Small Rural Hospital Transition (SRHT) Project Guide

Road to Value: Financial Strategy to Transition to a Value-based System

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PREFACE

This guide has been developed to provide rural hospital executive and management teams with generally accepted best practice concepts in developing the necessary financial strategies to survive the transition from a volume-based reimbursement methodology to a system based on value. It is also designed to assist State Offices of Rural Health directors and Flex Program coordinators in gaining a better understanding of the necessary strategies for transition, so that they may develop educational trainings to further assist rural hospitals with performance improvement.

The information presented in this guide is intended to provide the reader with guidance on financial strategies for transitioning to a value-based reimbursement model. The materials do not constitute, and should not be treated as professional advice regarding the use of any particular financial strategy or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The National Rural Health Resource Center (The Center), Rural Health Innovations (RHI), Eide Bailly LLP, and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation, and should independently determine the correctness of any particular insert subject matter planning technique before recommending the technique to a client or implementing it on the client's behalf.

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INTRODUCTION TO THE ROAD TO VALUE

The *Road to Value* guide has been created to help rural hospital administrators identify and create the necessary financial strategies that assist their facilities in transitioning to the new health care payment and delivery models. The financial strategies presented in this guide are designed to assist small rural hospitals in preparing for the transition process from a reimbursement methodology that rewards providers based on the volume of services to a model that compensates providers defined by their ability to deliver value through cost and quality of care.

This guide was also designed to support the Health Education and Learning Program (HELP) Webinar series titled, *"Road to Value"*. This three-part series provides hospital administrators and managers additional information about financial strategies that can help them to improve performance now, which better positions the hospital for a successful transition to the new health care environment. The *"Road to Value"* webinar series outlines and explains what administrators need to know and ways to financially position the hospital for the future.

Root Causes for the Transition from Volume to Value

There are many causes for the transition from a volume to value-based reimbursement methodology. A significant amount of information has been published regarding the forces causing change at the national level. This includes, but is not limited to, incentives and penalties initiated by the Centers for Medicare and Medicaid Services (CMS), the advent of accountable care organizations (ACOs) and bundled payment programs. Nevertheless, there is a more important reason than the development and adoption of these programs by governmental payors. Unlike any time in history, health insurance companies, employers and our patients are taking a more active role in their health care and are now demanding value for the services they are purchasing. They are questioning both the cost of the care and the clinical outcomes they receive from their health care providers. Through technology and transparency, patients and their families are able to

access data that allows them to question their current health care providers. Patients are now able to make alternative choices for deciding where to obtain their care and when necessary. Rural hospitals that wish to survive must plan and prepare for the future.

Importance of Financial Planning for the Transition

Successful transition to new payment methodologies will be best accomplished by developing and implementing a strong financial plan prior to the transition. Historically, major changes in payment methodologies have resulted in significant cash flow pressures. Proper planning and implementation of a financial strategy can often minimize the impact of the change and allow the provider to continue to focus on the provision of care. Therefore, rural hospitals should develop and implement an updated financial plan with the goal of loading up the balance sheet. Exceeding benchmark standards on key financial indicators and stockpiling cash reserves will assist in providing the financial strength necessary to surviving a difficult transition process.

FINANCIAL PREPARATION FOR THE TRANSITION

Expected Financial Challenges During the Transition

The financial challenges are expected to be great during the transition from a volume-based to a value-based reimbursement methodology. The uncertainties that lie ahead should create a sense of urgency for rural hospital administrators to create their financial strategies now in preparation for the transition process. A strong balance sheet will be one of the hospitals' greatest assets to assist in surviving the challenges that are expected during the shift in payment methodologies. During the transition, one should anticipate cash flow problems as providers and insurers learn new billing

rules and requirements for payment. These problems may occur as the processing of claims are delayed due to confusion or new billing systems. Additional cash flow issues may occur as providers see a reduction in the volume of services being provided and a reduction in payment rates by insurers.

One of the biggest challenges for rural hospitals will be managing the timing of changes in reimbursement methodologies amongst the various payors. While it is expected that most payors will transition to a value-based reimbursement methodology, they will not all shift at the same time. This will result in a system that will have some insurers providing reimbursement based on value while others are still compensating based on the volume of services rendered. This is anticipated to create financial uncertainty as the actions to increase value may provide additional financial rewards from some payors while reducing reimbursement from others. The timing and management of the transition process will be key.

Areas of Opportunity to Improve Financial Performance

Managing and strengthening the top 10 financial indicators, as identified in the *Critical Access Hospital Financial Leadership Summary*, will be key in preparing for the transition. A definition of the indicators, their calculations and national standards are included in Appendix A. The standards are based on the *Summary of 2012 Indicator Medians by State (FMT Data Summary Report #16)*, published by the Flex Monitoring Team in October, 2014. The Flex Monitoring Team updates this information on an annual basis. Updates can be found on the Flex Monitoring Team Website. While these key performance indicators (KPI) were selected for the CAHs, they are directly applicable to rural hospitals that are acute perspective payment system (PPS) facilities.

In order to improve these financial indicators, rural hospital administrators should focus on increasing revenues, decreasing expenses, improving cash collections and managing the timing of cash outlays. The opportunities to improve these indicators will be found in increasing market share, improving the revenue cycle, reviewing service line performance and managing labor

costs. Examples are discussed below to assist administrators with how to target improvement in these areas. The key for preparing for the future will be not only meeting the national standards for each indicator, but also exceeding them. The additional financial strength provided by exceeding these standards will provide the needed cash flow to assist hospitals during the transition of payment methodologies.

Revenue Cycle Process Improvements

The revenue cycle management processes in health care have been in need of improvement for decades. Historical payment levels, minimal patient engagement and a lack of transparency has allowed many providers to survive without implementing efficient and effective revenue cycle management programs. However, the changes in patient out of pocket responsibility, transparency and overall reimbursement levels are requiring hospitals to restructure their revenue cycle in order to improve the efficiency (cost) of the process while also improving its effectiveness (cash flow generated).

Improving the performance of the revenue cycle begins with the establishment of policies and procedures that are based on best practices. This includes policies and procedures that identify the processes from the time it is determined a service will be provided through the successful resolution of any outstanding account balances. The establishment of effective policies and procedures is a great start, but all is lost if there is not accountability assigned for following them. Too often, significant financial resources are committed in order to create the necessary policies and procedures, only to find that they are not properly implemented due to a lack of ownership in the organization. Many organizations could improve the financial performance of their revenue cycle process by just following their current policies and procedures.

To learn more about revenue cycle best practices and to discover opportunities for performance improvement, refer to the *Best Practice Concepts in Revenue Cycle Management Guide*. This comprehensive guide provides an explanation of nine (9) revenue cycle management concepts

that are considered industry accepted best practices. It steps hospital leadership teams through the entire cycle: from the creation of a customer focused and patient-centeredness approach to pre-registration to closing the revenue management process with payment and collections. This guide also includes sample scripts, online resources, best practice self-checklists and recommended KPI for revenue cycle management. Hospitals are encouraged to use the best practice guide in conjunction with the supporting four-part webinar series, to build internal capacity and department accountability. The goal here is to encourage hospital administrators to use the guide as a tool to assist them in identifying opportunities to implement best practices within their revenue cycle and develop strategies for improving performance, which can in turn, improve the KPI and their hospitals' financial position.

Service Line Assessments

Too often, hospitals continue to operate service lines at a financial loss. There can be many reasons that this occurs. These can be low volume services that were previously added to meet a perceived or an unmet need in the community or as someone's pet project. However, they can also be larger service lines that struggle financially due to poor reimbursement levels, high costs or a combination of both.

As fiscal stewards, rural hospital administrators and managers must understand the profitability of the services they provide. In the past, hospitals frequently were able to generate adequate profits in many of their service lines. These profits allowed facilities to provide unprofitable services as loss-leaders. Unfortunately, the ability to generate adequate profits to support these loss-leaders has greatly diminished. This requires facilities to identify those service lines that are losing money. Once identified, the hospital executive team needs to complete further analysis to identify opportunities to improve reimbursement, reduce costs and/or eliminate the service line. Eliminating the service line can be accomplished by either closing down the service line or transitioning the service to another external provider. Partnerships with external providers to deliver the services the

hospital cannot provide efficiently and effectively can eliminate losses to the hospital while also reducing the total cost of care in a given market.

Service lines are defined by provider types (i.e. hospital, clinic, nursing home, home health, hospice, etc.) or by service within a provider type (cardiology, MRI, diabetic education, orthopedics, etc.). The ability to determine the direct and fully absorbed cost for providing services within a service line as well as determine the net revenues generated can be a challenge. The level of the challenge is frequently dependent on the technology available to the facility and the knowledge level of the internal staff tasked with performing the analysis. While it is very beneficial to be able to obtain extremely detailed information during a service line assessment, this can be a very expensive and time-consuming process. It is important to note that an analysis that lacks detail and is based on assumptions is still better than no assessment at all. Tables 1 and 2 show two examples of methods for analyzing a service line.

Table 1: Service Line Analysis: Nursing Home, Clinic and Home Health

	Nursing Home	Clinic	Home Health
Net Reimbursement for Provider Type*	$9,300,000	$2,300,000	$750,000
Fully Absorbed Cost for Provider Type**	$9,000,000	$2,500,000	$1,000,000
Net Income for Provider Type	$300,000	($200,000)	($250,000)

* Per Hospital's Internal Records

** Per Medicare Cost Report or other internal cost finding model. Analysis can also be broken down between fixed and variable costs

Table 2: Service Line Analysis: Cardiology, MRI, and Diabetic Education

	Cardiology	MRI	Diabetic Education
Net Reimbursement for Service Type*	$75,000	$300,000	$10,000
Fully Absorbed Cost for Service Type**	$90,000	$240,000	$30,000
Net Income for Service Type	($15,000)	$60,000	($20,000)

* Per Hospital's Internal Records

** Per Medicare Cost Report cost to charge ratios or other internal cost finding model. Analysis can also be broken down between fixed and variable costs

In the examples, the analysis would indicate that the hospital needs to focus on the profitability of Clinic, Home Health, Cardiology and Diabetic Education services. Further analysis would be warranted to determine the underlying cause of the losses. This investigation could identify volumes, costs, reimbursement levels or a combination of these factors to be the source of the losses. The hospital can then determine what actions are possible to improve the financial performance of the service line or whether the service line may need to be discontinued.

Labor and Productivity Management

Managing labor costs and productivity can be one of the most challenging aspects of any organization, regardless of the industry. Health care is no different. With salary and benefit costs typically ranging from 45 – 60% of total costs, it is understandable that this is the largest area of focus when looking to control ongoing, variable costs. It is important to note that productivity management is more than a process to reduce staffing levels. Productivity management is a process to maximize the output provided by current staff. While labor and productivity is an area of focus, there are three significant challenges to overcome to successfully manage labor and productivity in the rural hospital setting.

The first challenge is the perception by organizations and individual departments that they are already minimally staffed and working at an efficient and effective level. The reality is that even in the smallest of hospitals, there are typically several departments that could operate effectively with lower levels of staffing. Management must challenge this notion of already performing with minimal staffing levels if they are going to have any chance to initiate meaningful change in staffing and cost structure.

The second challenge is obtaining meaningful departmental benchmarks for use in comparison to current staffing levels. It is important for organizations to accept that no benchmark is perfect, but they can be an effective guide to the potential opportunity for operational improvement within an organization. External benchmarks can be hard to find and can be costly. The majority of free and readily available staffing benchmarks are at the total organizational level. While they may be somewhat helpful, they do not provide the individual departmental benchmarks needed to pinpoint areas of opportunity to reduce labor costs. Due to the cost associated with external benchmarks, many providers rely on internal benchmarks that are based on the best internal operating performance of their organization or other related organizations in the same health care system. Ultimately, if external benchmarks are available, they are preferred, as they allow a comparison to best practice facilities in the industry.

The final challenge is the ability to gather and report the necessary staffing levels and volumes by department on a timely basis. The best benchmarks are useless if the organization cannot provide meaningful reports back to the departments on a timely basis. Effective management of labor requires timely reporting in order for leaders to adjust staffing levels on a more proactive basis. Table 3 is an example of benchmarking for Acute Care Nursing and Dietary.

Table 3: Service Line Analysis: Acute Care Nursing and Dietary

Department	Statistic	Benchmark	Actual	Deviation
Acute Nursing	Hours / Patient Day	10.0	12.0	2.0
Dietary	Hours / Meal	0.30	0.28	(0.02)

The table above would indicate there may be an opportunity to improve efficiency and effectiveness in Acute Nursing. However, it is important to note that labor and productivity management is about more than just comparing current staffing levels against a statistic. Successful long-term management of labor and productivity requires hospitals to identify broken processes that are the root cause for excess staffing and poor productivity levels. Frequently these process issues are identified and corrected through the implementation of lean concepts. Hospitals that fail to analyze and improve processes will not usually be able to maintain efficient staffing levels over time. Broken processes drive the need for higher staffing levels and must be addressed. As efficiencies in processes are identified, the staff time that is now available can be used to address other existing needs, such as building resources for new care models, adding new services or as an opportunity to reduce salary costs through staff reductions.

ORGANIZATIONAL AND OPERATIONAL CHANGES

The transformation of payment methodologies will also bring changes in how hospitals are structured and how they operate in the future. For many small rural hospitals, these changes will be significant. The key will be to determine areas of focus to prepare for the transition process.

Focus Areas to Prepare for the Transition

Matching Needs Of Your Population To Value-based Payment

The needs of your patient population are constantly changing and are often hard to determine. The hospital's Community Health Needs Assessment (CHNA) or similar assessment can provide valuable insight as to the service desires and needs of your service area. Hospitals need first to determine what services they can provide, versus which services they can identify for other entities to provide. Hospitals will want to focus on providing those services they can provide in a high quality and cost effective manner due to the future financial rewards for improving value. This will lead to encouraging other health care providers to offer those services for which they do not have the expertise to provide or are unable to provide in a cost effective manner. Under the value-based payment methodology, providers will need to avoid the temptation of attempting to provide all services needed by the patient, regardless of the cost. This will create special challenges for providing services that frequently have low demand, but are still critical to the health of the community.

Matching the needs of the population will also require providers to begin to access more data relating to patient utilization trends. This will allow the provider to begin developing strategies to improve coordination of care, reduce resource utilization and improve quality. The following steps should be considered when focusing in this area:

- Access data to determine needs of the populations
- Assess services that can be rendered by the hospital effectively and efficiently

- Identify necessary external health care providers that could provide complementary service lines
- Begin a process of analyzing utilization data to identify opportunities to improve coordination of care, reduce cost and improve quality

Development and Maintenance of Provider Relationships

One key strategy to maintain volumes of services in the future will be to increase the number of patients being served versus the number of services to be provided to each patient. Successful hospitals will be those that develop strong relationships with primary care providers rendering services to patients in their service area and identify the patient care needs of that population. In general, patients do not choose the hospital they use for services. More often, it is the physician or mid-level provider that refers their patients to the providers of hospital services. Under most value-based reimbursement methodologies, the primary care provider will be the individual that has greatest control on where patients will receive services. For this reason, hospitals need to develop and implement strategies to not only engage with primary care providers, but to develop an aligned vision with these providers.

The process of alignment with physicians can be challenging, due to a lack of consistent incentives and motives in the past. However, it is imperative that hospitals reach out to physicians to create a shared vision and strategic plan. This will include involving physicians more in decision making and governance, improving communication, establishing mutual accountability and assisting these providers in becoming more clinically and financially successful. Working together, rural hospital administrators and physicians will be able to better explore strategies to reduce resource utilization and improve overall quality of care. Those that strengthen these hospital-physician relationships will be well prepared to move into a value-based reimbursement methodology.

The following steps should be considered when focusing in this area:

- Identify key providers in the market area

- Develop strategies to deepen relationships and engage identified providers
    - Provide input in decision making
    - Include in governance
    - Improve physician-hospital communication
    - Establish mutual accountability
    - Improve physician, clinical and financial performance
- Establish a monitoring system to gauge the strength of these relationships, and take action as appropriate

In addition to developing and maintaining relationships with primary care providers, it is important to work together to build support from the community for services offered by all providers. This includes the following activities:

- Developing marketing and outreach programs to provide patient education and build awareness of services offered by the hospital and medical staff
- Educating patients on their ability to ask local and external physicians to refer them to the local hospital and other local providers when available
- Developing and implementing strategies to become the provider of choice by delivering high quality care in a cost effective manner, as noted in patient satisfaction, quality and cost reports.

Understanding Your Market Today and Tomorrow

While preparing today for the transition tomorrow, it will be necessary to understand the market today. However, for long term strategic planning it is also important to understand the market of the future. The market assessment of today includes demographics of the service area, including age, sex, nationality, education, health status, income, population dispersion in the service area, incident rates of disease, etc. Providers also need to understand the demand for services by service line in their market, their

market capture for these services and their competition. This information is crucial in developing programming and marketing strategies to address patient demand for services, attract patients to the organization, and determine where patients go to receive services when not coming to the local facility.

Preparing for the future is more difficult and is often ignored. This requires facilities to access analytical models that can predict changes in local demographics over a period time, typically 5-10 years. These analytical models may be available through local governmental entities, institutions of higher learning or external vendors. In addition to providing predictions on local demographics, there are models than can also provide information on future volume trends. This information can identify inpatient versus outpatient trends as well as trends by medical condition. The information can be used to assist providers in their strategic planning to help prevent the organization from continuing to invest in services or enter markets that are anticipated to diminish in the near future. The following steps should be considered when focusing in this area:

- Gather current demographics for the market to determine current needs and demands
- Obtain projected changes in demographics over next 5-10 years to include population and service demands
- Determine anticipated changing needs in the market during next 5-10 years to determine service line gaps and service lines that may become obsolete
- Develop strategies to address potential gaps and obsolescence

MANAGING THE TRANSITION

Expected Challenges as Payors Implement Changes in Payment Models

The timing of changes in payment models will vary by the type of payors and region of the country. While new payment models may emerge slowly in some markets, they are already moving quickly in other markets. In addition, just because they have been emerging slowly in a market in the past does not mean they will not move quicker in the future. For this reason, all hospitals should be preparing for change as if it could occur tomorrow.

While it is understood that payment will transition to a value-based methodology, the specific models for payment may vary significantly by payor, and the timing of the transition may vary tremendously. In a perfect world, all payors would convert from a payment for volume methodology to a value-based system at the same time. However, there is no legal requirement or mandate driving this change, and each payor will have the ability to determine the timing for any shift in payment methods. One can argue that early conversion in payment models could provide a payor a competitive advantage against their competitors. Payors may also vary their transition dates by market area and by the various types of insurance products they offer. This will result in a period where there will be financial incentives that vary depending on the patient's insurance coverage. Some payors will provide financial rewards to the hospital by improving value through improved care coordination and reduction in resource utilization, while the same actions will reduce payment from those payors that continue to focus on payment for volume of services.

It is also anticipated that the methodologies for determining value of care and rewarding providers for this value will vary by payor and potentially by the various contracts offered by the payors. This can create two obstacles for the health care organization. First, it is expected that the determination of value will require some form of data gathering and reporting. Providers must be prepared to gather and report the necessary information to

demonstrate the value they are providing in order to obtain any value-based payments. In addition, providers will have to possess or obtain the expertise to properly monitor the value-based calculations of each payor to ensure proper payment has been calculated and received. Addressing these issues will take careful planning, and most likely a financial commitment for staff consultant expertise and technology.

The added challenge to this transition is the historical impact of any changes in payment methodologies. Governmental and commercial payors have a long history of struggling to make appropriate payments on a timely basis during the transition to new payment models or implementation of new billing requirements. In some situations, payments have stopped for an extended period of time during the transition. The heavy toll this puts on cash flow can cripple or even close some hospitals. This potential drain on cash flow is a major reason providers must take action now to strengthen their financial position and accumulate cash in preparation for the transition process. Failure to prepare adequately for this financial transition process could bankrupt even the strongest of organizations.

PREPARING FOR CHALLENGES

When to Begin Implementing Changes in Organizational Behavior

Implementing changes in organizational behavior will most likely occur in steps. The first steps will be the changes required to strengthen the financial performance of the hospitals. These changes should begin immediately as the earlier these changes begin, the greater opportunity the organization has to create the financial strength necessary for successful transition to value-based purchasing. The opportunity lost due to delays in implementing changes to improve financial performance most likely cannot be recovered.

The data gathering and planning related to determining the needs of the patients, developing relationships and strategies with providers, and

understanding the future markets should all begin as soon as possible. These processes will take time, and cannot wait until the changes in payment methodologies begin to occur. While the exact timing for implementing changes in strategies for providing care to a value-based methodology may be unknown, administrators must have the strategies and necessary data ready for implementation. It is important to note that some strategies in these areas such as strengthening relationships with providers and new efforts to increase the number of patients coming to your organization for care can begin immediately. The majority of changes that will be delayed will be those strategies that change the coordination and provision of care.

Determining the timing for final transformation in organizational behavior to move to processes that will improve coordination of care and create value may be more of an art than a science. It is possible that hospital leadership will have little or no choice in deciding this timing. Administrators that prepare early in the process will be able to determine if they wish to enter the transition market early, and to take advantage of their planning to grab market share through early negotiation with payors.

Providers that elect to make the transition voluntarily will need to determine when they have created the necessary financial strength to proceed, and have developed the necessary strategies to coordinate care, reduce resource utilization and improve quality. Preferably, facilities will have created a situation in which they exceed the benchmark standards on a majority of the Top 10 financial indicators before they voluntarily attempt to speed up the transition process. Administrators may also consider initiating the transition if they determine that the hospital has reached a peak in their financial performance as indicated by the key performance indicator (KPI). For some hospitals, this could be before they are able to exceed the benchmarks on the majority of the Top 10 financial indicators.

Many hospital administers and boards will wait as long as they can to enter the transition process and will only enter into such contracts when forced to by payors and patients. Entering into these payment methodologies does not necessarily mean the organization and operational changes will begin to occur. The timing for organizational and operation transition will be that

point when it is apparent the financial penalties for delaying transition will soon outweigh maintaining the current model of care. At this point, the organizational and operational transition will become a necessity and the hospital leadership will most likely be unable to control its timing. The timing for each hospital will vary based on the speed by which payors are transitioning the payment methodology and the size of these payors. Executive and management teams will need to monitor this transition closely to determine the best timing for their hospital.

How To Manage Conflicting Incentives During The Transition To A Value-based System

The existence of conflicting incentives during the transition process can create confusion and cause internal frustration. It is anticipated that some hospitals will try to manage the provision of care to patients differently based on the payor incentives for that patient (i.e. volume-based versus value-based). This is an unrealistic strategy and will likely only lead to increased confusion and frustration amongst hospital staff and patients. The reality is that the implementation of new strategies for providing care will probably all need to occur at the same time for all patients. This conversion process will be a challenging thought process for many hospital administrators, financial officers and their boards, as the natural instinct will be to chase every dollar, treat patients differently based on payor incentives, and maximize financial returns. Unfortunately, the additional dollars that may be available under such a strategy could quickly be offset by lost productivity in the organization and frustration amongst care providers and staff.

In order to manage the expectations during the transition process, it will be important to communicate the anticipated challenges and planned strategies before embarking on the transition. Throughout the transition, it will be important for the executive and management teams to monitor the challenges to determine if changes in the course of action need to occur. The impact of financial challenges can be monitored through the ongoing reporting of the top financial indicators as found in Appendix A. Unexpected

deterioration in financial indicators should be an indication that management needs to consider alternative courses of action. Finally, leadership teams will need to manage the pressure to care for patients differently, based on individual payor incentives, and resist constantly changing the course of action. Developing a compelling vision as well as timely value-based strategies, and then staying the course as much as possible, will produce the best long-term results.

CONCLUSIONS AND RECOMMENDATIONS

The transition from a reimbursement model that rewards volume to a methodology that compensates for value will create challenges for all hospitals, especially those located in small rural communities. The key for a successful transition includes strong informed leadership, improving current financial strength, early planning and execution of the plan. Rural hospitals that begin the process early may feel like they are stepping out onto an extremely shaky bridge to the future. The speed of the transition, however, may not allow adequate time for hospitals to have all the answers before they and the strategies change over time. This will require many rural hospitals to alter their course as market forces create previously unknown challenges. However, those hospitals that have begun their planning early will be much better prepared to make the necessary changes organizationally and operationally, as they will already have gathered more data, dug deeper to develop long-term strategies, tested proposed strategies in a controlled environment and adjusted strategies. It is recommended that hospital administrators begin the planning and preparation phases of the transition immediately, as the transition to reimbursement determined on value has already begun and is expected to continue.

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APPENDICES

Appendix A: Top 10 Financial Indicators

Financial Indicator	Calculation of Financial Indicator	2012 US Median	Preferred Trend
Days in Net Accounts Receivable	Net Accounts Receivable / (Net Patient Revenues/365)	52.74	Down
Days in Gross Accounts Receivable	Gross Accounts Receivable / (Gross Patient Revenues/365)	52.74	Down
Days Cash on Hand	(Cash and Temporary Investments) / ((Total Expenses – Depreciation and Amortization – Provision for Doubtful Accounts) / 365))	69.07	Up
Total Margin	Change in Net Assets / Total Revenue	2.61%	Up
Operating Margin	Net Operating Income / Total Operating Income	1.13%	Up
Debt Service Coverage Ratio	(Change in Net Assets + Interest + Depreciation and Amortization) / (Principal Payments + Interest Payments)	2.52	Up
Salaries to Net Patient Revenues	Salaries / Net Patient Revenues	44.87%	Down
Medicare Inpatient Payor Mix	Inpatient Days for Medicare / (Total Inpatient Days – Nursery Bed Days – Nursing Facility Swing Days)	73.59%	Down
Medicare Outpatient Payor mix	Outpatient charges for Payor / Total outpatient charges		Down
Average Age of Plant (Years)	Accumulated Depreciation / Depreciation Expense	9.83	Down
Long Term Debt to Capitalization	Long Term Debt, Net of Current Portion / (Long Term Debt, Net of Current Portion + Net Assets – Accumulated Earnings)	17.26%	Down

Appendix B: Preparation Road Map

1. Implement revenue cycle improvements to maximize revenue in the current payment system
2. Complete service line assessment
    a. Implement steps to improve financial performance of services lines as appropriate
    b. Divest unprofitable service lines, particularly those that will not be of value in the new payment model
3. Complete labor and productivity assessments and implement changes as identified in assessment
4. Match needs of your population to value-based payment
    a. Access data to determine needs of the population
    b. Assess services that can be rendered by hospital effectively and efficiently
    c. Identify necessary external health care providers to provide complementary service lines
    d. Begin process of analyzing utilization data to identify opportunities to improve coordination of care, reduce cost and improve quality
5. Develop and maintain provider relationships
    a. Identify key providers in market area
    b. Develop strategies to deepen relationship and engage identified providers
        i. Input in decision making
        ii. Input on governance
        iii. Improve communication
        iv. Establish mutual accountability
        v. Improve their clinical and financial performance
    c. Establish a monitoring system to gauge the strength of these relationships.

6. Understand your market today and tomorrow
    a. Gather current demographics for market to determine current needs and demands
    b. Obtain projected changes in demographics over next 5-10 years to include population and service demands
    c. Determine anticipated changing needs in the market during next 5-10 years to determine service line gaps and service lines that may become obsolete
    d. Develop strategies to address potential gaps and obsolescence
7. Confirm Top 10 financial indicators have been strengthened
    a. Greater than 50% exceed the standard
    b. Anticipated maximum performance has been achieved
8. Confirm strategies are in place for improved coordination of care, customer service and quality
9. With strategies developed, take action to implement a comprehensive plan to prepare for transformation to a value-based system.
    a. Monitor activities on a timely basis
    b. Alter course as indicated