

# Stay in Control As Budgets Change

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BY SUSAN C. THOMSON, M.A., M.B.A.

**T**he Patient Protection and Affordable Care Act of 2010 provides little direction for hospital budgeters and financial forecasters. The law's 2,000-plus pages are heavy on policy but light on specifics. What must hospitals actually do to comply? What kinds of data must they collect? What types of reports must they submit, how often and to whom? What will compliance cost? How will the changes affect bottom lines? The answers will begin to come only with the new law's regulations, and most of those remain to be written.

A few fiscal generalities have emerged:

- Reform substantially undercuts U.S. medicine's traditional fee-for-service system by drastically overhauling how hospitals account for, charge for and are reimbursed for their services

- The rate of increase in Medicare reimbursements will continue to slow, ratcheting up the government's pressure on hospitals to control patient-care costs and generally do more with less

- The new pay-for-performance model requires hospitals to simultaneously improve the quality and effectiveness of their care

These economic impacts are on the scale of those that accompanied the advents of Medicare and Medicaid and the introduction, in the 1980s, of the prospective payment system of predetermined, fixed reimbursement rates for Medicare. So said Martin Arrick, a New York-based managing director and senior analytic leader for the U.S. not-for-profit health care group at Standard & Poor's, the credit-rating agency.

Robert Valletta, a Boston-based partner with PricewaterhouseCoopers and leader of the firm's health care provider sector, termed the industry's current era "transformational." He said hospitals

will survive in part by focusing on their costs.

John Tiscornia, a managing partner and lead health care expert with Chicago-based Huron Consulting Group, said reform accelerates the existing needs for hospitals to control their costs for:

- **Labor**, by matching employees' schedules to the day-to-day, even shift-to-shift fluctuations in patient counts

- **Supplies**, by negotiating the lowest prices for needed purchases and limiting to the extent possible the variety of different items — hip joint replacements, for example — bought for the same purpose

- **Employee benefits**, by adjusting pensions, health care coverage and policies for premium pay and time off

Hospitals, he added, should make sure they are charging for all of their services and billing for them in a timely and efficient way.

Tiscornia acknowledged all of the above are time-honored, best fiscal practices that hospitals would be well advised to follow, reform or not. Given the rollout of reform, however, he suggested hospitals keep 200 days' worth of cash on



hand. Cash management will be extra important during this transitional time, he said, for the new law certainly will bring new expenses.

Among the expenses hospitals already know about are the costs associated with conducting community needs assessments every three years, a new requirement for tax-exempt hospitals. Kristin Wilson, assistant professor of health management and policy at St. Louis University's School of Public Health, points out it would be advantageous for hospitals in the same market to pool resources and do the assessments together.

In Arrick's view, many hospitals already face major investments in new or upgraded technol-

ogy systems. "Reform readiness" goes hand-in-hand with information technology — without the right systems, he said, hospitals simply can't comply with new requirements that they measure the kinds of patient outcomes the law will link to reimbursements. Health reform also requires hospitals to move toward electronic storage and transmission of patient records.

Hospitals also may find themselves spending money to enter into new business combinations that reform makes financially attractive. Take, for example, the financial penalties coming under the law for hospital readmissions resulting from inadequate initial treatment of certain diagnoses. (See Financial Markers, left.) Add "bundled payments," by which hospitals will share their reimbursements with their patients' other providers, such as physicians and outside agencies. Together these two provisions of the law make hospitals newly responsible for patients after discharge and put a premium on new and closer relationships between hospitals and those other providers. Hospitals can forge these essential ties by contracting with these outside entities — for instance, nursing homes, home health agencies, clinics, rehab centers and physician practices — or they may find it more financially advantageous to buy them.

Physicians are seen as a key but elusive element in these new mixes. Traditionally autonomous and accustomed to having privileges at a variety of hospitals, some may resist committing themselves to any one hospital or, in the case of their practice's outright purchase, becoming hospital employees. On the other hand, the desire of younger physicians for manageable lives and the escalating cost of maintaining solo or small medical practices, particularly with the costly mandate for electronic records, may be enough to persuade physicians that affiliation with one or a more limited number of hospitals is worth their while.

Integrated health care organizations consisting of physicians, hospitals and other care providers and offering a continuum of care are "the way of the future," Valletta said. Those that go the distance of providing one-stop health care shopping for the populations they serve can qualify under reform as "accountable care organizations" (ACOs) and for certain financial incentives that go with the designation. The term, while relatively new and somewhat ill-defined, applies to a type of well-integrated, managed care organization that has been around for some time. Kaiser Permanente of California and the Geisinger

## HEALTH CARE REFORM'S FINANCIAL MARKERS FOR HOSPITALS

### 2011

Hospitals must begin converting to electronic medical records.

### 2012

**JANUARY**

Providers organized as accountable care organizations (ACOs) may qualify to share in the Medicare savings they realize.

**OCTOBER**

Medicare will start imposing financial penalties on hospitals that readmit Medicare patients for preventable reasons within 30 days of discharge after heart failure, a heart attack or a stroke.

Medicare will begin rating hospitals and paying them accordingly for the efficiency and quality of their treatment of certain conditions.

### 2013

Medicare will start phasing in "bundled" payments, cutting a single, fixed-rate, lump-sum check for each "episode" of patient care, such as a surgery or an illness. Hospitals, physicians and other providers taking part in the patient's treatment will divide the proceeds.

### 2014

The federal government will begin drastically cutting "disproportionate share" payments — reimbursements to hospitals for uncompensated care.



Health System of Danville, Pa., are frequently cited as models.

As reform began, Denver-based Catholic Health Initiatives (CHI) had several of the requisite pieces for it in place. The 19-state system was already well integrated vertically with what chief operating officer Michael Rowan described as a “pool of resources that is pretty deep and includes all elements of the market.” Among those were not only 73 hospitals but also 40 residential facilities of various types, two community health services organizations and home health agencies.

The system also had already begun cementing relationships with physicians by taking them on as employees. Officials say plans call for doubling the current count of 1,500 of them over the next two or three years.

Reform also found CHI launching a \$1.5 billion investment in information technology that will be installed in all of its hospitals and the offices of all of its physicians over the next six years. Officials say the systems will enable them to not only capture more clinical data on patients, improve access to it and provide evidence for improving the quality of care, but also control costs by increasing productivity and eliminating the duplications that result from paper records.

The outcome of discussions that officials say were under way months before health care reform became law, CHI in November 2010 announced plans to merge its eight Kentucky hospitals with the University of Louisville Hospital and Jewish Hospital & St. Mary’s HealthCare Inc., the latter a Louisville-based system of more than 70 hospitals and other health care units. The merger, which is expected to be completed in the first half of 2011, will create a statewide health care network of more than 90 locations within reach of 2 million patients.

The new network “would certainly better position CHI to be an ACO” but that was not the primary objective in creating it, Rowan said. “We believe that there are advantages in size and there are advantages within an individual state in pulling together individual [health care] entities.” Those advantages, he said, include leverage to negotiate lower prices with vendors, better deals with government and private insurers and the ability to speak with a single, large voice to state legislators.

In their ability to spread capital and other costs

over broad bases of operations, larger hospitals and hospital groups like CHI enjoy a natural business advantage over smaller ones. Economies of scale become even more urgent with reform, which Tiscornia said is creating an environment for even more consolidation of the industry. Some see that accelerating trend as calling into question the viability of independent hospitals. “The day

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MICHAEL ROWAN

of the stand-alone hospital is over,” Valletta said. Arrick predicted that, while there will be fewer of them in the future, they won’t be “going away” completely.

For Catholic hospitals, mergers may create even more nontraditional bedfellows, as they have in the past. In November, Cerberus Capital Management, a private equity firm, took over financially troubled Caritas Christi Health Care and converted that chain of six Catholic hospitals in Massachusetts into a for-profit enterprise. In December, the company announced plans to expand by buying two more Massachusetts hospitals, secular and for-profit. The original deal, announced in March, drew objections from Catholic groups fearful that the Caritas hospitals would lose their religious identity, but management of the new eight-hospital system, now known as Steward Health Care, has insisted that will not happen.

The new Kentucky system CHI is joining is a combination of not-for-profits, not all of which are Catholic. The Catholic identity of the CHI parts is not at risk, however. “One of the ways we remain Catholic, besides declaring it, is that we abide by the *Ethical and Religious Directives*,” Rowan said. “We make sure that the organizations that we become a part of also follow the directives.”

As a group, Catholic hospitals began reform with a couple of advantages. Reform demands that hospitals meet community needs. “By and large Catholic hospitals have been much more in the forefront of this concept of community benefit,” St. Louis University’s Wilson said. “Community benefit is caring for the most vulnerable,” said Wilson’s colleague Kathleen Gillespie, associate professor of health management and policy

at St. Louis University's School of Public Health. "Community benefit is part of [Catholic hospitals'] mission."

Catholic systems also get a higher-than-average grade for quality, a major principle of reform. A Thomson Reuters study released in August 2010 concluded that Catholic systems were more likely to provide high quality care than investor-owned, secular not-for-profit and even other church-related systems. The study, titled *Differences in Health System Quality Performance by Ownership*, was based on a statistical analysis of patient outcomes at 255 health systems.

Reform went into effect as hospitals in general were regaining their financial footing after what experts describe as a rough financial patch. During the recession, patient volumes dropped and margins were squeezed as millions of Americans lost health insurance along with their jobs, and workers with insurance, put off by their plans' rising co-pays and deductibles, deferred medical care.

As a whole, the hospital industry returned to financial stability in 2010, S&P's Arrick said. He based that assessment on analyses of a host of financial ratios calculated from the income statements and balance sheets of the more than 600 hospitals and hospital groups that his agency rates for creditworthiness.

In his view, though, there is no returning to hospital business as usual. On the contrary, he said, reform requires "a transformation to a new business model."

"Right now we get paid for what we do," said Dean Swindle, CHI's chief financial officer. "Our business model today is built on [the premise] that the more we do, the better off we are financially." Reform, with its promise to pay for quality rather than quantity, turns that old model on its head. The transformation to the new one will take time, he predicted. "The industry is a big ship, and it takes a while to move that ship."

In Tiscornia's view, time is of the essence. In addition to good cost controls and strong cash positions, hospitals best positioned to survive reform are those with strong governance, good management, "a culture of change and the ability to change" — and to do it quickly. Their rate of internal change must equal the rate of external change, he said. "And this is an era of great external change."

More external change is possible as Congress revisits the law and challenges to it wend their way through the courts. As long as he is in office, President Barack Obama can be counted on to veto any attempt at full repeal. Arrick, for one, said he is going on the assumption that the law will survive as written until 2014.

In that last big year of phase-in, the law will be giving to hospitals with one hand and taking with the other. The gift will come in the form of millions more people with health insurance, the

### **Catholic hospitals get a higher-than-average grade for quality, a major principle of reform.**

result of the law's mandate, effective that year, that most Americans either buy it or pay a penalty for not doing so. In a response sent by e-mail, Anthony J. Speranzo, senior vice president and chief financial officer for Ascension Health, St. Louis, welcomed that eventuality as "an unprecedented historic step and a recognition that our health care system needs to be more inclusive."

Also in 2014 the federal government will take away by beginning to drastically cut "disproportionate share" payments — reimbursements to hospitals for uncompensated care. The rationale is that there should be less need for it as a result of more people with commercial insurance and the law's expansion of Medicaid. At the same time, the aging U.S. population will mean more Medicare patients.

All told, hospitals in 2014 will be able to draw on larger pools of prospective patients. Arrick predicted, however, that not all hospitals will benefit in the same way — if at all. For the "big safety-net hospitals," the gains in patients may not offset the cuts in Medicare and disproportionate share payments, he said. Plus, as he pointed out, the newly insured will have a choice of hospitals and may not be loyal to any one in particular.

Where they choose to go for their care will shake up patient mixes, with even more reform-related financial consequences for all hospitals. Only time will tell what they will be.

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