

WHITE

PAPER

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U.S. hospitals have seen dramatic drops in volume and revenue in the first nine months of the recession. Traditional sources of capital have all but dried up, forcing the postponement or cancellation of capital projects and major equipment purchases. And the federal government is issuing new challenges as it rolls out RAC and health care reform. It's a nearly perfect storm, but hospital executives aren't waiting for it to clear. This paper discusses where you can take fast, targeted action to recover some of the financial ground lost over the past few quarters.

What Next?

Regaining financial momentum over the next 90 days.

Five performance areas will be particularly critical for hospital finances in the next 6-12 months. Here's what executives will be focused on to move their hospitals forward as the economy rebounds.

HELPING HOSPITALS SURVIVE *and* THRIVESM

INTRODUCTION

In the early months of the recession, many hospital managers saw, for the first time in their careers, a significant drop in patient volumes. The Healthcare Financial Management Association (HFMA) reported that more than half of America's hospitals saw inpatient volumes drop in the six months leading up to HFMA's January survey¹. In many markets, every service saw declines between Q3 2008 and Q1 2009: inpatient admissions, outpatient and elective surgeries, ED visits and physician office visits.

In Q2 2009, volumes stopped their precipitous fall and began to level off. But hospital executives aren't sure whether volumes will stay level, return to former levels or go into a new slide.

Volume uncertainty is a proxy for all the financial challenges hospital executives face right now. This white paper discusses how the perils of the recession may have changed since the early days of the crisis. Then we will focus on strategies and tactics that will help executives regain control and restore the financial health of their hospitals.

FORECAST: CLOUDY, CHANCE OF MORE STORMS

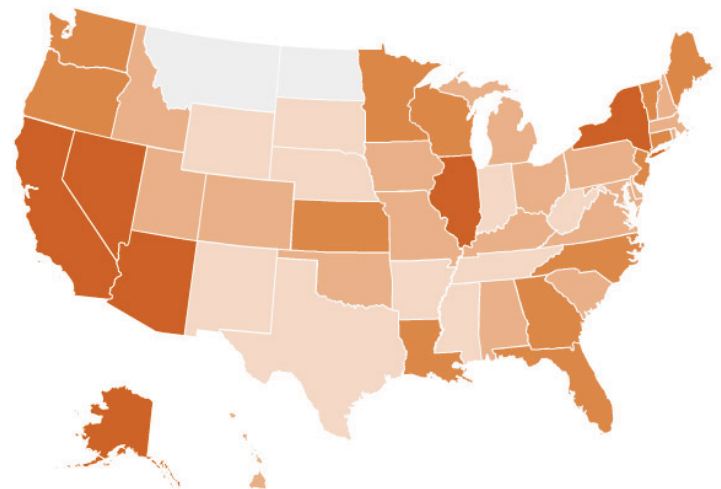
The conditions that are making life difficult for hospital CFOs have been well documented, but it may be helpful to consider where we are today.

- **Payor mix trends remain negative.** Even if millions of people weren't losing their jobs and their benefits, hospitals would be suffering from the changes in payor mix. The shift from employer-paid to individually paid coverage is a long-term trend. Workers are struggling to pay for their own coverage or pay their own medical and hospital expenses. The trend is causing an increase in hospital AR days and making bad debt a more formidable challenge. It is also contributing to decreased volume as people postpone the treatment they need because of inability to pay.
- **State safety nets are shrinking.** While the numbers of unemployed and uninsured patients is rising, many

states, trying to cope with their own budget crises, are cutting indigent care payments. This important safety net, for patients and hospitals, will be letting more and more people fall through. The cuts will hurt patients and the institutions that provide their care.

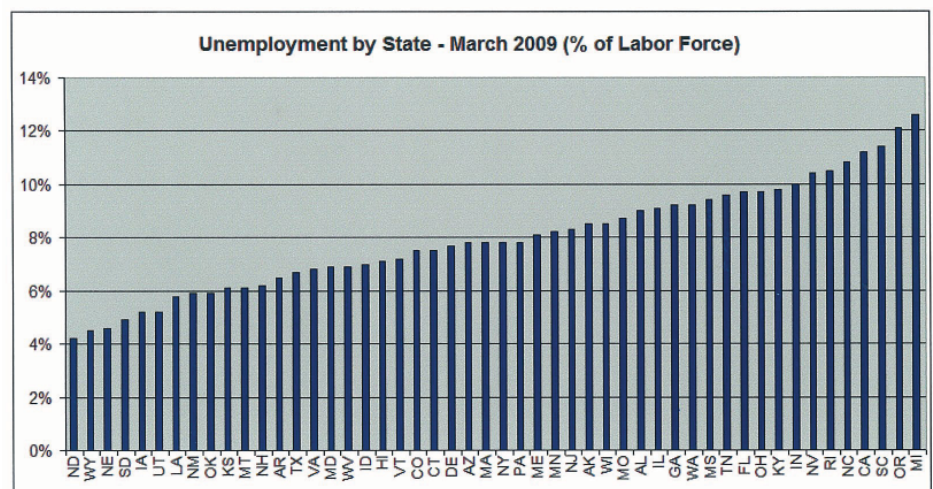
States with projected FY 2010 budget gaps

10% or less 10.1 to 20% 20.1 to 30% More than 30% No data



Source: National Conference of state Legislatures, July 2009

- **Hospital balance sheets remain vulnerable.**
 - ◆ Hospitals' investment returns are dramatically down. They are unlikely to return to pre-September 2008 levels in calendar year 2009.
 - ◆ Hospitals' cash and cash equivalents are down, as collections have slowed. Cash expenses have slowed too, but not as much as collections.



Source: Bureau of Labor Statistics

- ◆ Many hospitals are in technical default on their debt covenants, because they don't have adequate cash on hand.
- ◆ Accounts Receivable valuations are down.
- **Collapse of the variable debt market.** The shaky bond market is affecting almost every hospital in the country. In early 2009, borrowers saw interest rates on auction bonds jump from 2%-3% to 12-15%². Thanks to bond insurer distress and bank consolidation, there is essentially no market for new variable debt issues right now, and hospitals who are already carrying variable debt are seeing some of it, or all of it, called as banks struggle to remarket the debt at higher rates. Most hospitals are trying to avoid taking on new debt of any kind. An American Hospital Association survey in January 2009 showed that half of all hospitals had delayed a capital project they had scheduled; 15% had halted a project already begun³. Many of those who couldn't cancel or postpone projects were forced into the fixed rate market, at rates higher than they budgeted. (Another factor contributing to the high cost of debt is the record-breaking number of hospitals whose bond rating has been downgraded in the past 12 months.)

There is a small light at the end of the tunnel. Since January, tax-exempt bonds have regained some of their appeal in the institutional and retail markets. *Modern Healthcare* reported in June that Citigroup's healthcare finance group had seen individual buyers "[snap] up an average of 40% of three tax-exempt bond deals Citigroup recently brought to market."⁴

REGAINING CONTROL

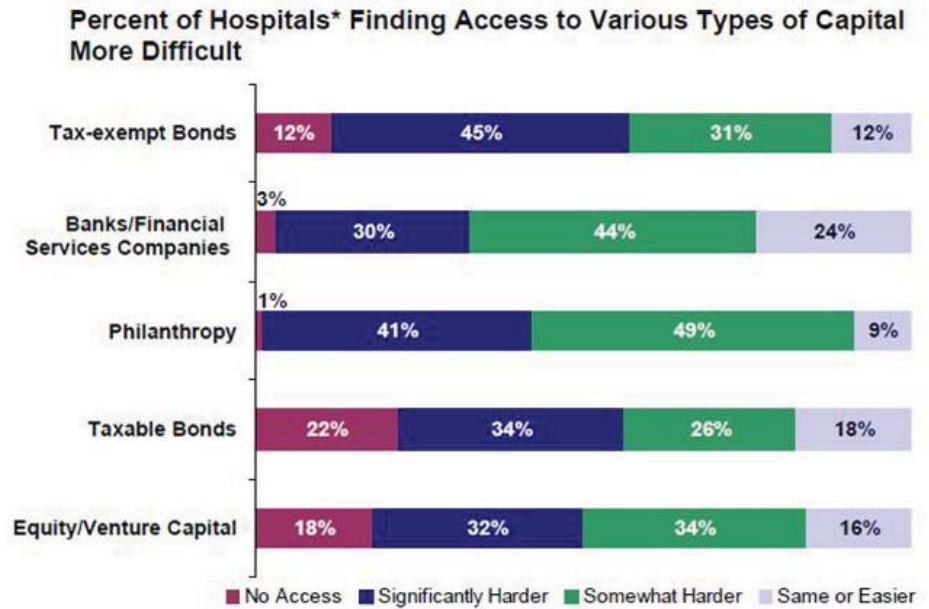
As the economy struggles to revive, there are strategies hospital executives should implement to regain some of the ground that has been lost. In this section we will discuss five performance areas on which you should focus in the next six months.

1. Implement pre-admittance screening.
2. Change your view of overhead costs.

3. Align staffing costs with your reduced volume.
4. Rethink your capital priorities.
5. Put contingency triggers in your FY 2010 budget.

1. Implement a pre-admittance screening program.

In the short term, most of the measurable increases in cash payments are likely to come from changes in point-of-service collections. Calculate the opportunities that exist from tightening procedures to collect



*Excludes those hospitals indicating that they don't use that source of capital

deductibles, co-payments, co-insurance and payments from self-pay patients. Then establish improvement targets for each site of service – particularly the ED and hospital-owned physician practices. Monitor carefully.

You can also stanch the bleeding from uncollectable accounts by setting up screening procedures at all admittance points. Verify coverage and screen for medical necessity and acuity up front. Redirect the patient if the case can be handled elsewhere in your organization at a lower cost. Have counselors at critical points, especially the ED, to enroll indigent patients in Medicaid.

2. Change your view of overhead costs.

Virtually every hospital has overhead costs that can be reduced, but most hospital executives don't have the data to tell them which reductions would have the greatest impact.

A typical benchmarking approach is to compare like departments – your IT department versus that of a peer hospital, for example. But these analyses often leave the executive team with more questions than answers.

A more effective approach to using benchmark data is to cluster overhead departments together, then compare the total expenses of these clusters to hospitals with similar net patient revenues, case mix index and adjusted admissions. Your IT costs, for example, may be higher than your peers because you're going through a system conversion. That higher cost is acceptable, but you know that you'll have to tighten up expenses in other areas in order to bring the costs of the whole cluster of departments in line and to stay competitive.

Prepare for RAC

The rollout of the RAC (Recovery Audit Contractor) program began in March 2009 in half the states. Hospitals nationwide should have strategies in place for reducing or appealing RAC denials. The keys are proper coding and correct documentation that makes a solid case for medical necessity. You must explicitly demonstrate patient clinical acuity and the risk of morbidity and mortality.

QHR's white paper "*Surviving the RAC: It's All in the Details*" outlines the roles that staff members – from nurses and physicians, to HIM coders, to billing staff, to utilization review – must play to assure that cases are properly documented and coded, and that mistakes are caught early and within the hospital – not in a RAC audit.

You need to be identifying your vulnerabilities and putting process improvements and staff education programs in place now. In the process, you may well see some financial benefits, as your staff becomes better equipped to assess medical necessity, reroute cases to the most appropriate level and department for care, and determine most appropriate lengths of stay.

3. Align staffing costs with your reduced volume.

Obvious, yes. Easy, no. But changes in the labor market can work to your advantage right now.

Differential pay. When volume was high, most hospitals implemented shift differential pay models to incent nurses to work second and third shifts. Now, higher unemployment rates (for both nurses and their spouses) make these positions more desirable. You may no longer need to pay a premium to staff these shifts any longer, or at a minimum, you may be able to scale back on differential pay programs.

Part-time staff. A good rule of thumb is that 20% of all front-line clinical positions should be part-time. Too many hospitals operate far below that guideline, which means that many of them have had no ability to flex staffing to match reduced volume during the past nine months.

Outsourcing. During the past five years, outsourcing has proliferated, primarily in overhead areas such as food services, housekeeping, biomedical engineering and information technology. Many hospitals have not tested their assumptions that outsourcing was improving their service delivery or reducing their overall costs. Now is the time to make sure you're getting full value for these arrangements.

You should analyze these metrics: 1) Compare the total cost of the service you're outsourcing to what peer hospitals are paying for the same service, whether outsourced or performed by permanent staff. 2) Make sure *you* define your ROI for outsourced services, and then track it. Don't let the outsourced vendor define ROI for you. Establish your own measures and hold the vendor accountable to meet them.

Benefit programs. The cost of benefit programs should be reviewed in the aggregate to identify programs that may impact only a small percentage of employees. Some of these programs may be targets for cuts, but keep an open mind. Spending a bit more on certain benefit programs during the downturn may pay dividends. Many hospitals froze retirement contributions and executive variable compensation as their margins dropped. Hospitals that expect to attract a talented work force may want to reassess those tactics.

4. Rethink your capital priorities.

Capital spending. Many hospitals' capital projects were frozen or truncated in the fourth quarter of 2008. Until debt markets stabilize, major projects are better left on hold, but routine capital spending can't be delayed more than 9-12 months without serious consequences. Capital improvements are essential, especially for revenue-generating services. Neglecting them can

diminish your ability to attract patients, recruit physicians and deliver quality care. And catching up later, after improvements have been too-long postponed, can cost far more than the original budget.

Prioritize your capital spending. Protect the projects that will maintain or increase revenues and profits. You may want to invest in new technologies that will increase specialty referrals (at the same time enhancing your ability to recruit new specialties).

Equipment and technology. Review medical equipment purchases in light of your adjusted volume and revenue forecasts. Imaging technologies may drop on your priority list. Imaging procedures are coming under heavy federal scrutiny. Many are presumed to fall into the 'unnecessary and avoidable testing' category – one of the specific targets of healthcare reform. Expect demand for new procedures to grow, but at a slower rate than in previous years. Also expect outpatient reimbursement rates to level off or even decline over the life of these purchases.

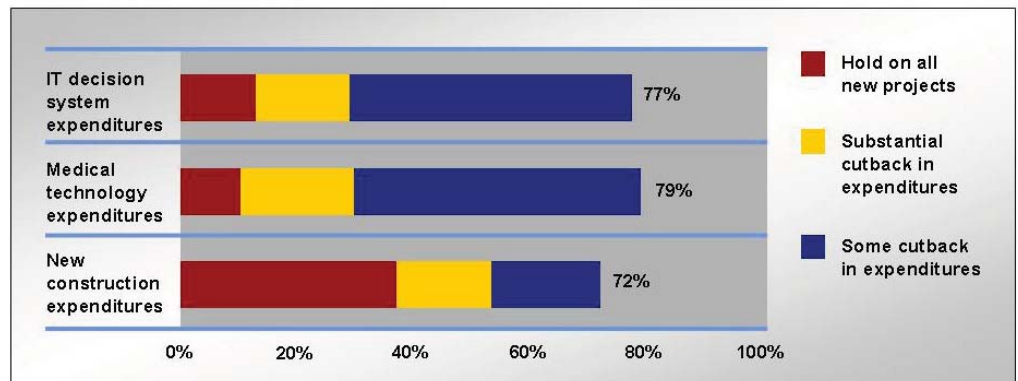
On the other hand, EHR technology purchases are being supported in the ARRA (**American Recovery and Reinvestment Act**) (See sidebar). If you haven't already taken steps to make sure your hospital qualifies to receive your allocated incentive funds, you should do so in the next few months.

5. Put contingency triggers in your fiscal year 2010 budget.

Uncertainty around volume and other drivers of hospital performance create a need for a 'rapid response' monitoring system. The system should be based on **net cash flow and net revenue**.

Adjust if net cash flow drops by 10%. Every month, assess net cash flow from operations and investments. A cash flow reduction of 10% below budget in any month should tell senior management to make adjustments. An adjustment could be cost avoidance, e.g., waiting to fill an open position. Or it could be a

Pulse Survey: Respondents expect substantial capital spending cuts if credit constraints continue



Source: Healthcare Financial Management Association, www.hfma.org

cost reduction, e.g., reducing hours in the departments where volume is down.

Adjust if you see a -5% variance in net revenue. Also track net revenue against budget each month. Look at both monthly and year-to-date performance. A -5% variance should trigger cost reductions in revenue-producing departments. If the variance is -10% or greater, reduce costs in overhead departments.

Focus on these five performance areas in the next six months:

1. Implement a pre-admittance screening program.
2. Change your view of overhead costs.
3. Align staffing costs with your reduced volume.
4. Rethink your capital priorities.
5. Put contingency triggers in your FY 2010 budget.

CONCLUSION

Some prognosticators predict the U.S. will pull out of the recession sometime in 2010. Hospital executives aren't waiting to see what happens. To be ready if things improve – or if they don't – hospital executives are improving performance in the five areas discussed in this paper:

1. Focus on point-of-service collections and put pre-admittance screening in place to avoid uncollectable accounts.
2. Reduce overhead costs – intelligently. Analyze costs using a department-cluster technique.
3. Align staffing costs with your reduced volume. See whether your full-time/part-time staffing ratio is giving you adequate flexibility. Revisit differential pay programs and make sure your outsourcing programs are meeting the intended objectives.
4. Rethink your capital priorities. Funds are tight, but some projects shouldn't wait.
5. Put contingency triggers in your FY 2010 budget. Monitor expenses vs. budget monthly, and be able to respond if cash flow drops below 10% or revenues drop 5% or more.

The most strategic executives are also preparing to avoid the financial threat of the RAC and to embrace the financial opportunity of the ARRA. (See sidebar.)

QHR can help you improve in these and other areas of strategic performance. QHR – Quorum Health Resources – is among the top 15 largest healthcare consulting firms and the market leader in hospital management services in the U.S. To discuss how QHR can help reinvigorate your financials, contact John Johnston, vice president of QHR Consulting at 800/233-1470, ext. 4547 or John_Johnston@qhr.com. Or read more about how QHR has helped hospital clients improve their financial performance at www.qhr.com.

¹ Healthcare Financial Management Association. The financial health of U.S. hospitals and health systems. January 2009. <http://www.hfma.org/NR/rdonlyres/E59B2DD1-C1DF-AD71-B9E1-1D273A55CF80/0/FinancialPulse_Highlights.pdf> (Accessed March 11, 2009)

² ModernHealthcare.com. Making a comeback, Melanie Evans. posted June 15, 2009. <<http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20090615/REG/906129983&AssignSessionID=273361547610371>> (Accessed July 27, 2009)

³ American Hospital Association. Report on the capital crisis: Impact on hospitals. January 2009. <<http://www.aha.org/aha/trendwatch/2009/twjan2009econimpact.pdf>> (Accessed March 11, 2009)

⁴ ModernHealthcare.com. Making a comeback, Melanie Evans. posted June 15, 2009. See full citation above, footnote 2.

Prepare to make the best use of the ARRA Stimulus Funding

In the ARRA (American Recovery and Reinvestment Act) Stimulus Funding program, the federal government has earmarked some \$19 billion to promote healthcare IT. Hospitals receive a share if they can demonstrate 'meaningful use' of health information technology.

At this writing, Congressional committees are still working to fine-tune the definition of 'meaningful use,' but hospitals have enough information to start taking steps to make sure they qualify for the incentive funds.

- Assess your hospital's current IT capabilities to determine how they can be better utilized.
- Identify technology gaps.
- Determine where and how to restructure clinical processes to better leverage information systems.
- Ascertain which physicians and clinicians will help you champion HIT best practices and which physicians and clinicians must change their attitudes and behaviors in order to adapt.

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