

Uncharted Waters:

Navigating Unknowns of Reform at America's Large Hospitals

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Siemens Financial Services, Inc. is pleased to provide you with the results of independent research conducted by Health Industry Writers, which reveals that the financial unknowns of health care reform are hindering the abilities of America's large hospitals to prepare for reform.

Executive Summary

Beset with still-growing numbers of uninsured and non-paying patients due to the economic recession, the nation's largest health-care facilities are struggling to increase efficiencies. Their hope: a closer alignment of costs with payor reimbursements—before those reimbursements decrease under reform.¹ But at this point, future hospital income to be generated by reform's newly insured patients is only a murky projection. Thus, administrators at many large institutions are navigating without a compass, unsure if their facilities can afford to correct inefficiencies *and* pay for new technologies and processes required by reform.

In-depth interviews with officers at selected hospitals of more than 250 beds, as well as an analysis of current literature on the topic, revealed fiscal planning to be the number-one challenge at many large health-care facilities today. Said the CEO of a large Michigan hospital, "We're looking at defined reductions in revenue streams with a promise of future revenue streams—and we're not sure what these future revenues will be." Reform legislation includes the reduction of Medicare reimbursements to all hospitals by \$155 billion over 10 years starting in 2014.² But rule changes in Medicare and Medicaid contracts could bring fiscal surprises as early as 2011,³ "And that can have a bigger effect on how we're paid than the actual rate at which we're paid," said the CFO of a 537-bed hospital system in Virginia.

¹ PRWeb, "Faced with Recession, Hospitals Innovate to Reduce Equipment Costs," July 2009

² New York Times, March 21, 2010

³ Interview, Mary Washington Healthcare, Fredericksburg, Virginia, May 2010

Executives interviewed at four large hospitals in as many U.S. geographic areas listed the broad area of quality as their second major challenge. Until a definition of quality of care is accepted across the health-care industry, large hospitals must be positioned to reorganize or reclassify their data to meet evolving standards of quality. "You always hope the standard-setters will choose the methods we've employed," said the CFO of a northern Illinois health system. "But we expect that we may have to modify our methods or even adopt new ones."

Meanwhile, administrators at large hospitals are already monitoring an array of processes and procedures. "We need to be sure we do the right number of tests—not more and not less—so we don't go on fishing expeditions when patients come in," said one CFO. By correcting inefficiencies now, he said, more capital may be available later when reimbursement rates drop.

The continuing growth of free care ranked third among large hospitals' concerns. Not-for-profit hospitals are required to spend a percentage of their revenues providing community benefits to those who cannot pay. But the number of non-paying patients has been growing year-over-year at large and mid-size hospitals across the U.S. since 2005,⁴ placing pressure on large hospitals to increase revenues by offering new services and outsourcing select services that already exist. "We understand and accept our obligation to the community," said one CFO, "but we have limits to that to remain viable as a business."

Yet another major challenge at America's large hospitals is access to capital and rising debt, plus higher costs. In March 2010, *The Illinois Business Law Journal* reported that the current credit crisis affects hospitals more than other health care organizations due to the high levels of uninsured, patients and lower reimbursement rates from Medicaid and Medicare. "Now more than ever," wrote Mirianna Kiselev, "hospitals face increasing debt without the ability to obtain more capital or refinance existing loans."⁵ "We're tapped out," said the chief financial executive for a Maryland health care system. "We can't exceed our debt covenants. We just have to get into our new building and make it pay for itself."

Complicating the capital situation at large hospitals is the financial condition of states in which the hospitals are located. States have the policy option to tax most types of providers and services, including health care, and to designate the revenue for any state purpose.⁶ In 2009 alone, Alabama increased its hospital assessment by \$200 million, Colorado authorized \$337 million in new provider fees from hospitals, and Oregon assessed its hospitals for \$102 million⁷. In Maryland, where hospitals were assessed \$340 million over three years to help shore up the state's ailing finances,⁸ the General Assembly approved \$123 million in Medicaid reductions to hospitals for fiscal year 2011.⁹ Some states have promised that hospitals will see a portion of their assessments returned

⁴ American Hospital Association, "Uncompensated Hospital Care Costs" Fact Sheet, November, 2009

⁵ *Illinois Business Law Journal*, March 16, 2010: "Hospitals in Distress: How the Economy Has Affected Financing of Health Care"

⁶ National Conference of State Legislatures, "Health Care Provider, Industry and Tobacco Taxes and Fees," August, 2009 and March, 2010

⁷ State Tax Update, July 2009, National Conference of State Legislatures

⁸ Raymond Grahe, Chief Financial Officer, Washington County Health System, Hagerstown, Maryland

⁹ Holy Cross Hospital, Montgomery General Hospital, Suburban Hospital: Letter to Montgomery County, Maryland, legislators, May 5, 2010

in the form of increased Medicaid reimbursements,¹⁰ but hospital executives are dubious, believing such increases could recede or disappear under health care reform.

¹⁰ National Conference of State Legislatures, "Health Care Provider, Industry and Tobacco Taxes and Fees," August, 2009 and March, 2010

Fiscal Planning

“The question is, what can a hospital afford, and what will be the payback?”

– Jack Weiner, CEO, St. Joseph Mercy Oakland, Pontiac, Michigan

Costs continue to climb as large hospitals struggle to do more with less. An example, Information Technology operating expenses at facilities with more than 600 beds jumped 1.52% in 2009, the largest increase for all hospital sectors.¹¹ In general, total hospital expenses were expected to grow 9.6% in 2009, down only slightly from the 9.9% increase of 2008.¹²

Because he can't foresee all coming regulatory changes at either the federal or state level, Sean Barden, executive vice president and CEO of Mary Washington Healthcare in Fredericksburg, Virginia, is concerned that state reimbursement contracts beginning January, 2011 could hold unpleasant surprises. “Through the end of 2010, I can state fairly clearly what we'll be paid by government payors and commercial carriers,” he said. But reimbursement rules can change with each contract period, “and that can have a bigger effect on how we're paid than the actual rate at which we're paid,” Barden said. Particularly vulnerable are readmissions, he said, for which “Regulators can come in and take money back.”

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At NorthShore University HealthSystem in Evanston, Illinois, CFO Gary Weiss says hospital executives are anticipating how reform and related reimbursements will affect their health system. State economic pressures must also be considered: As of April 2010, Illinois was nearly \$10 billion in debt, and its debt rating second-worst only to California's. “Reimbursement cutbacks are scheduled for hospitals, providers and physician groups, and discussion would have you believe the additional funding for the previously uninsured will offset those cutbacks,” said Weiss. But lack of information about rates and reimbursement structure is causing NorthShore executives anxiety. “Our expectation is that we'll have a net loss,” said Weiss, “and that additional reimbursement won't keep pace with specific cuts already identified for the next 10 years.”

¹¹ 2010 Annual Report of the U.S. Hospital IT Market, Healthcare Information and Management Systems Society and HIMSS Analytics

¹² PriceWaterhouseCoopers Health Research Institute, “Behind the Numbers: Medical Cost Trends for 2009”

Concerns expressed by the American Hospital Association align with Weiss's view. Speaking of the Medicare Proposed Inpatient Prospective Payment System Rule introduced by the Centers for Medicare and Medicaid Services (CMS), AHA President Rich Umbdenstock said, "We take issue with the coding offset that assumes inpatient payments have increased solely due to changes in coding—ignoring that hospital patients are getting sicker. Hospitals supported the move toward a more refined payment system that would better characterize patient severity, yet CMS' coding offset distorts any improvements to payment accuracy." Should the rule take effect, Umbdenstock warned, "Billions of dollars would be taken out of the system just as hospitals are grappling with sweeping changes and payment reductions contained in the new health reform legislation."¹³

¹³ Rich Umbdenstock, President and CEO, American Hospital Association, April 19, 2010

Case Study: St. Joseph Mercy Oakland, Pontiac, Michigan

St. Joseph Mercy Oakland (SJMO) is a 443-bed comprehensive, community, and teaching hospital in southeast Michigan, about 30 miles inland from Detroit. As part of the Saint Joseph Mercy Health System, the facility is also a subsidiary of Trinity Health, the nation's fourth-largest Catholic health care system. SJMO is Michigan's first certified primary stroke center and is also known for its cardiovascular program. The hospital's palliative care, orthopedics and women's and children's services have also received national recognition.

Trinity Health provides SJMO with funding in the form of bond debt and internally generated cash. This combination of funding was used by SJMO to complete a \$60-million surgical center in 2010. Jack Weiner, SJMO's president and CEO, said the center replaced operating rooms built in 1927 and updated in 1950. Smaller capital projects up to \$2 million are typically paid for with cash.

Despite the hospital's ownership by a corporation with 2009 revenues of \$7 billion, Weiner says the unknown financial picture is SJMO's top challenge. "We're not sure what these [revenue] streams will be, due to pending health care reform," he said. He specifically worries that budgets at SJMO will be insufficient if payment levels are inadequate. "If that happens," he said, "it will be health care providers who feel the brunt of budget-balancing."

Secondly, Weiner is concerned about the cost of newer medical technology. The hospital began work six years ago to implement electronic health records (EHR), so this multi-million-dollar project is complete. But Weiner lists smart-infusion pumps, robotic surgery systems and fiber-optic communications as expensive upgrades that may be mandated or indicated to meet future standards of care. "The question is, what can a hospital afford, and what will be the payback?" he says.

A balance is needed between capital projects providing direct returns and those improving safety and quality of care, Weiner says. But if reform regulations require the purchase of multiple technologies lacking definitive financial returns, Weiner fears that SJMO will suffer.

Yet, Weiner says the pending healthcare reform could benefit hospitals located in urban settings, such as SJMO. "We're constantly balancing the demands of a population that is uninsured or under-insured," he said. If government reimbursement programs are responsibly structured, SJMO could possibly meet reform regulations and not require Trinity Health to take on more debt. "But if there's not enough money to fund existing programs like Medicaid, the government could reimburse at 10 cents on the dollar," he says. "Nobody can exist in such a world."

Quality

“You always hope the standard-setters will choose the methods we’ve employed, but we expect that we may have to modify our methods or even adopt new ones.”

– Gary Weiss, CFO, NorthShore University HealthSystem, Evanston, Illinois

Delivering the right care at the right time in the right setting is the core mission of hospitals across the nation.¹⁴ But hospitals are feeling pressure to lower their costs of care while improving their quality of care, and critics wonder if the drive might create a “penny-wise and pound-foolish” approach, with hospitals discharging patients sooner, only to increase readmission rates and incur greater inpatient use—and costs—over time.¹⁵ The Patient Protection and Affordable Care Act, signed into law in March, 2010, requires the penalization of hospitals for readmissions deemed avoidable. But the law makes no distinction between planned readmissions that provide needed care, and unplanned readmissions. Unless this provision is corrected, hospitals may be penalized for providing appropriate services.¹⁶

Thus, ensuring that patients receive the most effective and efficient care and services is critical to keeping costs in check and the quality of services high. Said the CFO of a Virginia-based health system, “We need to be sure we do the right number of X-rays and tests—not more and not less—so that appropriate resources are used in caring for our patients.”

¹⁴ American Hospital Association, “Quality and Patient Safety,” May 2010

¹⁵ The Commonwealth Fund, “Hospital Cost of Care, Quality of Care, and Readmission Rates: Penny-Wise and Pound-Foolish?,” February 22, 2010

¹⁶ American Hospital Association, “Quality and Patient Safety,” May 2010

Case Study: NorthShore University HealthSystem, Evanston, Illinois

NorthShore University HealthSystem (NorthShore) operates four hospitals in Northern Illinois: Evanston Hospital, Glenbrook Hospital, Highland Park Hospital and Skokie Hospital. The principal teaching affiliate of the University of Chicago Pritzker School of Medicine, the system supports 916 licensed beds, 368 of them at Evanston Hospital, the corporation's flagship facility. More than 2,400 physicians are affiliated and on staff with the system; roughly 675 are employed by NorthShore.

Among NorthShore's specialties are cardiac, neurological, orthopedic and cancer care. In March 2010, the health system was named one of the nation's Top 100 Hospitals by Thomson Reuters for the 14th time. The American Nurses Credentialing Center awarded NorthShore "Magnet" status, the organization's highest honor, during the same month.

In 2003, NorthShore became one of the first health systems in the U.S. to install electronic health records (EHR) technology. NorthShore University HealthSystem Executive Vice President and CFO Gary Weiss says that prior to the EHR launch, physicians were required to complete 16 hours of training as a prerequisite to receiving a log-in to the application. Since implementation of the system, focus has turned toward using the technology to benefit patients and hospital staff most effectively.

"Having patient data in an electronic environment makes the data more accessible and positions us to better understand quality outcomes of our patients," said Weiss. Because physicians can more easily compare patients with identical diagnoses who were treated at different times, they are making progress identifying outliers in certain areas as well as systemic issues that can be altered to ensure quality care.

The entire issue of quality is one of NorthShore's major challenges. Until a standard definition of quality of care is accepted throughout the health-care industry, hospitals such as NorthShore must be positioned to reorganize or reclassify their data to meet evolving standards of quality. "You always hope the standard-setters will choose the methods we've employed," said Weiss, "but we expect that we may have to modify our methods or even adopt new ones."

Establishing proof of meaningful use is part of the quality issue. Although NorthShore has used EHR for more than six years, a 500-page initial definition of the term was released by DHHS' Centers for Medicare and Medicaid (CMS) just in December, 2009. Said Weiss, "We're in the throes of understanding what meaningful use means under these new regulations."

Overall, Weiss says, the challenge is to "keep up with all external factors pushing against us, whether reimbursement or the increasing complexity of regulation." Health care reform "will create many challenges moving forward," he said, "but I believe they are challenges the management team at NorthShore will successfully address."

Free Care

"We understand and accept our obligation to the community, but we have challenges there so that we remain viable as a business."

– Sean Barden, EVP and CFO, Mary Washington Healthcare, Fredericksburg, Virginia

Not-for-profit hospitals are required to spend a percentage of their revenues providing community benefits to those who cannot pay. But the number of non-paying patients has been growing year-over-year at large and mid-size hospitals across the U.S. since 2005, and exceeded \$36 billion in 2008,¹⁷ the latest year for which figures are available. While reductions in Medicare reimbursement payments have already been defined by health-care reform, projected income to be generated by newly insureds has not. Consequently, executives at large hospitals fear budget gaps that won't be easily closed.

Despite evidence that the U.S. economy is improving, the ranks of uninsured and non-paying patients at hospitals continues to rise. Even at a large Illinois health system with a record operating income in 2009 of \$65 million and a 4.3% operating margin, financial pressures continue to grow as the organization provides community benefits to its patient population. In 2009, these benefits increased by 14% to \$172 million. "The more community benefits we provide, the more sources of funding we will need," said the system's CFO.

To lessen the expense of free care, many large hospitals are building, purchasing or partnering with outside care facilities and ambulatory surgical centers. Trinity Health, owner of Michigan's St. Joseph Mercy Oakland, recently bought a physician-owned surgery center that was struggling. The health system is also growing its outpatient services in diagnostic testing, radiology, laboratory services and cardiac diagnostics. "We do not expect our core in-patient business to go away," said SJMO's Weiner. "We expect aging society and increases in chronic diseases to put a lot of pressure on our in-patient business for quite a while."

¹⁷ American Hospital Association, "Uncompensated Hospital Care Costs" Fact Sheet, November, 2009

Case Study: Mary Washington Healthcare, Fredericksburg, Virginia

Mary Washington Healthcare (MWHC) comprises two hospitals and 30 outpatient facilities in north-central Virginia. The system's largest facility is Mary Washington Hospital, a Level II Trauma Center in Fredericksburg with 437 beds and approximately 400 physicians on staff. MWHC's second hospital, 100-bed Stafford Hospital in Stafford, Va., opened in February, 2009.

Medical specialty services from the system include robotic urologic surgery and neurosurgery; stereotactic brain surgery will be available in 2011. MWHC also provides a 48-bed ICU and a 40-bed psychiatric unit at Mary Washington Hospital. The hospital is additionally a Certified Primary Stroke Center and a Magnet Hospital, as recognized by the American Nurses Association in September, 2009. The hospital also won the Spirit of Excellence Award for Quality in December, 2009, from Sodexo Health Care and *Modern Health* magazine.

Sean Barden is executive vice president and CFO of MWHC, and he says a major fiscal challenge is the growth in free care. "We understand and accept our obligation to the community, but we have challenges there so that we remain viable as a business," he said. Free inpatient care alone costs the system roughly \$60 million per year, and the free outpatient clinic MWHC supports is "almost overrun," Barden said, with as many as 75,000 patients each year. But use of the clinic stretches the system's community benefits dollars, because patients are often given care before their situations become emergent. The free clinic also provides patients with drugs at low or no cost.

Capital Structure and Debt (Access to Capital / Rising Debt & Costs)

“S&P wants to downgrade us, but there’s nowhere to go when you’re already a triple-B.”

– Raymond Grahe, CFO, Washington County Health System, Hagerstown, Maryland

Hospital construction costs rose nearly 10% per year from 2004 to 2008, with the price in 2008 averaging \$400 per square foot.¹⁸ Many large hospitals obtained financing during this period before credit tightened and built new inpatient wings, surgical centers and main buildings. But demand for additional space continues, to serve aging populations, to accommodate new equipment and services, or to comply with state regulations: A mandate from the California Legislature, for example, requires all California hospitals to be renovated or reconstructed by 2013 to withstand a 6.0 earthquake.¹⁹

These pressures, along with debt remaining from previous capital projects, have hospital executives on edge. CEO Sean Barden at Virginia’s Mary Washington Healthcare said his system has “a fairly significant amount” of fixed-rate debt from construction of its primary hospital in 1993 and a 100-bed tower that was added in 2003. A 100-bed addition built 10 years later added new debt, as did tax-exempt bonds sold through an industrial development authority in 2008 to finance the new Stafford Hospital.

To service its debt, the system has traditionally relied on factors that include a certain patient load and a return on MWHC’s investments. But a light influenza season during winter, 2009-2010, kept patient count lower than expected, and major snowstorms in early 2010 damaged the local economy. Prior to these events, hospital investments lost \$31 million at the height of the recession. Only this spring did holdings reach their previous levels. “We’re pretty well tapped out,” said Barden. “We just opened Stafford, and that investment hasn’t yet begun to provide a return.”

The organization is working to adapt to downward volatility, “but at the end of the day, it’s about striking a balance,” he said. On one end of the scale are efficient operations; at the other are payor reimbursements sufficient for the health system to remain viable.

NorthShore’s Gary Weiss offered a succinct summary. “It’s not that we’re looking to borrow more money,” he said, “but we need to continually ensure we have sufficient liquidity to meet our ongoing operating needs.” To predict sources and uses of cash going forward in light of health care reform “requires good cash-flow forecasting capabilities, maintaining strong credit ratings and nurturing banking relationships,” he said. Large hospitals short on these criteria can only hope they won’t need more credit until lenders—and the national economy—develop more solid footing.

¹⁸ FierceHealthcare, “Hospital Construction Costs Skyrocket,” and Healthcare Financial Management Association, November, 2008

¹⁹ Santa Barbara Independent, “Cottage Hospital Construction Update,” May 22, 2010

Case Study: Washington County Health System, Hagerstown, Md.

Washington County Health System (WCHS) is the parent corporation of Washington County Hospital, Antietam Health Services, Inc., and three financial entities that include an endowment fund, a foundation and an insurance company.

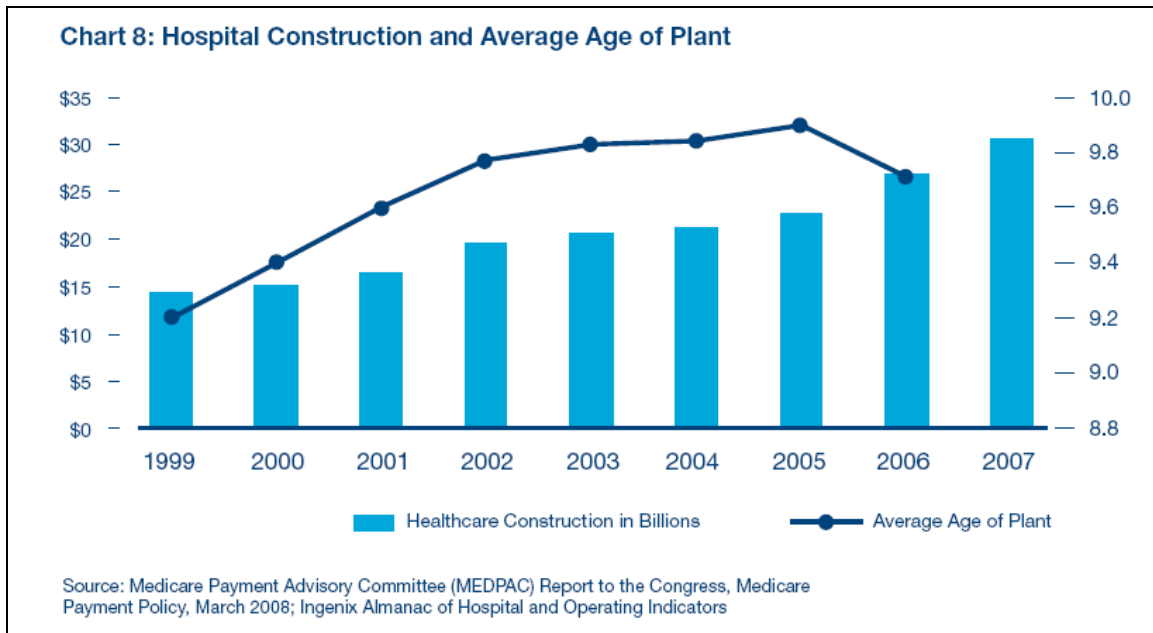
The 341-bed, not-for-profit hospital serves residents of western Maryland, southern Pennsylvania and the panhandle of West Virginia. A regional Level II Trauma Center, the facility also offers obstetrics and newborn care, cardiac catheterization, and inpatient rehabilitation. Further services include intensive and progressive care, and in- and outpatient mental health care.

Washington County Health System received approval in early 2008 from a large national bank for partial financing to replace its 74-year-old main facility. All 3- to 5-year bonds were offered at 5.91% and sold on the day they were issued. "We did not use any derivatives and we had no insurance to provide a higher credit rating," said Raymond Grahe, CFO. "We went with straight fixed debt on just our credit standing."

Three weeks later, the banking crisis closed much of Wall Street and credit markets dried up, leaving the hospital with just 44% of its \$150-million debt service for the new building funded. "S&P [Standard & Poor's] wants to downgrade us," said Grahe, "but there's nowhere to go when you're already a triple-B."

Were it not for other capital challenges, however, WCHS would likely be in better financial condition. Grahe said the state of Maryland has assessed hospitals within its borders a total of \$340 million over the last three years to help cover a \$2-billion shortfall in the state's budget. WCHS' share of that assessment is \$6 million annually. Add to this obligation flat-to-declining patient volume, an increase in uninsured patients, and a statewide 200,000-patient increase in Medicaid enrollments since the onset of the economic recession, and it's not hard to understand Grahe's worries.

Asked if the system could apply now for further financing, Grahe said, "No. We're tapped out. We can't exceed our debt covenants. We just have to get into our new building (scheduled for completion in December, 2010) and make it pay for itself."



Used with permission, PricewaterhouseCoopers Health Research Institute, "Behind the Numbers: Medical Cost Trends for 2009"

Independent research in this report was conducted by Susan Hodges of Health Industry Writers, www.healthindustrywriters.com. The white paper findings represent only a "snapshot" of views and concerns gathered during 2010 and based on the interviews conducted. The concerns addressed were those that seemed to be top of mind at this time.

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