

Hospital Financial Strategies for Tomorrow



As the specter of a double-dip recession, stubborn unemployment, and volatile inflation looms, savvy healthcare executives are taking the longer view, seeking to mitigate the impact of today's pressures while positioning themselves for long-term opportunities. In the short term, it won't be easy.

Moody's 2011 outlook for the U.S. not-for-profit healthcare sector remains negative. "Anemic economic growth and high rates of unemployment have contributed to lower rates of healthcare utilization and increased exposure to governmental payers and self-pay," notes the ratings agency. "The thinning ranks of well-insured patients remain an unambiguous driver of weaker financial results, manifested in softer volumes, weaker payer mix, and stressed operating revenues."¹

What's more, "expense reduction and operating margin improvement" was ranked as the year's top financial priority by more than 60 percent of 545 healthcare executives in the Premier healthcare alliance's *Economic Outlook* March 2011 member survey. The next highest priorities—preparing for potential reductions in payment, investing in IT, and enhancing revenue cycle—didn't even come close.²

At the same time, pressures to support quality-driving efforts also are increasing. Whether it's reducing readmissions, improving patient satisfaction, or meeting payer performance goals, hospitals are examining the best ways to use resources to support improving the value of care provided.

Economic Picture

On numerous fronts, healthcare systems are facing significant economic assaults. The tough economy has brought changes in patient volume and coverage, made affordable access to capital more difficult for some providers, and contributed to cuts in government payment. At the same time, organizations must position themselves for the challenges—and opportunities—brought by reform.

Revenue threatened by shifts in volume, coverage.

Patient volume and mix began to change during the recession and the year that followed, as one out of four adults lost work that provided health benefits. And evidence shows that more than half of adults that became uninsured have stayed that way.³

"Nationally, hospital volumes are down," says James G. Lee, FHFMA, FACHE, executive vice president and CFO, Adventist HealthCare in Rockville, Md. "The tough economy continues to push many people out of work, and the uninsured—or soon to be uninsured once COBRA expires—suddenly

become much more conscious of health spending. As a result, primary care visits go down significantly. Patients postpone needed tests and subsequently arrive at the hospital as much sicker patients requiring greater levels of care. And the self-pay balances that the unemployed accrue become far more difficult for them to pay, which pressures a hospital's top line."

Valley Health System, a six-hospital system serving northern Virginia, West Virginia, and Maryland, has seen charity care and bad-debt writeoffs reach more than 9 percent of gross revenue as self-pay has climbed as well. According to Craig Lewis, CFO, this shift has been an Achilles heel for the system. "The old saying is, unfortunately, increasingly true: 'Self-pay' too often means 'no-pay,'" he says. "We've seen major declines in outpatient revenue. Hopefully as the economy improves, these metrics will improve as well. But it takes time for people to get jobs, get back on insurance plans, and stop delaying diagnostic procedures and treatments."

Capital in high demand. Many hospitals today are carrying significantly larger debt loads than in previous years. The backlog of capital projects is growing and reaching a critical turning point. This pent-up demand encompasses not only upkeep and maintenance challenges but also the need to pursue cutting-edge facilities, equipment, and treatments that attract better physicians, a stronger payer mix, and greater patient volumes that lead to an improved operating margin. But with concern of taking on too much debt and competing projects, such as the need to achieve meaningful use, many of these long-term plans are languishing. When healthcare executives surveyed by Premier were asked to name the areas in which their organizations were planning to make large capital investments or expansions over the next year, 35 percent of respondents listed IT and telecommunications, and 30 percent stated infrastructure. But 7 percent said their organizations had no plans to invest substantially in either of these areas, or in other areas, such as surgical or lab equipment.⁴

Managing funding of liabilities also is a concern for providers. "We're not unusual in that our pension funding has been under tremendous pressure for the past few years," notes Eric Melchior, senior vice president and CFO, Greater Baltimore Medical Center. "The market returns certainly are much healthier in the past few months, but our defined benefit plans saw some pretty significant deterioration. In response, we froze that plan and have moved to a defined contribution plan. We're also seeing spikes in our self-insured healthcare costs and workers' compensation experience."

Payment cuts. For state and federal officials in virtually every corner of government, ballooning deficits mean that the policy momentum lies with those eager to trim—sometimes slash—healthcare budgets. Many industry watchers are predicting a decline in Medicare spending to offset federal budget deficits. And those reimbursement rates will likely spill over to commercial payers as well.

“All hospital revenue streams are under pressure—including Medicare, Medicaid, commercial payers, and philanthropy. These pressures are likely to be exacerbated as federal stimulus funding comes to an end and the shift begins toward alternative payment schemes,” notes Moody’s.⁵

For Self Regional Healthcare in Greenwood, S.C., an aggressive pursuit of market share is one of its key responses to the reshaped payment landscape. “We’re focusing on growing our business by increasing our market share,” says Camie Patterson, CPA, FHFMA, FACHE, CMA, senior vice president of operations and CFO. “We’re opening new patient centers in outlying counties and taking a competitive stance where joint venture opportunities aren’t available. We need patient volume to keep our experts busy. We’re also taking several steps to better capture charges and improve documentation to ensure we get paid appropriately for the services we provide and to reduce incidence of payment denials.”

At Valley Health System, payment cuts have been dramatic. “We’re seeing the Virginia legislature cutting further into our reimbursements for Medicaid,” says Lewis. “We’re typically receiving only 60 percent of our cost. We’re going to have to adjust our operating expense levels significantly to stay in line with that reduced revenue.”

Positioning for Reform

Of course, the largest long-term impact on the financial outlook for hospitals is also the most uncertain: the Affordable Care Act of 2010, the most sweeping healthcare reform in decades.

“Whether it arrives in its current form or some other format, we must fundamentally accept that the game will have a completely new set of rules,” says Patterson. “The costs across the U.S. healthcare system are unsustainable. Reform-generated legal and regulatory response is the biggest—and most uncertain—issue we face because it will force sweeping changes that will reach every corner of our institution. But without some clearer vision of exactly what this new landscape will be like, it’s difficult to move forward with speed and certainty—you don’t want to go down the wrong path.”

Others express similar views. “The status of healthcare reform is just too uncertain,” says Valley Health’s Lewis. “Anyone who says that they have it all figured out isn’t being truthful. We’re evaluating everything, but we want to be cutting edge—not bleeding edge—because we can’t afford to spend our resources unwisely and prepare for something that’s ultimately altered, deferred, or even repealed. We can’t afford to prepare for possibilities as opposed to certainties. Until some stability is brought to the final regulations allowing us to fine-tune our plans, we—like everyone else—will be focusing on costs and quality.”

Melchior from Greater Baltimore Medical Center sees a need to position for reform regardless of certainty. “I’m focusing on healthcare reform—in whatever form it eventually takes,” he says. “That ship has sailed and something *will* be happening in one form or another. My job is to prepare my organization for this major change. In fact, my biggest concern is the transitions that must take place across providers, payers, and patients. We will be embracing a lot of change, no question. Some are advocating for a longer, drawn-out transition, but that strikes me as dangerous—having one foot in the old system and one foot in the new, so to speak, could tax the capacity of our infrastructure.”

Lewis also expresses concern for the future. “Healthcare reform is a big question mark for me,” he says. “I’m not sure if it will be repealed or dramatically reshaped. But if it doesn’t change all that much, I think we’ll see that *all* payers will be

A TIME TO SPEND?

Although hospitals are facing numerous financial challenges and clamping down on expense, many also are recognizing the importance of investing in technologies and infrastructure to support initiatives driving low-cost, high-quality care.

Electronic health records and telemedicine often are seen as valuable tools to support the communications and care management of value-driving care delivery models, such as medical homes and accountable care organizations.

Despite the tough economy, 46 percent of more than 500 healthcare executives surveyed in the Premier healthcare alliance’s March 2011 *Economic Outlook* publication note increases in their organization’s capital budget from the previous year. Nearly one-fourth indicate an increase of 10 percent or more. Notably, 35 percent of respondents say they will be making their largest capital investment in IT and telecommunications.

Source: www.premierinc.com/economicoutlook.

paying at Medicare rates—and that will create a substantial reduction in revenue. We will be forced to cut back accordingly.”

Notes Patterson: “We’re all going to have to go on a ‘Medicare diet.’ If all payers start paying at the Medicare rate—and it’s not unreasonable to think that day is coming—then our system would have to plug a revenue hole of tens of millions of dollars, which is a sobering prospect.”

Strategies for Success

Regardless of the form that healthcare reform ultimately takes, one thing seems clear to many forward-looking executives: Enhancing quality while managing cost will be inextricably linked in one form or another to payment. The unsustainable path of current healthcare spending is creating calls from every corner for better use of healthcare dollars, improved efficiencies, and higher quality of care.

With this in mind, healthcare executives should consider the following three strategies for post-reform success.

Structure for clinical-financial collaboration. Whether it’s preparing for bundled payment or performance-based incentives, those hospitals with strong physician relationships will be best prepared for the clinical and financial coordination needed to improve value of care.

Creating structures that support collaboration across the continuum of care will be key, whether that means enhancing communications under existing organizational units or readying the organization to participate in formal collaborations through a medical home or accountable care organization (ACO) model.

Greater Baltimore Medical Center is trying to get a head start on implementing an ACO strategy. “No matter what you think will happen with healthcare reform, the ACO is a good concept and will, we believe, emerge in some form as the preferred model for care delivery,” Melchior says. “So we’re building our base of employed primary care physicians and specialists, and we’re implementing an EMR infrastructure for them to help make the ACO concept feasible.”

Melchior adds: “Our board has completely bought into this vision. We have a plan in place to expand our employed physician base and strengthen our referring-physician base. No matter what happens with healthcare reform, we will have a strong base of physicians that will work well in any environment. That’s my focus, and my biggest economic challenge is finding the right way to finance and fund this ACO vision for the first couple of years.”

The medical center doesn’t expect to see return from this effort for at least 24 months, notes Melchior. “We already invest \$10 million a year in our physician practice, and this new initiative will add \$4 million to \$5 million to that,” he says. “We think we have the financial strength to endure the transition, but not every hospital can absorb that kind of cost. And there’s no ‘brick-and-mortar’ component to this, which makes capital financing a little trickier.”

According to Lee, the ACO model’s link to quality might be a powerful incentive to sharpen the focus on quality of care and patient outcomes. “Finance and quality are interconnected in this model—and that can be a great thing if we work together closely,” he says.

Focus on improving case management. Competencies for timely tracking and management of patient health are increasingly important in a post-reform era where hospitals face a significant financial penalty for potentially avoidable complications or readmissions. Yet the task ahead isn’t easy.

“We’re working on reducing readmissions and hospital-acquired infections,” notes Lee. “Although use of healthcare billing data isn’t necessarily the best way to measure quality, it’s what the industry is working with right now. So, like others, we are focusing on improving our documentation to ensure we capture the patient’s condition fully and accurately on admission. Readmissions are even more complex. How can we ensure that patients follow through with their discharge orders, physical therapy, and/or prescriptions so that they don’t have to come back to the hospital?”

Whether it’s reducing readmission rates or targeting defensive medicine practices that lead to unnecessary tests and treatments, providers in the next era of health care will be called on to improve care processes and demonstrate high-quality outcomes.

“It’s clear that the federal government is quickly losing its willingness to pay for readmissions,” Melchior says. “If that patient comes back within 30 days for something that’s even peripherally tied to the first admission, then we’re not going to be paid. We need to get much more efficient and build the right systems to extend our reach to the patient after he’s left our facility. That might be home care, outpatient facilities, support, counseling, or other measures to increase the level of patient compliance. It’s ironic, really—for years, hospital leaders have been focusing on shortening the length of stay. Now, I can easily foresee many organizations eating a denial for a day or two longer of patient stay in order to reduce the probability of a subsequent readmission.”

OUR SPONSOR SPEAKS

FUTURE FOCUS: GLOBALIZATION AND SUPPLY CHAIN

*Supply chain plays a key role in many organizations' strategies for the future. Although hospital leaders typically are focused on factors affecting utilization, consideration of sourcing trends, such as globalization, also is important. With this in mind, **Mike Alkire, president, Premier Purchasing Partners, Premier healthcare alliance**, shares the following discussion from the Premier healthcare alliance's March 2011 Economic Outlook (www.premierinc.com/economicoutlook).*

In the commodities markets, we've seen dramatic upticks in pricing for raw materials that are foundational to many healthcare products, including oil and cotton, largely due to increased demand in developing countries.

This is the current reality of the globalization trend. When we source from all over the globe, we're at the mercy of everything from foreign demand to economic development swings to weather trends, all of which we in the United States have almost no control over.

But the issue of globalization affects more than just pricing. It can also affect the quality of patient care. For example, today more than 90 percent of all nutritional supplements, face masks, exam gloves, enzymes, and amino acids are manufactured overseas. Even basic items are produced outside the U.S. For example, China manufactures two-thirds of the world's aspirin and 70 percent of its penicillin, and it is poised to become the sole supplier within a few years.

Source: Premier healthcare alliance.

So if there was a global pandemic, whose population do you think would get the goods? I'm going to guess it would not be the U.S., or at least not in the quantity that would support our demand. We've already seen an example when the Olympics were held in Beijing and our hospitals struggled to get exam gloves.

But is the healthcare industry actually promoting this type of behavior? We continually see suppliers dictating demand, rather than the other way around, and we have done little to change this dynamic. Essentially, this creates pressure on manufacturers to make money by eliminating supply and production costs through offshoring, rather than developing products that satisfy real needs and capitalizing on savings based on demand-based volume.

Sourcing to specification is a key strategy to curb this trend. It involves working with clinicians, documenting the product attributes that are medically necessary, and then working with manufacturers to create a product that only includes those features. We need to inject rationality into the marketplace by making better, more informed purchasing decisions that put the product's end-user in the driver's seat, factor in the cost of safety, and carefully consider the need for a diverse network of supply alternatives.

According to Lee, case management programs can have a stronger impact in an ACO environment. "We've created an internal case-management program for our self-insured employees," he explains. "We know that 5 percent of our people generate 60 percent of our costs because of chronic conditions. The key is to know them and work with them so that they're seeing the right doctors at the right time and complying with care plans by doing prescribed exercises and taking their medication as indicated." The effort appears to be working, Adventist HealthCare has medical inflation of less than 5 percent—when the national average is 10 percent.

"Last year, we took these efforts a step further," says Lee. "We identified employees or family members with multiple doctors who are taking multiple medications to participate in a medical home pilot and recruited eight of our primary care physicians to meet with these employees or family members (pilot participants) individually each month for

one hour to review their medication compliance, identify potential overlaps or interactions, and minimize potential for repeated procedures and unnecessary tests. We saw a significant impact on those pilot participants. Many have dramatically reduced their number of physicians and medication use, and the average cost per pilot participant was down nearly 35 percent compared with the prior year. Yes, the physicians spend more time per patient—supported by a case manager. But the payoff has been huge. We're hoping that by showing our results to payers, we can replicate these successes elsewhere."

It's a model that Patterson also finds appealing. "We're self-insured as well, and the one piece that's missing from current reform is patient accountability," she says. "We need to incentivize patients to make smarter health decisions. Patients can control close to 50 percent of their health care by the lifestyle choices they make—from smoking to diet.

How can we hold them accountable? We've been testing this on our own employee base by using discounts to encourage non-smoking, receiving flu shots, and scheduling check-ups with primary care physicians—and it's already led to substantial reductions in costs."

Seek improved utilization and efficiency. Hospitals are long familiar with efforts to lower supply and labor expense. However, today's cost management also entails driving efficiencies and utilization—while eliminating unnecessary steps or services—to reduce the overall cost of care.

At Self Regional Healthcare, leadership has used involvement in a group purchasing organization to not only obtain favorable pricing but also leverage peer data to identify targets for improvement and set realistic benchmark goals. The strategy is yielding a savings of \$6 million per year for supplies. "We're pushing our vendors, our physicians, and our staff to change utilization patterns," notes Melchior. "It's not just asking about savings in terms of supplies, such as syringes. It's also about building efficiencies and streamlining operations: 'Should we really do this MRI?'"

Going Forward

More than ever, a growing range of forces are reshaping the future of health care. To ensure long-term financial sustainability, greater levels of leadership and nimble organizational response are needed. Providers should not only develop a vision for improving quality and reducing cost of care, but also enlist the help of others in obtaining this vision, whether it be communicating with physician leaders or engaging in strategic business partnerships. Those organizations that position themselves as innovators striving to meet long-term challenges will best meet the demands to come.

Endnotes

- ¹ Negative Outlook for U.S. Not-For-Profit Healthcare Sector Continues for 2011, Moody's Investors Service, Feb. 3, 2011.
- ² *Economic Outlook*, Premier healthcare alliance, March 2011.
- ³ *Help on the Horizon: Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*, The Commonwealth Fund, March 2011.
- ⁴ *Economic Outlook*, Premier healthcare alliance, March 2011.
- ⁵ *Negative Outlook for U.S. Not-For-Profit Healthcare Sector Continues for 2011*, Moody's Investors Service, Feb. 3, 2011.



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