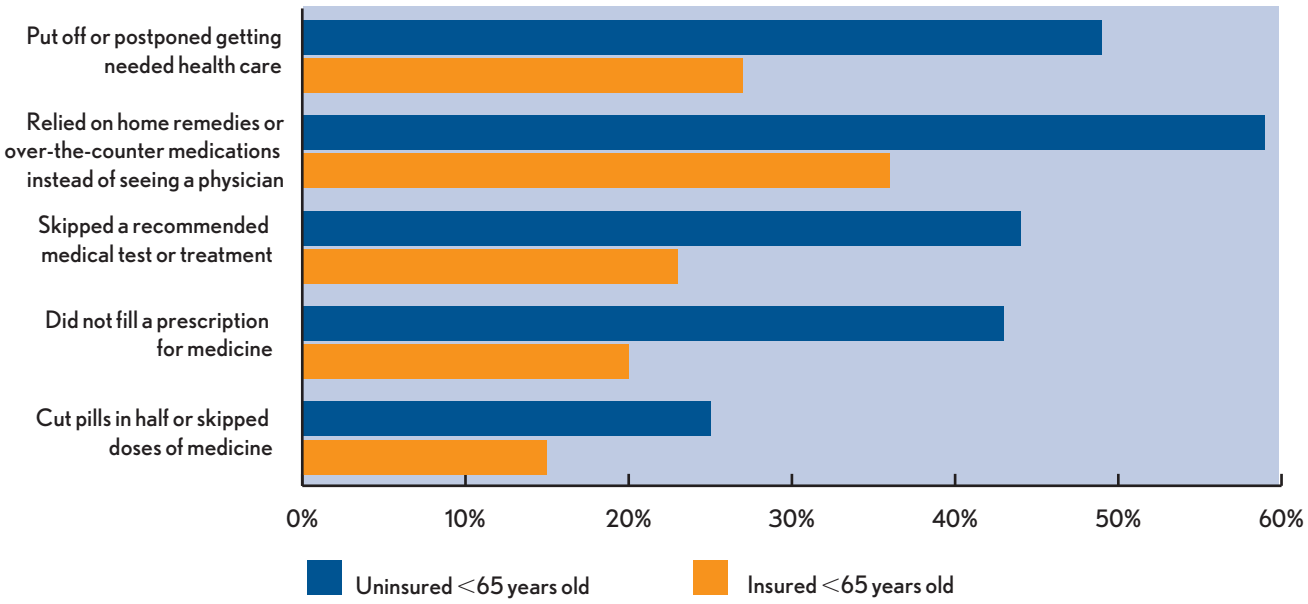
Finance at a Glance

Nonelderly Insured and Uninsured Are Skipping or Delaying Care



Source: Kaiser Family Foundation Health Tracking Poll conducted May 8-14, 2012.

A May 2012 survey found that 55 percent of insured patients and 81 percent of uninsured patients skipped or delayed care in the past year due to cost.

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Budgeting & Forecasting

By Dean Sorensen

How Unwritten Rules Can Sabotage Budgeting/Forecasting

What are unwritten rules? They are the way that people believe that they must behave to be successful. These rules evolve over time to fill gaps in business and human performance systems. They are reinforced by the behaviors people observe as leading to success.

Why are unwritten rules relevant to finance? Because they undermine the ability to make significant improvements to how hospitals plan and manage their businesses. For example, you're unlikely to reduce budget cycle time when leaders and staff believe that they can't be honest about resource requirements. And you're unlikely to completely focus people on delivering quality outcomes when they believe that budget attainment trumps all other objectives. It is for this reason that chief quality officers often feel like they are "pushing a rock up a hill."

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Examples of Unwritten Rules

The following are examples of unwritten rules, together with the underlying beliefs that shape them.

Unwritten Rule	Underlying Belief
> Never submit your real budget the first time and always inflate it	> Your budget will always be cut, irrespective of whether it is reasonable / accurate or not
> Always under promise and over deliver	> People are rewarded for beating their forecasts, not how much value they add to the organization
> Always make your budget	> People are rewarded for making their budget, irrespective of what our vision and values say
> Protect your budget	> Resource allocation within hospitals isn't always fair and it's often based on who "screams the loudest"
> Always spend your budget	> If you don't use your budget, you won't be able to get the resources back
> Only accept responsibility for measures that can be influenced in your department	> People aren't rewarded for driving cross-functional performance improvement