The Bottom Line

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healthcare financial management association

From the President's Desk — Winter 2017

We recently held our Winter Meeting in Tulsa and I appreciate all that attended. We did not realize that the timing of changes that HFMA was making to their website would impact our registrations so significantly. In spite of the problems, attendance was great. The conference was well worth the effort for those who attended. The lineup of speakers was very informative.

As I previously shared, our chapter has been involved with a community service called "Ready for Success". This organization provides donated clothing to low income women and men that are suitable for job interviews and the workplace. We took final donations at our Winter Meeting. Let's hope they give new life to those in need.

Our Annual Meeting will be April 20th and 21st at the Embassy Suites in Oklahoma City. Using an Innovation Grant offered by HFMA we are planning to focus a portion of the meeting on Early Careerists. We would appreciate your help in spreading the word to those that might be interested but have not yet become a member of HFMA. This event will feature a craft beer tasting as part of the social.

Finally, I want to request that you take a few minutes to consider becoming more involved. We are in the process of developing next year's leadership team for OHFMA. If you have interest or know someone who does, please reach out and let us know.

Respectfully,

Julie Ward, FHFMA, CPA
President, OHFMA

thrive

The Future of Rural Health Care: Challenges and Solutions

Few topics are as emotional and personal as health care. Imagine your child breaking an arm playing football in the backyard, your mother calling to relay some bad news about your father's health after a visit to the doctor or your sibling telling you about an upcoming battle with cancer. Fear, anger, sorrow, uncertainty and other emotions flood over you instantly. It's inevitable that everyone will face health care issues in one form or another.

But rural Americans are suffering unique health care challenges that urban residents typically do not face. Simply accessing health care can be a significant hurdle for many. Even more challenging may be finding affordable care.

Defining Rural

The U.S. Census Bureau identifies two categories of urban areas: the first is an urbanized area of 50,000 or more people, including cities and metropolitan areas; the second is an urban cluster of at least 2,500 and less than 50,000 people, including suburbs and large towns. Rural encompasses all population, housing, and territory not included within either of the designated urban area definitions. According to 2010 census data, approximately 20% to 25% of the U.S. population lives in rural areas.

Typical demographic trends of rural areas include lower median incomes, a high proportion of seniors, higher acuity levels and lower life-expectancies. Based on 2010 census data, per capita income is on average $7,417 lower in rural areas than in urban areas, and rural Americans have a higher likelihood of living below the poverty level. According to the Rural Health Foundation, nearly 24% of children in rural areas live in poverty. And as younger residents leave home to attend colleges and universities, or seek employment in urban centers, the remaining population in the rural communities they leave behind becomes older. The fastest growing age cohort in rural America are residents 85 years old and above.[1]

Rural populations typically have high numbers of lower income and aged residents, and there are specific ailments that impact these communities at a higher rate than urban communities. Obesity, lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease are statistically more common in rural areas. Finally, the gap between urban and rural life expectancies is growing. According to a 2014 study published in *American Journal of Preventive Medicine*, consistent overall increases in U.S. life expectancy was noted during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. However, the study reveals the rural-urban gap widening from 0.4 years in 1969 to 1971 to 2 years in 2005 to 2009.

To make matters worse, the providers of rural health care suffer alongside the populations they serve. From reimbursement cuts to a suffocating regulatory environment, smaller facilities located outside urban and suburban population centers have a more difficult path to managing cash flow and scaling fixed costs. This article will focus on two of the primary challenges that both residents and providers face in rural communities.

Challenge One: Access to Health Care

In most U.S. cities, access to physicians and hospitals is a quick drive, a cheap public transit fare, or a taxi ride away. However, people in rural settings are likely to live further away from health care providers, particularly specialist services. Additionally, the deficiency of dependable transportation can be a barrier. Transportation services that exist in urban areas are often lacking or non-existent in rural areas.

Besides the geographical barriers to accessing health care, there are fewer providers. As noted earlier, about 20% to 25% of the population is rural; however, only about 10% of physicians practice in these communities.[2] Ask any rural hospital or skilled nursing CEO to list the top issues in the industry; most would likely tab finding qualified staff as a key concern. Per *Healthy People 2010: A Companion Document for Rural Areas*, a project funded by the Office of Rural Health Policy, more than 33% of rural Americans live in "health professional shortage areas," and nearly 82% of rural counties are classified as "medically underserved areas."

Compounding these issues is the rate at which rural health care facilities are shutting down. The National Rural Health Association recently teamed with the University of North Carolina and iVantage, a health analytics firm, to conduct a study that identifies current and potential rural hospital closures. The ultimate goal is to identify potential closings before they occur. The research targeted approximately 2,000 rural hospitals across the country, and labeled 210 as "most vulnerable" with another 463 labeled as "at risk." Those dubbed "most vulnerable" could close any day, while "at risk" ratings are reserved for hospitals that may only last another few years without adjustment. Ultimately, closing these sites will not only have a negative impact on the access to care in the service area, but also eliminate a top employer in the community.

Challenge Two: Affordability

With a new presidential administration on the horizon, the future of the Affordable Care Act (ACA) is unclear. The general purpose of the ACA was to create more affordable health insurance for the uninsured, thereby reducing the drain on the health care system created by caring for uninsured. According to *The Affordable Care Act and Insurance Coverage in Rural Areas*, a 2014 report, rural populations have a larger proportion of low-income residents who could potentially benefit from the ACA to receive health insurance coverage.

However, approximately 66% of uninsured rural individuals live in states that chose not to expand Medicaid. In some states that chose to expand, the enrollment has far exceeded the projections, which has caused strain on the Medicaid funds from the state. Additionally, several national insurers have pulled out of the ACA state exchanges as their losses piled up. In some cases, to offset losses, premiums on employer-provided insurance plans have increased, creating strains on small businesses subsidizing these plans to employees. Limited employment opportunities combined with mounting health care premiums continue to drive costs higher. Ultimately, these factors equate to rural individuals having fewer affordable health insurance choices.

Aside from the ACA complications, Medicare payment systems and reimbursement practices typically do not acknowledge the distinctive situations of small and rural hospitals. These hospitals are disproportionately impacted by the continual cuts to Medicare reimbursements, including the bad-debt program and disproportionate-share hospital payments. At some facilities, the average age of plant for health care and hospital facilities far exceeds acceptable levels. Improvements to the physical plant and the demand for new information systems climbs, yet access to capital financing can be limited. Reinvesting in the facility is difficult with dwindling revenues and limited financing options.

Solutions and Paths Forward

Though the landscape seems bleak, not all hope is lost. Many rural health facilities are using rural clinics, allowing them to open smaller yet impactful health care facilities across their service areas. This model allows for easier access to general care, but still limits the ability to access specialty care, such as cancer treatment centers or heart specialists. Accessibility is also being driven by new delivery methods, like telehealth, online prescription subscriptions and delivery services and 24/7 on-call doctors via the internet. Supplementing hands-on care with technology should allow greater access as long as communities become connected.

Health care organizations must also address affordability in expense reductions. Specialized consulting groups, such as Health Care Resource Group, focus on working with smaller rural facilities to navigate through difficult waters and improve operations.

A thoughtful capital structure is a good way for hospitals to address expense reductions through minimizing debt service payments. Several financing programs are available to rural hospitals that can address the need to reinvest their facilities through expansion, acquisition, rehabilitation, or even a modern replacement facility and meet the needs of the community. The USDA Community Facilities Program is reserved for rural nonprofit organizations, including hospitals and skilled nursing facilities, and provides below market fixed-rate, long-term, non-recourse financing for construction and refinance. Other non-recourse financing solutions include the Federal Housing Administration (FHA) Sec. 242 mortgage insurance programs, which also provide agency-insured, long-term, fixed-rate debt at relatively high leverage points.

The aforementioned challenges in rural communities impact a significant portion of the U.S. on a daily basis. Simply accessing affordable health care is something the majority of the nation may take for granted. Without strategic financial action, our rural health care system will continue to face obstacles that severely inhibit community members from receiving necessary care.

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[1] "The Demographics of Aging..." http://transgenerational.org/aging/demographics.htm
[2] "Primary Care: Current Problems And Proposed Solutions" http://content.healthaffairs.org/content/29/5/799.full

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Webinars

Learn about timely healthcare finance topics and earn CPEs. Most live webinars are free for HFMA members and $99 for non-members, unless otherwise noted. Details may be found at the HFMA website: http://www.hfma.org/

Upcoming Live Webinars

(Use Control, Click on the titles below to be directed to the linked page)

FEB. 8
QUALITY AND RESOURCE USE REPORTS: KEY CONSIDERATIONS TO OPTIMIZE MACRA'S MERIT-BASED INCENTIVE PAYMENT SYSTEM PERFORMANCE

FEB. 9
HEALTHCARE ANALYTICS DESIGN: SMART, CREATIVE, FORWARD-THINKING

FEB. 14
AN OVERVIEW OF THE OFFICE OF INSPECTOR GENERAL'S 2017 WORK PLAN

FEB. 28
HEALTHCARE'S IDENTITY CRISIS: MANAGING IDENTITIES AND AUTHENTICATION PATHWAYS IN HEALTH CARE

MAR. 7
THE IMPACT OF MACRA: PRACTICAL APPLICATIONS AND YOUR PREPARATION

MAR. 21
DRIVING ORGANIZATIONAL EFFECTIVENESS THROUGH DATA TRANSPARENCY

HFMA Certification – CHFP
Give It a Try—Test Your Knowledge

Business of Healthcare - Sample Questions

1. All of the following are critical elements of working with a budget EXCEPT:
   a. Budgets need flexibility as the business environments shifts
   b. Budgets are a management tool, not a financial tool
   c. Budgets are critical to accurately benchmarking organization performance
   d. Budgets are the concern of upper management only

2. The process where mangers start each budget projection as if there were no past experience and each item in the budget must be justified as to its reasonableness each year is known as:
   a. Evidence based budgeting
   b. Zero based budgeting
   c. Strategic budgeting
   d. Expense bases budgeting

3. The operating budget provides:
   a. A benchmark for the normal, day-to-day operation of the business
   b. An understanding of the expected volume of services provided
   c. Estimates of expenses by knowing operational relationships
   d. Determination of capital investments

4. The analysis process that determines the variance between actual results and a budget projection that has been "flexed" to the actual service volume experienced is:
   a. Simple variance analysis
   b. Budgeted volume variance analysis
   c. Flexible budget variance analysis
   d. Volume projection analysis

5. The comparison of an organization's performance on key performance measures relative to the competition, other organizations, or groups of organization is known as:
   a. Market Analysis
   b. Key Performance Indicators management
   c. Competitive positioning
   d. Benchmarking

6. A health plan incentive for the patient to use insurance only when needed is:
   a. A high premium
   b. Out-of-pocket patient co-pays
   c. A benefits "cap" on reimbursement amounts
   d. Tired reimbursement based on volume of service used

7. The average time it takes for a hospital or physician to be paid for services by a health plan is measured by:
   a. Days in accounts receivable ration
   b. Claims collection rate
   c. Average claims resolution rate
   d. Cash flows due from health plan receivables

8. The price set by a hospital or physician for their services is:
   a. An estimate of cost absent full loaded fees
   b. A "charge"
   c. A retail price that is negotiable
   d. The amount the insurer can be expected to reimburse

9. There are two broad categories of payment for healthcare services. They are fee-for-service and:
   a. Bundled services payments
   b. Negotiated discounts
   c. Capitation
   d. Preferred provider rates

10. The Affordable Care Act initiated two fundamental reimbursement reforms. These are:
    a. A cap on "out-of-pocket" expenses and mandatory health insurance coverage
    b. Value-based purchasing and bundled payments
    c. Reduction in Medicare Physician Reimbursement and bundled payments
    d. Mandatory health Insurance Coverage and Value-Based purchasing

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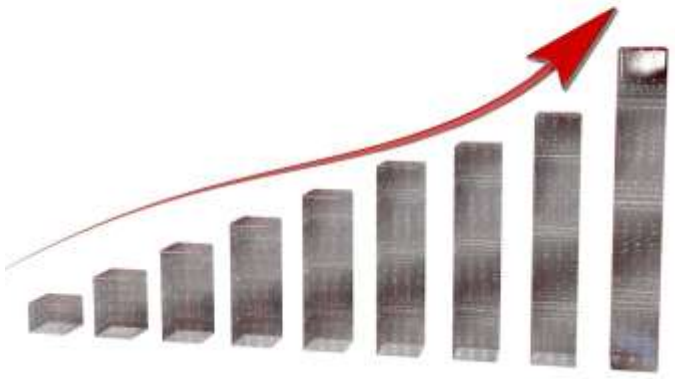
Answers:

1 – D	6 – C
2 – B	7 – A
3 – A	8 – B
4 – C	9 – C
5 – D	10 – B



Membership Goal for 2016-2017 is 358

Current Membership is 318!!!!

Event Calendar

2017

Spring Meeting and Officer Installation
April 20 and 21, 2017
Embassy Suites
Oklahoma City, Oklahoma

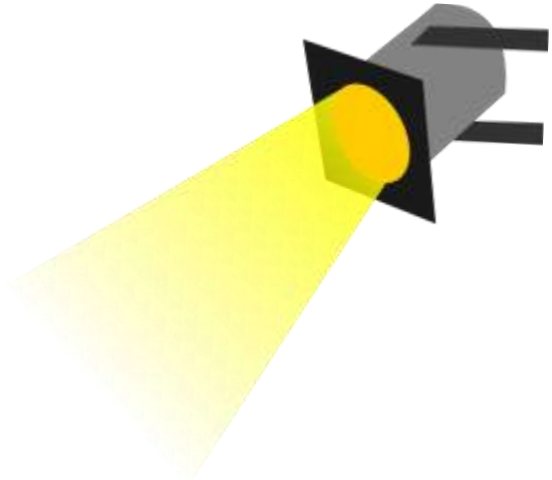
Summer Mini LTC
TBD

Summer 1 Day Tulsa Meeting
TBD

Summer 1 Day OKC Meeting
TBD

Welcome to Our New Members!

Stephen Sparks	Director of Business Analytics	OU Medical Center
Amanda Thomas	Managed Care Contract Specialist	St. John Health System



Member Spotlight

Amanda Thomas
Managed Care Contract Specialist
St. John Health System/Ascension Health

If you could only eat one meal for the rest of your life, what would it be?

Pasta...any kind of Pasta.

Do you like or dislike surprises? Why or why not?

I like surprises! Life would be too boring if you knew everything would happen before it did. Even the tiniest of surprises can put a smile on someone's face and make their day.

How many pairs of shoes do you own?

According to my husband…too many. I own at least 20 or more. A girl can never have too many shoes!

Award presentation by Julie Ward to Linda Short of Morgan Financial Group. Linda is a Chapter Life Member.

Session member with gift from Beth Ziesenis, *"Your Nerdy Best Friend"* presenter.

Bingo!!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