

Healthcare Reform and the Impact on Financial Planning



healthcare financial management association  
Rockland, Maine / September 16, 2010



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Discussion Agenda

- The Emerging New Era and Implications for Hospitals
  1. Reform
  2. Strategic Realities/ Issues
  3. Competency Requirements and Attributes
  4. Financial Planning is the Foundation
- Financial Planning In the New Era
  1. Back to Basics – Sound Fundamental Planning as a Basis
  2. Factoring in Healthcare Reform Related Impact
    - ✓ Quantifiable Factors
    - ✓ Non-Quantifiable Factors

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The Emerging New Era and Implications for Hospitals

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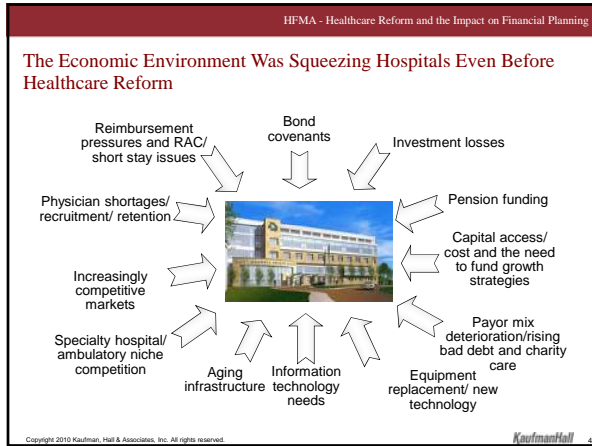
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- HFMA - Healthcare Reform and the Impact on Financial Planning
- ### Leading to Negative Rating Agency Industry Outlooks
1. Access to capital is materially impaired and more costly
  2. Variable-rate debt structures and swaps add considerable risk
  3. Investment portfolio losses are adversely impacting cash flow and cash, resulting in weakened balance sheets and less financial flexibility
  4. Pension funding is a major financial concern for those with defined benefit programs (i.e., current market value ↓, discount rate ↓, earnings rate ↓)
  5. Physician employment strategies are increasingly more important and prevalent, but are creating more demands on finite liquidity
  6. Economic recession is reducing utilization and adversely impacting payor mix and bad debt
  7. Expect more industry consolidation as the credit gap widens
  8. More capital plans will need to go back to the drawing board given all of the above
  9. **Good management and governance now more important than ever**
- Source: Adapted from Moody's "Not-for-Profit Healthcare Sector Outlook Revised to Negative from Stable", November 2008. Copyright 2010 Kaufman, Hall & Associates, Inc. All rights reserved. KaufmanHall

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### Healthcare Reform Has Added Urgency to Industry Response

2010	2011	2012	2013	2014+
<ul style="list-style-type: none"> <li>• High risk pools</li> <li>• Dependents covered to 26</li> <li>• Small business tax credits</li> <li>• End rescissions and coverage limits</li> <li>• Market basket productivity reductions begin</li> </ul>	<ul style="list-style-type: none"> <li>• Report healthcare benefits on W-2</li> <li>• Community health center funding</li> <li>• No Federal Medicaid matching for hospital acquired conditions (HACs)</li> <li>• Innovation center created by CMS</li> <li>• Brand-name pharmaceutical assessments</li> </ul>	<ul style="list-style-type: none"> <li>• Accountable Care Organization (ACO) Pilot</li> <li>• Penalties for high readmission rates begin</li> </ul>	<ul style="list-style-type: none"> <li>• Bundled payment pilot</li> <li>• Increased Medicaid payment for PCPs</li> <li>• Administrative simplification</li> <li>• Co-ops established</li> <li>• Medical device tax</li> </ul>	<ul style="list-style-type: none"> <li>• Individual and business mandates</li> <li>• Exchanges and affordability credits</li> <li>• Medicaid expansion</li> <li>• Medicare/Medicaid DSH cuts</li> <li>• Independent payment advisory board</li> <li>• Reduced payment for high levels of HAC</li> </ul>

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**Strategic Realities**

1. **Change in federal budget pressures:** The federal deficit is projected to grow substantially in the absence of major policy change. The government's obligations related to reducing the number of uninsured, growth in Social Security payments, and ongoing defense funding requirements are all contributing factors. Reducing healthcare costs is one of the only viable options to address this issue.
2. **Change in premise:** HHS Secretary Kathleen Sebelius recently said there is the need to "change the incentives in our healthcare system so doctors and hospitals get rewarded for providing high-quality care." She added, "...too often we pay for quantity, not quality... volume, not value."
3. **Change in payment:** In this regard, many healthcare executives now expect the fee-for-service payment system to go away over time and be replaced by something that looks more like capitation. Alternatively, at a minimum, most anticipate increased linkage to outcomes, quality, and cost effectiveness.
4. **Change in results:** Governmental, commercial insurer, and provider-based pilots/ initiatives that truly link payment to quality and cost effectiveness are yielding impressive results. These efforts are steadily expanding across the country.

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**Strategic Realities (continued)**

5. **Change in prices:** Average payment rates, from all payors, will likely, over time, begin to approach Medicare rates. This will have a profound impact on revenue growth and will force most providers to take a completely new look at costs and the organization of care.
6. **Change in utilization:** Many observers are now predicting a flattening, or perhaps an absolute decline, in overall utilization. It now appears that the "cost curve cannot be bent" without bending the utilization curve.
7. **Change in competitive landscape:** Consolidation will drive a real change in the provision of care. The most transformational aspect of healthcare today is the rise of the super-regionals and the changes they are forcing in the competitive landscape.

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**Key Business Issues**

1. Slower revenue growth
2. Uncertain demand
3. Less predictable access to capital
4. Payment linked to quality and outcomes
5. New delivery models for efficient, rational access
6. Tightly coordinated care
7. New physician culture
8. Increasing consolidation
9. Transparency/ rigorous reporting requirements
10. Increasing reliance on technology

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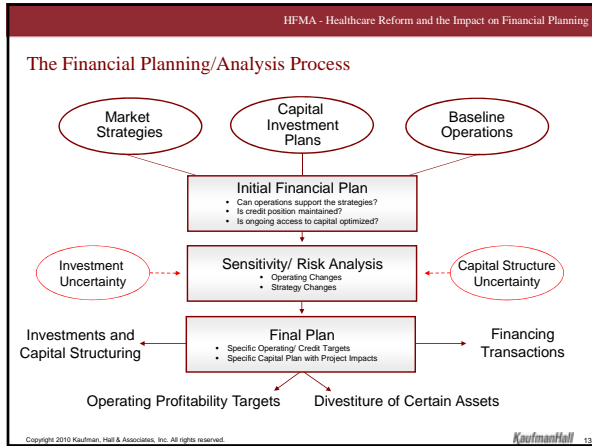
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### Seeing a Clear Path to the Future Requires Thinking and Planning Before Acting

<b>Think</b>	<ul style="list-style-type: none"> <li>• A comprehensive market, strategic, new era readiness and financial position assessment</li> <li>• A "future state" vision of how the organization intends to serve the market in the near, intermediate and long term</li> </ul>
<b>Plan</b>	<ul style="list-style-type: none"> <li>• Articulation of key strategic objectives that will close the gap between the "current state" and the desired "future state"</li> <li>• Financial projections and a financial plan tied to the strategy and action plan</li> </ul>
<b>Act</b>	<ul style="list-style-type: none"> <li>• An action plan identifying specific objectives related to each action plan as well as implementation timing and execution responsibility for each initiative</li> <li>• Action plan development and quantification – fully developed action plans, including expected impact on volume and/or costs as well as operating and capital requirements necessary to support execution</li> </ul>

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## Financial Planning in the New Era

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### The Strategic Financial Planning Framework – More Important Than Ever

**The corridor of control is the balancing point between two opposing goals:**

1. Compete as effectively as you can, which requires aggressive investment of capital and commitment of operating dollars, BUT
2. Respect the fiduciary role of management and the board to maintain the long-term financial integrity of a community asset.

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### Appropriate Planning/ Analysis Starts with the Basics

**Develop a Sound Financial Plan Based on Existing "Known" Variables**

- Credit analysis
- Debt capacity analysis
- Capital position analysis
- Development of baseline financial projections
  - Typically covers 5 to 10 years
  - Sufficient detail to support real evaluation of individual entities/ operations
  - Same store analysis – population based volumes without assumptions regarding strategic initiatives or market shifts
  - Operations based on current structures
- Sensitivity analysis
  - Operating initiatives (e.g., productivity, non-salary inflation)
  - Known strategies
  - Downside risks (e.g., investment income, volume, costs)

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### Measured Financial Projection Results – The Plan (\$ millions)

Ratio/Statistic	S&P "BBB"	Moody's "Baa"	Actual FY09	Projection Years				
				FY10	FY11	FY12	FY13	FY14
Net Patient Service Revenue	\$158.4	\$234.2	\$141.3	\$157.3	\$168.7	\$177.5	\$186.8	\$196.1
Operating Income	----	\$0.4	(\$0.0)	(\$0.4)	(\$3.1)	(\$0.9)	\$1.7	\$3.8
Operating EBIDA	----	\$17.3	\$7.5	\$10.7	\$12.0	\$14.3	\$17.1	\$19.4
Net Income	----	\$4.4	\$1.2	\$1.4	(\$0.8)	\$1.6	\$4.6	\$7.1
Cash Flow (N + Depr)	----	----	\$8.7	\$11.3	\$10.8	\$13.4	\$16.5	\$19.4
Unrestricted Cash	----	\$75.4	\$40.5	\$44.0	\$47.5	\$53.2	\$61.5	\$72.5
Total Debt	----	\$123.1	\$45.5	\$68.8	\$67.5	\$66.2	\$64.8	\$63.3
Capital Spending	----	\$20.3	\$35.5	\$30.0	\$5.5	\$5.5	\$6.0	\$6.0
<b>Profitability</b>								
Operating Margin	0.9%	0.3%	(0.0%)	(0.2%)	(1.8%)	(0.5%)	0.9%	1.9%
Operating EBIDA Margin	----	7.5%	5.2%	6.7%	7.0%	7.9%	9.0%	9.7%
Excess Margin	2.4%	2.1%	0.8%	0.9%	(0.4%)	0.9%	2.4%	3.5%
<b>Debt Position</b>								
MADS Coverage (x)	2.5	2.8	2.7	2.6	2.9	3.4	4.1	4.6
Debt to Capitalization	42.3%	50.6%	30.7%	38.7%	39.5%	38.6%	37.1%	35.1%
<b>Liquidity</b>								
Cash to Debt	80.2%	63.9%	89.0%	64.0%	70.4%	80.5%	84.9%	114.5%
Days Cash On Hand (Days)	121.1	99.9	108.0	106.3	106.1	114.2	127.0	144.1
<b>Other</b>								
Average Age of Plant	10.1	10.3	14.5	12.1	11.3	12.1	12.9	13.6
Capital Spending Ratio	135.4%	140.0%	470.7%	304.0%	47.7%	46.9%	53.2%	48.9%
FTEs	----	----	1,358	1,387	1,398	1,410	1,420	1,431
Compensation Ratio	52.1%	----	51.9%	49.5%	48.5%	47.4%	46.1%	45.1%

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### Factoring In Healthcare Reform

*Principles and Mechanisms*

**The Principles Are Articulated**

- Expansion of the total insured population (32 million)
  - 15 million Medicaid
  - 17 million Commercial
- Reduced costs – \$1.2 trillion target (over 10 years)
- Improved value – highest quality for lowest cost
- Increased provider accountability for outcomes through economic rewards and sanctions

**Mechanisms Being Discussed to Change the Quality/ Value Proposition**

- Payment based on “best practice” levels of value (quality/ cost)
- Bundled payments
- Quality incentive payments
- Reductions in readmission rates
- Reduction in certain outpatient procedures, e.g., imaging
- Competitive bidding for Medicare Advantage plans
- Increased access with a larger insured population

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### Factoring in the “Quantifiable” Dimensions of Healthcare Reform

Medicare Impact

- Medicare “market basket” inflation rates
  - Legislated rate changes net of projected “market basket” inflation
- Medicare and Medicaid DSH payment reduction
  - Estimated reduction in payments effective 2015

Expansion of coverage Impact

- Transition of the uninsured population into commercial/ managed care and government health plans

Penalties

- Readmission penalty
  - Financial penalty for excess readmissions
- Hospital acquired conditions penalty
  - Imposes 10% payment penalty

Continuum of Care

- Plan for physician alignment
  - Estimated costs to position organization for tight physician-hospital integration through ACOs and other means to receive potential bundled payment by 2015

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### Medicare Payment Rates

Impact	Description	Assumptions
Medicare Market Basket	<ul style="list-style-type: none"> <li>Market basket update adjustments for productivity reduce reimbursement by \$112.5 billion over 10 years starting in FFY 2010</li> <li>Other Medicare cuts in the reform bill begin in FFY 2010. Annual cuts range from 0.10% to 0.75%; additional cuts are through FFY 2019</li> </ul>	See slide that follows
Coding Adjustment	<ul style="list-style-type: none"> <li>Proposed by CMS to compensate for “inflation” in acuity coding</li> <li>A 2.9% reduction spread across FY11</li> <li>A 3.9% reduction spread across FY12 to FY14</li> <li>While not formally a part of Health Reform legislation, it is in the spirit of reducing Medicare program costs</li> </ul>	See slide that follows
Disproportionate Share	<ul style="list-style-type: none"> <li>Medicare (\$22 billion) and Medicaid (\$14 billion) DSH payments are reduced by approximately \$36 billion over 10 years starting in FFY 2014</li> </ul>	See slide that follows

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## Impact of "Quantifiable" Reform

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### Example of Summary of Reform Impacts (\$000s)

	2012	2013	2014	2015	2016	2017	2018	2019	2020
<i>Operating:</i>									
Medicare Rates	\$(21,329)	\$(24,749)	\$(29,290)	\$(33,873)	\$(24,452)	\$(19,311)	\$(13,432)	\$(8,713)	\$(4,215)
Medicare Advantage	(2,900)	(2,900)	(2,900)	(2,900)	(2,900)	(2,900)	(2,900)	(2,900)	(2,900)
DSH	-	-	(607)	(10,085)	(10,663)	(14,025)	(15,351)	(17,846)	(17,956)
Expansion of Coverage	7,355	7,878	8,419	8,996	9,613	10,273	10,977	11,730	12,535
Readmissions	(106)	(108)	(110)	(113)	(115)	(117)	(120)	(122)	(124)
Hospital Acquired Conditions	-	-	-	(8,409)	(8,602)	(8,790)	(8,931)	(9,096)	(9,264)
<b>Total Annual Operating Impact</b>	<b>\$(16,980)</b>	<b>\$(19,879)</b>	<b>\$(24,489)</b>	<b>\$(46,383)</b>	<b>\$(37,118)</b>	<b>\$(34,841)</b>	<b>\$(30,356)</b>	<b>\$(26,747)</b>	<b>\$(21,925)</b>
Cumulative Operating Impact	<b>\$(6,859)</b>	<b>\$(61,349)</b>	<b>\$(107,731)</b>	<b>\$(144,849)</b>	<b>\$(179,690)</b>	<b>\$(210,046)</b>	<b>\$(236,793)</b>	<b>\$(258,719)</b>	

**\$145 million negative impact over 5 years compared to Baseline**

- Years 2017 to 2020 operating assumptions based upon 2016 assumptions

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## Ongoing Reform Analysis

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**Conclusions**

- Current industry stresses require rigorous, comprehensive financial planning
  - Quantification of strategic initiatives
  - Objective definition of operating assumptions
  - Establishment of specific Board and senior management level success metrics
  - Integration of metrics into the annual operating budget process
- Risk and sensitivity analyses are vital to validating the affordability of the plan
  - Ability to access required external capital (understanding scenarios)
  - Understanding variability of the plan results
  - Definition of proactive management responses to industry and market changes

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