

No Easy Answers

Carrie Vaughan, for HealthLeaders Media, April 9, 2008

A few weeks back I asked how you plan to [diversify your hospital's revenue stream](#) in the face of reduced Medicare payments. I had hoped to share these stories and ideas in an upcoming issue. As it turns out, however, either no one has any good ideas or those who do aren't sharing. If this note from a hospital administrator is any indication, rural hospital leaders are still searching for answers.

Small, rural, critical-access hospitals have already tried all the tricks of the trade, so to speak, but if anyone comes up with something new let me know, as I'm open to anything new or "outside of the box." Your comments are right, and we will fight until we have to close the doors. We are in crisis mode up here in the severe northeastern part of California. When we have to absorb 10% cuts in MediCal payments along with 2 or 3 months of deferred payments, which means no MediCal revenue for 3 months this summer, we might as well dial 911 and hope that someone is there to answer our SOS. Where will we send our patients? To Sac City?!

Wanda Grove
Administrator
Surprise Valley Health Care District
Cedarville, CA

Here is some feedback on how critical-access and small community hospitals need to ensure that their revenue cycle is as efficient as possible in the face of likely reimbursement cuts.

You raise some very timely and important issues. I'm sure you get all sorts of comments and feedback from your hospital contacts, especially when you ask for it, but one thing I might suggest you examine is patient access. Our work at Passport surrounds revenue cycle management, so the looming CMS reimbursement cuts are very real for our clients and hit us close to home by association.

We're trying to help our clients by educating them and getting them focused on front-end efficiencies as a means to collect as much revenue as possible. Initiating patient collections (deductibles, co-pays) up front, before services are rendered, for instance. And making sure the benefits data for each patient is accurate so the billing office can bill the proper amount to the right payer or the right address if it's the patient. And checking patients who present as self-pays for Medicaid coverage and running credit checks on them as part of financial counseling.

My point is that--as you know--there is a whole host of things that providers have to consider as they figure out how to get paid with all the pressures in the industry, but the revenue cycle process should start at the first patient contact.

Dave Chaney
Passport Health Communications, Inc.

I agree that hospitals--especially the little guys that are operating on tight margins--need to ensure that they are collecting every penny that they can. But streamlining front-end operations is often easier said than done. Many community hospitals are still verifying insurance coverage and qualifying patients for Medicaid or charity care through a manual process. This is not to say that they shouldn't evaluate what automated technologies can help them better manage [point-of-service collections](#). But it may end up being just one more item on a long list of technologies that these facilities would love to have--like computerized physician order entry, for instance.

This comment came in response to a [column](#) that I wrote about how some critical-access hospitals are missing out on Medicare reimbursement.

Your recent column highlighted the difficulties critical-access hospitals face in managing administrative and clinical data while operating on very tight margins. One of the ways CAHs can afford new financial and clinical software is to acquire it on an ASP (application service provider) basis. ASPs enable hospitals to obtain software on a subscription or "pay-as-you-go" basis, rather than requiring upfront purchase. In many cases, the software vendor will also assume responsibility for installation and maintenance, reducing the need for additional hospital IT staff.

Fred Beck
President
Opus Healthcare Solutions

Here is a response to my [inquiry](#) about what issues top your list for 2008.

I've been in healthcare administration for 33 years counting military service, and I've never seen such an adversarial approach to hospitals from the federal government as we are seeing now. Attacks on sole community provider funding by CMS could significantly hamper the ability of rural communities to sustain access to general medical/surgical and emergency services. In many cases, downsizing to a critical-access hospital would be an almost inevitable result, and access to specialty services in urban areas would be problematic for those who have to drive long distances.

The pay-for-performance approach is almost cynical in nature, at least as I understand the latest proposals from CMS. There would be an upfront withholding of payment similar to a managed care approach, but the upside bonus will be limited to recovering what was withheld, with CMS retaining the withheld payments not returned for projects of their choosing. With anywhere between 2% to 5% of reimbursement at risk via this methodology, many rural (and urban) facilities would see the last vestiges of their operating margin disappear. Reductions in services would seem to be a more predictable result than necessarily improving quality across the board. This

plan has definite winners and losers, and rural hospitals with an already adverse reimbursement and payer mix will face an even more difficult future.

I have no quarrel with the pay for performance concept, so long as excellent performance is rewarded thereby providing incentive for all providers to improve the quality of care in their institutions. The latest proposal seems, however, to be more of a budget balancing measure than an effort aimed at truly improving quality.

On the bright side, we are seeing a much improved relationship with the University of New Mexico with respect to partnering on nursing, radiologic technician, and medical laboratory technician degree programs. Creating relatively high-paying jobs in rural areas is difficult, and these partnerships provide the ability for rural residents who are so inclined to be educated locally and secure a professional position with above average wages and a good future. Support from local government has been positive and essential to maintaining levels of services. There seems to be greater recognition of the economic importance of hospitals in rural areas and our contribution to the quality of life in the community, although that is certainly not shared by all politicians as you go to higher levels of state and federal government.

In terms of access to capital, I foresee more reliance on internally generated capital and local government financial support along with more restrictive access to bond financing. For most rural healthcare organizations, that will mean a much more modest approach to facility expansion and acquisition of new technologies than has been the case in the past. This is not all bad, so long as it doesn't prevent rural facilities from providing services in an environment that is conducive to patient safety and providing appropriate levels of care for our community.

*Chuck Wright
CEO
Rehoboth McKinley Christian Health Care Services
Gallup, NM*

I enjoy getting all the feedback, so keep these letters coming. And if you have found some way to prepare for the potential Medicare reimbursement cuts, by all means e-mail me your thoughts.

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