How to budget for top-line growth in a post-reform environment is a major challenge for many healthcare CFOs. Common budget-related questions include the following:

> How much are Medicare, Medicaid, and commercial plans cutting unit reimbursement rates, and when?
> What services are most likely to continue to grow? Which services will see a volume decrease as patient cost sharing continues to increase?
> How will payer mix change, assuming health insurance exchanges emerge?
> Will the collections rate decline, and if so, by how much?
> How should we modify our current budgeting and contingency planning process to generate better top-line and bottom-line budget forecasts in the future?

Making Budget Projections
Healthcare finance executives are particularly challenged to make budget projections related to unit reimbursement, volume, payer mix, and collections.

Unit reimbursement. Providers often make a wide range of Medicare, Medicaid, and commercial unit reimbursement assumptions in their budgets. For Medicare, many providers have updated their financial plans to reflect a 1 to 2 percent annual unit reimbursement increase for the next several years, down from 3+ percent historically. They do this for a couple of reasons. First, Medicare has already begun to reduce its annual market basket updates and has modified its productivity factors. Second, by 2015, the Independent Payment Advisory Board will have authority to reduce Medicare reimbursements when expenditures exceed gross domestic product + 1 if the current reform law stands (Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2011 to 2021). For the longer term, Congress is discussing moving Medicare from a defined-benefit/fee-for-service program to a premium-support/defined-contribution program. Under a premium-support program, Medicare beneficiaries would select qualified plans, and the
Aligning patient value with margins over the long term is the best way for providers to meet (if not exceed) budget in a post-reform world.

government would pay a portion of the premium directly to those plans.⁹

Budgeting for Medicaid is even more challenging for providers. Although many providers are budgeting for no Medicaid unit reimbursement increases for the short term, providers in some states, such as Arizona and Missouri, have already seen reductions in the past year. For example, many Arizona hospitals saw a 5 percent Medicaid reimbursement cut in 2010, while Missouri hospitals saw a 0.4 percent cut in late 2010, costing them millions of dollars in expected revenue.¹⁰ Currently, several states are announcing Medicaid unit reimbursement cuts (e.g., a 2 percent unit reimbursement cut in New York). These actions have prompted some health systems to anticipate 5 to 10 percent unit reimbursement reductions from Medicaid over the next several years.

Commercial unit reimbursement assumptions represent another wildcard. Hospitals will continue to attempt to maximize their commercial reimbursement over the next several years. But after years of double-digit commercial reimbursement increases, most providers are reducing their expected commercial reimbursement increases to the mid to high single digits. The Segal Group, for example, estimates hospital preferred provider organization (PPO) increases of approximately 8 percent and physician increases of 3 percent in 2011 (2011 Segal Health Plan Cost Trend Survey). A review of Wall Street quarterly transcripts from the nation’s largest publicly traded commercial health plans found recent hospital unit reimbursement increases around 6 to 8 percent. However, some providers are conservatively assuming closer to 3 percent annual commercial unit reimbursement increases over the long term from a consolidating commercial health insurance market.

Volume. After years of 1 to 2 percent growth in inpatient volume and up to 3 to 4 percent growth in outpatient volume industrywide, volume growth is slowing, according to American Hospital Association data and Moody’s 2010 Not for Profit Healthcare Medians. Nationally, admissions growth has slowed to a trickle over the past few years, with many systems seeing flat or even declining days, which can be detrimental if the majority of commercial contracts pay by percentage of charge or per diems instead of case rates. Outpatient growth has generally been a few percent annually.

So what’s a reasonable range of volume growth? More aggressive growth assumptions range 2 to 2.5 percent for inpatient and 4 to 6 percent for outpatient, which are often driven by projected population mix, growth, and market share increases. Less aggressive assumptions are in the range of 2 percent decline for inpatient volume and 2 percent increase for outpatient volume, particularly if the hospital is implementing medical homes in a market with minimal population growth.

Payer mix. Payer mix is a mixed bag, with more negative dynamics than positive ones. The recent economic downturn resulted in the largest increase in Medicaid enrollees (7.5 percent) in the program’s history, according to the Kaiser Commission on Medicaid and the Uninsured. The Congressional Budget Office (CBO) expects the number of persons qualifying for Medicaid to continue to swell over the next several years.

With regard to self-pay, the CBO, Rand, and other policymakers expect a considerable subset of these patients to move to health insurance exchanges at relatively low, but at least collectible, rates similar to those of Medicaid or Medicare starting in 2014. However, the exchanges will also attract current employees of small-to-medium businesses with relatively low wage structures. In states with small

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employers and relatively low wages, hospitals project at least half of the current commercially insured lives could move to exchanges, where unit reimbursement could be 10 to 40 percent lower than commercial reimbursement.

**Bad debt/collections.** Hospital bad debt and collections issues associated with the uninsured and/or underinsured continues to rise nationally. However, reform is likely to expand insurance coverage to millions of Americans by 2014, resulting in declining bad debt. But as patients continue to share a greater percentage of their healthcare costs, bad debt and collections issues will remain problematic, in terms of both the percentage that is collected and the timeliness of collection.

**Recommended Practice: Update Your Budgeting Process**

With all this uncertainty in unit reimbursement, collections, payer mix, and volume, an obvious question arises: How can organizations budget more effectively? Some finance teams tweak last year’s volume and cost assumptions for the next year’s budget, with minimal input from the rest of the organization. This incremental approach is error-prone, as unexpected declines in utilization, collections, payer mix, and unit reimbursement emerge. The approach can devolve into finger pointing among finance, revenue cycle, managed care, service line management, physician groups, and department directors.

One solution is for the CFO to define a forum and process to discuss and track top-line budget vulnerabilities, typically with a one-to-three-year time horizon. Often, clinical department leaders lack the one-to-three-year perspective on where managed care, volumes, collections, and payer mix dynamics are headed. On the flip side, clinical department directors often have deep insights into avoidable costs, pockets of excessive resource consumption, and clinical process improvement initiatives that will help maintain margins in an increasingly lower unit reimbursement environment. Getting the insights of these clinical departments on not only revenue, but also the costs of an avoidable day, complication, or excess ancillary utilization is important as payers (including CMS) seek to share cost savings and risk with willing providers.

This solution may entail chartering an interdisciplinary team to meet periodically to identify margin variances from budget and take immediate corrective action (e.g., chargemaster price increase, staffing changes, facility configuration changes). Consideration also should be given to aligning the team with a longer term goal of aligning what patients value most with how the organization makes a margin. So have the team review where their margins are made today, and which margins are most vulnerable and why. Review the service offerings that generate the most margin today (e.g., imaging lab). Consider designing a bundle that includes those services but that patients value and will be willing to pay for out of their own pocket. Aligning patient value with margins over the long term is the best way for providers to meet (if not exceed) budget in a post-reform world, where patients will be responsible for an increasing portion of the healthcare dollar.

**Case Study: Creating a Budget for a Bundle**

A five-hospital health system with a considerable Medicaid population desired to revive its managed Medicaid product. The system CFO created a multidisciplinary team composed of managed care, revenue cycle, service line, physician-hospital organization (PHO), and operations staff to develop a diabetic management program and payment bundle for 100,000 Medicaid lives.

Operating in its historical “silo,” finance originally drafted a preliminary budget for the bundle before the CFO sanctioned the multidisciplinary budgeting team/process. Finance had assumed no major change in payer mix, an 8 percent unit reimbursement increase, a 3 percent outpatient volume increase, and no change in collections. Finance did not attempt to measure avoidable costs and complications required to maintain a margin with the bundle.

The team met three times to assess current clinical and financial performance of three diabetic populations (including shared cost savings opportunities), design an improved delivery approach, and define the plan to implement the diabetic management plan as part of a broader plan to revive its managed Medicaid product offering.
While assessing current resource utilization, margin drivers, and adherence to evidence-based standards, the team realized diabetic management was not owned by any team or individual in the health system. Instead, several teams managed elements of the bundle, each with different points of view on the “right” protocols, avoidable costs, and complications. After quantifying numerous extra medications, inpatient days, admissions, and emergency department (ED) visits for diabetic patients, the team realized the managed Medicaid product was struggling because no one was truly managing the product or its component disease management programs.

As part of its second meeting, the interdisciplinary team undertook a team-based approach to design and budget for the bundle. Physician leaders led the process, reminding the finance team that the catalyst for the bundle was a new Medicaid program, which would influence payer mix substantially. Unit reimbursement would likely be equivalent to 100 percent of Medicare given local market rates, plus a flat percentage of savings the hospital could keep from reductions in avoidable costs (e.g., diabetes with renal failure, coma, wound care).

Finance’s original 8 percent reimbursement increase assumption was faulty and based on outdated information from a long-range financial plan spreadsheet that hadn’t been updated. The planning team provided an analysis that estimated a 5 percent increase in outpatient service volume and 20 percent reduction in admissions and ED visits due to the program.

These assumptions, and the business plan that emerged, were quite different than finance’s original estimates, as shown in the exhibit below. The bundling budget process gave all the parties a much better appreciation for how they would need to work together in the future.

**Recommended Practice: Anticipate Different Scenarios**

Healthcare organizations’ budget teams also should anticipate different scenarios as part of the budgeting process. The health system in the case study failed to do any scenario planning. Although many providers have adopted scenario planning for strategic planning purposes, reform puts several different scenarios and variables on the table simultaneously:

- Patient mix changes
- Volume declines
- Reimbursement rates decrease
- Inflation increases
- Certificate-of-need programs are eliminated in key clinical service lines, creating new capacity
- Geographic encroachment from regional competitors occurs
- Technological advancements decrease demand for key services
- New technologies create demand for totally new services (e.g., genomics)
- Staffing and supply costs dramatically increase

**Case Study: Budgeting for a Full-Risk Contracting Scenario**

A large health system was updating its long-term budget. The executive team wanted to prepare for

<table>
<thead>
<tr>
<th>Variable</th>
<th>Original Finance Team Estimates</th>
<th>Team-Based Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer mix</td>
<td>No change</td>
<td>Major increase in underserved population (Medicaid, self-pay)</td>
</tr>
<tr>
<td>Unit reimbursement</td>
<td>8% increase</td>
<td>3% increase in physician rates; 6% increase in facility rates</td>
</tr>
<tr>
<td>Volume</td>
<td>3% increase</td>
<td>5% in outpatient, but 20% decrease in admissions and emergency department use</td>
</tr>
<tr>
<td>Avoidable costs and complications</td>
<td>Not evaluated</td>
<td>25% savings opportunity</td>
</tr>
</tbody>
</table>
much slower top-line growth than it had experienced in the past 20 years. The team did not get caught up in theoretical debates on whether capitation, single payer, or any other doomsday scenarios would occur. Rather, the team took a balanced approach to construct its budget under multiple scenarios:

- Facility COOs were charged with quantifying avoidable costs and identifying cost-saving technologies to improve care delivery and efficiency, recognizing that both low- and high-hanging fruit opportunities existed that had not been systematically identified to date.
- PHO and physician practice leaders were charged with identifying changes to incentives and ambulatory delivery models to reduce avoidable costs, recognizing that current incentives could reward overuse of resources.
- Managed care contracting was charged with designing phased reimbursement changes with payers that would optimize margin (not simply revenue) in concert with hospital and physician leaders, recognizing that current per diem contracts took away incentives for reducing length of stay and that competitors were aggressively seeking Medicare Advantage and capitated HMO contracts.

Finance began by populating its current budget using historical assumptions by year, payer, facility, physician group, and service line. Over six weeks, operations, service line leaders, PHO, and managed care met to refine their volume, cost, unit reimbursement, mix, and potential shared savings opportunities across the enterprise. As if this was not enough of a challenge, the CFO posed three key questions for the interdisciplinary team to address, along with generating the final budget assumptions:

- What will we do to maintain our positive 20 to 30 percent market reimbursement differential versus competitors?
- How will we eliminate incentives to use more resources and services than is medically necessary?
- How will we reduce the administrative costs of getting paid by 50 percent over the next decade?

These team-based budgeting recommended practices will be important to vet through the organization as payment reform takes hold in the healthcare industry.

The result was not only more rational budget figures, but also a much deeper insight into what the organization would need to do to succeed under multiple reform scenarios.

**Take a Team-Based Approach**

When finance excludes key functions (e.g., managed care, revenue cycle) from the budgeting process and plugs in low-ball estimates (e.g., no managed care rate increases), critical questions, such as those posed in the case studies, are overlooked. Instead, finance executives should take a team-based approach to benchmark historical trends for their organization, share the results with department and functional leaders, formulate future scenarios for each of the variables (along with estimated probabilities), and analyze several budget scenarios before finalizing the budget.

These team-based budgeting recommended practices will be important to vet through the organization as payment reform takes hold in the healthcare industry.

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