SAILING THROUGH THE REGULATORY STORM: HOW COMMUNITY HOSPITALS CHART A PATH TO PROFITABILITY
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Community hospitals have been struggling to stay above water for years. Healthcare executives responding to a recent TransUnion survey reported seeing a steady increase in bad debts over the past three years, and 86% of respondents said that bad debts now account for more than 2% of their total cost of providing healthcare services.1

Moody’s Investors Service has issued a negative outlook for not-for-profit hospitals since 2008, citing federal cuts to medical spending and reimbursements, shrinking patient volumes, and slow revenue growth.2

But all is not doom and gloom. In fact, average hospital financial performance has improved in recent years. Moody’s reports that the median operating margin for not-for-profit hospitals inched up to 2.5% in 2012, from 2.0% in 2008.3

“Operating margins and leverage metrics have not deteriorated in recent years, despite negative headwinds, because management teams have successfully managed expenses in light of weak patient volumes and less robust revenue growth,” Moody’s noted in a January 2013 press release.

Clearly, hospital executives are successfully engaging in cost-cutting and other efficiency measures. However, with regulatory reform driving down Medicare and Medicaid reimbursements to historical lows – and with future cuts to be implemented steadily over the next decade – measures that successfully contained expenses in the past won’t be enough to keep hospitals above water in the future.

“…A perfect storm of forces is hitting the hospital industry all at once. Industry executives have no illusions about the extent and magnitude of the forthcoming change. But the scope and complexity can be daunting, especially since hospitals have to rethink and refine core business and operating processes while continuing to deliver quality care to the communities they serve.”

– Heidi Toppel, Towers Watson senior consultant1

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1 Society for Human Resource Management. (2012, January) Big Changes Expected in Hospital Reimbursement Post Reform
2 TransUnion. (2012, November) Hospitals See Point-of-Service Intelligence as Key to Tackling Growing Revenue Cycle Challenges
3 Moody’s Investors Service. (2013, November) Moody’s: US not-for-profit hospital outlook remains negative for 2014; revenue growth to decline
4 Becker’s Hospital Review. (2013, August) Moody’s: 132 Statistics on Nonprofit Hospital Medians
CORRECT THE COURSE: 
CHANGES NEEDED TO OFFSET LOWER REIMBURSEMENTS

Cuts to Medicare and Medicaid disproportionate share hospital (DSH) payments and bad debt reimbursements could erase the meager operating margins of many currently profitable community hospitals. While the median national operating margin for not-for-profit hospitals is between 2% and 3%, margins for hospitals in rural and poor urban areas often are lower – and in some cases negative. In many cases, the reimbursements these hospitals receive for bad debts and DSH (both Medicare and Medicaid) are greater than the hospital’s entire operating margin. Therefore, decreasing those reimbursements can erase any existing profit margin or exacerbate a negative margin. In fact, the National Association of Urban Hospitals anticipated that Medicare DSH cuts will drive operating margins among urban safety net hospitals, already at -0.82%, to an unsustainable -2.58%.5

Without taking some drastic steps, these hospitals are in danger of going out of business or being swallowed by large hospital systems that have more resources and can better manage operating costs.

“We have several rural hospitals that are hanging on by a thread because they are trying to maintain the old, autonomous model of a hospital, provide full service, and be on their own,” says Dr. Richard H. Streiffer, dean of the University of Alabama’s College of Community Health Sciences, in a December 2012 edition of the UA News.6

“Rural hospitals need to change to a new model – to provide the first level of local health care that people need, and then coordinate effectively with a larger regional health system.”

For tradition-bound community hospitals, successfully making these changes will be difficult. Only 18% of hospital executives responding to a 2011 Towers Watson survey reported that collaboration with local providers was a top priority, despite the fact that the Patient Protection and Affordable Care Act (PPACA) and other recent regulations are making collaboration a pre-requisite for many incentives.7

To navigate successfully through today’s rough waters, hospitals must be ready to consider measures such as collaboration with local clinics and even other hospitals. Most importantly, they must understand how reimbursements will be calculated in the future (including known and expected decreases) so that they can track and report their costs in a way that appropriately maximizes those payments and minimizes the impact of potential reductions.

6 The University of Alabama, UA News. (2012, December) Some Rural Hospitals to Choose Between Merging Services, Closure
7 Society for Human Resource Management. (2012, January) Big Changes Expected in Hospital Reimbursement Post Reform
BATTEN DOWN THE HATCHES:  
REGULATORY REFORM DECIMATES REIMBURSEMENTS

While health systems of all sizes are struggling to generate profits and cash flows, decreasing reimbursements will be especially devastating to smaller community hospitals that serve a large Medicare, Medicaid, and uninsured population.

Following are current and upcoming changes that will have the biggest effect on hospitals’ bottom lines.

- **Medicare DSH.** By far, the most significant impact will come from the new formula for calculating Medicare DSH payments. Counting on a substantial decrease in the volume of uninsured patients and related uncompensated care costs, the PPACA mandated significant reductions in Medicare DSH payments. The Centers for Medicare & Medicaid Services (CMS) recently released its final rule for determining the payment in 2014 and 2015. (See p. 5.) The formula essentially redistributes these payments based on hospitals’ share of low-income patients. Part of the formula uses an uncompensated care proxy that is based on the hospital’s share of national Medicaid inpatient days and Medicare Supplemental Security Income (SSI) days. Hospitals with low inpatient Medicaid days and those that lack an accurate system for tracking and reporting these days will suffer under this new system.

- **Medicaid DSH.** While the PPACA mandates annual reductions to Medicaid DSH allotments, building from a $500 million national decrease in FY14 up to $4 billion in 2020, the last-minute Bipartisan Budget Act of 2013 shifted the implementation by two years (starting in FY16). Just a few months before the budget deal, CMS had adopted a reduction methodology for 2014 and 2015, which encouraged states to target Medicaid DSH payments to hospitals with high levels of uncompensated care and high Medicaid volume.8

- **Medicare bad debts.** Starting in October 2012, CMS reduced hospitals’ Medicare bad debt reimbursements from 70% to 65%, as required by the Middle Class Tax Extension and Job Creation Act of 2012. Reimbursement levels are expected to continue to decrease in coming years. Several sources, including a report from the HHS Office of Inspector General, recommend further reducing bad debt payments to 25%.9

- **Sequestration.** The Budget Control Act of 2011 introduced an across-the-board 2% cut for all Medicare reimbursements beginning April 1, 2013, and the Budget Control Act of 2013 extended those cuts for another two years. Critical access hospitals, which have traditionally been reimbursed at 101% of the costs of treating Medicaid patients, are currently being reimbursed at 100% of cost. This cut is devastating for small rural hospitals that already are often losing money on Medicaid and uninsured patients. In all likelihood, these reimbursement cuts will continue into the future.

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8 Centers for Medicare & Medicaid Services. (2013, September) Medicaid State Disproportionate Share Hospital Allotment Reductions Final Rule
Medicaid expansion. The landmark Supreme Court decision gave states the right to refuse the expansion of Medicaid, a key provision of the health care reform act. Governors in many states are resisting expansion, which would mean that hospitals in those states would still have to contend with a large uninsured population while also facing mandated reimbursement decreases. The National Association of Public Hospitals and Health Systems estimates that, because of states refusing Medicaid expansion, hospitals could incur $53.3 billion more in uncompensated care costs by 2019 than was originally estimated at the time the PPACA was passed.10

REIMBURSEMENT CLOUDS ON THE HORIZON

In addition to these current and proposed regulations, hospitals can tell which way the wind is blowing based on recent governmental proposals and reports.

Given all of the uncertainty surrounding the implementation of various forms of regulation and legislation, hospital executives should take note of the reimbursement-related items that could find their way into other legislation in the near future. In addition to a proposed delay of Medicaid DSH cuts, which did make it into the Budget Control Act of 2013, the budget also would have reduced bad debt payments to 25% by 2016, terminated the sequestration Medicare cuts, and repealed for 10 years the sustainable growth rate (SGR) reduction.

Keeping tabs on the bi-annual Medicare Payment Advisory Commission (MedPAC) reports also can reveal issues that often eventually make their way into law. Among the recurring recommendations from this Congressional commission include repeal of the SGR and substantial decreases in reimbursements for inpatient and outpatient prospective payments. In July 2013, the House Energy and Commerce Health Subcommittee also proposed repealing the SGR and replacing it with a simplified system of physician payment.

SET SAIL TO PROFITABILITY

So what can hospitals do to survive, and thrive, in the face of these stiff headwinds? If they can increase efficiency and take full advantage of every possible incentive and reimbursement, then hospitals may be able to actually widen their operating margins. And by extending those margins (however small) across an increased volume of insured patients, hospitals may begin to see smoother sailing ahead.

Unfortunately, the extent of the increase in insured patients is likely to be less than was anticipated when health care reform was proposed, since many states are resisting Medicaid expansion and the penalties on individuals for failing to obtain insurance are not severe. However, between the individual and employer mandates, the health insurance exchanges, and an aging population, hospitals can reasonably expect some increase in the coming years. Taking advantage of this increased volume requires hospitals to maintain a positive operating margin – and to achieve that

10 Wolters Kluwer Law & Business. (2013, February) Failure of States to Expand Medicaid Shifts Costs to Hospitals
goal, they must clearly understand how they will be reimbursed in the future, and how they can maximize those reimbursements – as well as their own efficiencies.

1. Know how reimbursements are calculated.

The most important step that hospital executives can take to improve their bottom lines is to first understand how their reimbursements will be calculated in future years. Then use that knowledge to appropriately report in a way that maximizes reimbursements (or minimizes the impact of potential reductions).

Proposed reductions to Medicare DSH reimbursement top the list of items that require hospital executives’ attention. CMS’ proposed DSH payment formula for fiscal year 2014 includes two components. The first component is based on the historical DSH formula, which is then reduced to 25% of the historical level.

But where CMS takes away with one hand, it gives back with the other. The second component of the payment is based on a new calculation. In lieu of the traditional uncompensated care numbers reported on Worksheet S-10 of a hospital’s Medicare cost report, which CMS has decided are subject to substantial error, the agency will (at least temporarily) use the hospital’s Medicaid inpatient days and Medicare Supplemental Security Income (SSI) days. Then, CMS will divide this number by the total Medicaid and Medicare SSI days for all hospitals in the country. (See formula)

Uncompensated Care Calculation equals

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\frac{(\text{Individual Hospital Medicaid Days} + \text{Medicare SSI Days})}{(\text{All DSH Hospital Medicaid Days} + \text{Medicare SSI Days})}
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This percentage is then multiplied by 75% of the national estimated DSH payments that otherwise would have been made under the previous DSH formula, as well as the anticipated rate of change in uninsured patients.

With most Southern states resisting Medicaid expansion, hospitals in those states may be on the losing end of this new calculation. More than half of U.S. states have agreed to expand their Medicaid rolls, and others are leaning that direction. That means the denominator of the above formula (Medicaid days) will swell, while many hospitals will see the numerator of the formula mostly stay the same. The bottom line: less money for those hospitals.
Aside from lobbying their state legislatures and governors to embrace Medicaid expansion, hospital executives can maximize their DSH reimbursements by properly tracking and reporting all Medicaid days, both paid and eligible. Software tools exist that can help hospitals more accurately track and report these days. Additionally, the recently finalized Medicare DSH rules noted that Worksheet S-10 on the Medicare cost report will be used in this calculation in future years (after federal fiscal year 2015). As such, hospital executives should make efforts to ensure that this worksheet is fully accurate and (most importantly) complete. If errors are noted in historical cost reports, hospitals should consider amending and discussing with their Medicare contractor.

2. Take advantage of incentives.

Hospitals also can take advantage of a variety of new incentives, such as enhanced compensation for transitional care provided within seven to 14 days after discharge.

The transitional care incentive is low-hanging fruit, since physicians can delegate the patient follow-up to a nurse practitioner or other lower-paid provider. In fact, nurse practitioners can be a key to increasing efficiency in many ways. Many states have expanded prescriptive authority to nurse practitioners. As a result, hospitals can increase efficiency by leveraging these professionals to handle an increased patient volume.

Incentive payments for meaningful use of electronic health records will be available through 2016, and these incentives also extend to nurse practitioners. Hospitals must certify each year to qualify for these incentives, so executives must stay up-to-date on these criteria.

3. Prepare to collaborate.

Many incentives available to hospitals are aimed at increasing collaboration between hospitals, physician practices, and other health care facilities.

A significant opportunity for hospitals is the ability to partner with Federally Qualified Health Centers (FQHCs), which provide primary care, typically to medically underserved areas. The PPACA established the Center for Medicare and Medicaid Innovation, an initiative that will pay incentives to FQHCs to coordinate care for Medicare and other patients. Hospitals can establish agreements with these health centers whereby they refer non-emergency cases to the clinics, keeping uninsured and Medicaid patients out of the hospitals’ emergency rooms and ultimately increasing the efficiency of primary care. To take advantage of this underutilized opportunity, hospitals must have formal agreements in place with local FQHCs that spell out the terms of collaboration.

Another significant opportunity for health care providers is to participate in accountable care organizations (ACOs). Hospitals, physician practices, labs and other providers stand to benefit from significant incentives – if they can put aside their differences and work together to lower the cost of care. Medicare offers several models for providers to follow, but the bottom line is that the participants potentially share in any savings they achieve.

While the ACO model has had limited success, some hospitals have shown a willingness to affiliate for a specific purpose, such as through group purchasing organizations or health information exchanges. These hospitals are recognizing that coordinating with their counterparts may be the only way to manage costs while improving care.

A more recent phenomenon involves hospitals in a region working together to recruit physicians. These hospitals, frustrated by the lack of good doctors, create an alliance specifically for the purpose of recruiting the best and brightest to their area. Hospitals also benefit from retaining these physicians once their residency is over, as many of them choose to establish practices in the region where they have already established beneficial relationships with the hospitals and community.

4. Leverage technology to improve efficiency.

While HIPAA and HITECH accelerated the implementation of electronic health records, many hospitals are still behind the times regarding leveraging technology to improve efficiency and effectiveness. A recent Ponemon Institute survey of health care professionals estimates that U.S. hospitals are losing more than $8 billion in productivity and increased patient discharge times due to technology issues such as inefficient pagers, no Wi-Fi access, email problems, and inability to use personal devices.13

Telemedicine is another way for hospitals to improve access to quality care while keeping costs low. “With telemedicine and internet technology, we can monitor and treat people in their homes, keep track of their blood pressure or blood chemistries, visually observe them, and deliver services to them while keeping them from getting institutional-borne infections,” says UA’s Streiffer in UA News.

5. Consider merging.

Some hospitals will not be able to make the financials work and will be forced to consider the option of merging or affiliating with a larger health system. Many community hospitals also are acquiring local physician practices to take advantage of consolidation of services and economies of scale, as well as physician reimbursements. In fact, Moody’s Investors Service cited mergers and acquisitions as one of the positive forces that have led to the gradual rise in median operating margins over the past few years.14

6. Stay current with Medicaid reimbursements and expansion.

Blindly following a well-established path and hoping for the best is no longer an option. Hospitals’ executives need to be scanning the horizon for indications of how reimbursements will be calculated in the future. They also must be aware of where their state stands with regard to Medicaid expansion. While some states have vowed to refuse funding for Medicaid expansion, many in the healthcare community continue to push for a compromise that would allow the states to expand access to Medicaid to a smaller population than the federal law requires or pursue alternative options, such as partially privatizing the Medicaid program.

13 USA Today. (2013, May) Hospitals lose $8.3 billion using old technology
14 American Medical News. (2013, February) Moody’s: Doctor integration vital to stronger hospital finances
WORK TOGETHER TO CREATE A RISING TIDE

Hospitals face a perfect storm of challenges in the coming years: increased regulation, decreasing reimbursements, a still-shaky economy, and a steady stream of poor and uninsured patients. But by putting aside their differences and working together to provide quality services at high levels of efficiency, hospitals and other providers can help create a rising tide that will lift all boats.

Most importantly, hospital executives must clearly understand how reimbursements will be calculated in the future and minimize the impact of cuts to reimbursements. For help making the changes that will right your ship and set a course for a profitable future, contact the CRI healthcare team.