

How Stand-alone Hospitals Can Continue as a Community Healthcare Asset

Facing an array of financial and competitive challenges, stand-alone community hospitals are wondering how much independence they can retain while still providing high-quality, low-cost, and accessible medical care to the people they serve. This report will help hospital leaders understand their options and begin a systematic, long-term planning process to determine their future course.

HOW INDEPENDENT CAN A HOSPITAL BE AND CONTINUE TO SERVE ITS COMMUNITY?

Community hospitals fall somewhere on a spectrum of independence. At one end of the spectrum are those hospitals able to remain completely independent as a result of unusual and hard-to-replicate circumstances—for example, hospitals with a high concentration of specialists and deep financial reserves. At the other end are hospitals which have chosen to merge with a larger network and yield all of their autonomy to that network. The key question every stand-alone hospital must address is, *Where should we be on the spectrum?* That is, *How can we survive financially and continue to meet the healthcare needs of our community?*

Answering this question requires hospital leaders to engage in a process of long-term financial planning. For the planning process to be effective, leaders must have the discipline to revisit and update their pro forma projections on a frequent, ongoing basis.

How to Determine the Degree of Independence Your Hospital Can Retain

Create a Long-Term Financial Plan

Identify Ways to Cut Costs and Raise Revenue

Gauge Your Ability to Enter into Risk-Sharing Agreements

Remain Independent or Consider Affiliating

The purpose in creating long-term projections is to get a clear picture of the hospital's future financial capabilities, taking into account historical performance data and any variables the hospital predicts it may encounter. In most cases, the projections reveal that unless the hospital makes operational improvements, its future capabilities will be weaker than expected or desired.

At this point, hospital leaders should identify traditional operational improvements, such as reducing costs and increasing revenues, to see whether and to what extent these approaches lead to improved financial stability and clinical excellence.

CUTTING COSTS AND RAISING REVENUE AS PART OF LONG-TERM PLANNING

A hospital's ability to cut costs and raise revenue plays a critical role in determining the degree to which it can remain independent.

Reducing spending means becoming cost competitive in areas such as productivity, labor, facilities, and access to capital, without sacrificing the quality of care delivered. Planners can turn to industry, state, and regional benchmarks to see how their costs compare to similar facilities, and adjust their spending accordingly.

One area in particular for potential cost reduction is pharmaceuticals. Planners and medical staff should work together to identify procedures for which it may be possible to use more cost-efficient drugs. Other opportunities for savings include reductions in the costs of non-pharma supplies, purchased services and professional service contracts.

At the same time hospitals look for ways to cut costs, they must also focus on revenue growth. Hospitals should consider the revenue that can be achieved by growing their market share, improving the payor and service mix, reducing the capital budget, and making improvements to the revenue cycle.

Additional revenue strategies could include serving more of the outpatient market or promoting certain better-margin procedures such as hip replacements. Of course, hospitals need to keep in mind that in order to offer these procedures, physician specialists must be attracted and hired. Furthermore, hospitals should be aware that any procedures which contribute significantly to net income will be offered by multiple hospitals, resulting in increased competition and the need for greater marketing expenditures.

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As part of the long-term planning process, hospitals should conduct a thorough service line review to ensure they are emphasizing only those lines which offer the best return. Unprofitable activities should be eliminated, and the resulting savings included in the projections.

It may sound straightforward, but determining which services to keep or let go can be quite difficult, especially since some services may be the only ones of their kind in the community. In making these decisions, hospital leaders and board members must focus on the services which best promote the organization's long-term survival as an important community asset.

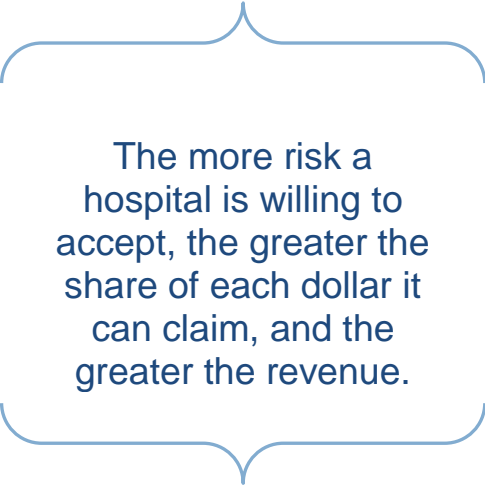
GAUGING A HOSPITAL'S TOLERANCE FOR RISK

Besides including the financial impact of reduced costs and added revenue, the long-term projections should layer-in the expected the costs and opportunities of sharing risk with other parties. A risk-sharing strategy can be an appropriate choice for community hospitals, but it should be approached with care.

Providers should recognize that a risk-sharing model, which inevitably includes capitation or some other fixed-rate pricing mechanism, almost certainly requires process improvements and clinical case-related cost reductions. Prior to engaging in a risk-bearing strategy, hospitals and physicians must ensure that they have undertaken financial modeling to understand potential impacts on the P&L, balance sheet, and financial ratios.

Whether an organization has the financial strength to take on risk should be evident from the long-term projections, especially after cost reductions and additional revenue are factored in. Financial modeling with “what if” scenarios should further clarify the hospital’s risk-bearing capacity. If projections show that the hospital won’t be in a position to tolerate such risk, or won’t be solvent even if it can take on risk, then affiliating or merging with a larger hospital network to consolidate assets, strengths and capabilities may be a community hospital’s best strategy for keeping its doors open and meeting the needs of its patients.

Before we consider affiliation options, let’s look at risk-sharing in more detail.



The more risk a hospital is willing to accept, the greater the share of each dollar it can claim, and the greater the revenue.

RISK-SHARING: THE RIGHT CHOICE FOR SOME HOSPITALS

The operational and financial improvements outlined above may allow hospitals to deliver high-quality services into the future, but oftentimes the resulting revenue won’t be sufficient to accomplish this goal. Fortunately, there is another way community hospitals can generate revenue: by establishing risk-sharing contracts with insurance carriers, physician groups or other risk-bearing entities. As mentioned earlier, not every hospital will be in a financial position to take on risk, but it’s important for all hospital leaders to understand this growing trend.

Traditionally, insurance companies and other risk-bearing entities have managed three types of costs: claims costs, the cost of administration, and the cost of assuming risk, which together are factored into the “premium dollar” that insurance customers pay. For insurers, the cost of assuming risk covers the provider costs of delivering services, the unpredictable utilization of health services, and the variable health of a given patient population. Hospitals, in contrast, have generally been compensated on the number and types of procedures they perform—the more procedures, the greater the income. Utilization and population health have not been, until recently, a serious concern.

But healthcare is changing. As operating costs escalate, competition increases, and reimbursement is reduced, hospitals are finding it harder to stay solvent simply by accepting payment for services provided. Increasingly, hospitals are negotiating what amounts to a percentage share of each premium dollar in exchange for accepting some of the risk, as well as some of the administrative costs, formerly borne by insurers. (Bundled payments, ACOs, and capitation, all of which involve fixed payments for services regardless of the amount of care delivered, are other examples of how risk is being transferred from insurers to providers.)

THE PROMISE AND PERIL OF RISK-SHARING

Taking a share of the premium dollar—“moving closer” to the premium dollar, in industry parlance—can make good sense financially, because it gives hospitals a fixed income stream. The more risk a hospital is willing to accept, the greater the share of each dollar it can claim, and the greater the revenue. At the same time, however, risk-sharing represents a profound shift in the provider’s responsibility, one that many hospitals won’t be fully ready for.

In a risk-sharing environment, the old fee-for-service model—in which a hospital performs a procedure, sends the bill and collects payment—is rendered obsolete. As hospitals take on risk, they have to manage the costs of all the services necessary to care for patients, such as doctors’ fees, facility expenses, lab tests, and rehab care, as well as costs incurred outside the walls of the hospital, such as home health care and hospice. Moreover, hospitals assume utilization risk in a risk-sharing model—whether a patient sees the doctor once or 10 times, the reimbursement amount for that patient stays the same.

For these reasons, in a risk-sharing model population health management becomes more important than ever before. If risk-sharing is to be financially viable, hospitals must do everything possible to keep their patients healthy and minimize their use of medical services. The goal is not to limit care, but to deliver better health outcomes while spending less money per patient.

USING LONG-TERM PROJECTIONS TO PLAN NEXT STEPS

The long-term planning process should give hospital leadership a much better idea of their ability, over a 5-10 year period, to cut costs, raise revenue, shift strategic and capital emphases (particularly in the latter years), and take on population risk. With a detailed financial forecast in hand, administrators should be able to address key questions such as the following:

- Will we have the funds to implement the latest technologies and attract good doctors?
- Can we afford to build modern facilities?
- The ACA will mean lower reimbursement rates—can we absorb the lost revenue?
- Can we adopt mandated changes such as achieving Meaningful Use criteria?
- Do we have sufficient cash reserves to handle periods of economic uncertainty?
- Do we have the expertise and financial resources to participate in risk-sharing models? Are we willing to take the risk?

87% of hospitals are at least considering an alignment with a larger organization.¹



If the answers to these questions are “no,” or even “maybe,” then the hospital’s future as a fully independent entity may be in jeopardy. To continue as a local healthcare provider, the hospital should begin exploring the possibility of affiliating or merging with a larger healthcare system.

AFFILIATION MODELS

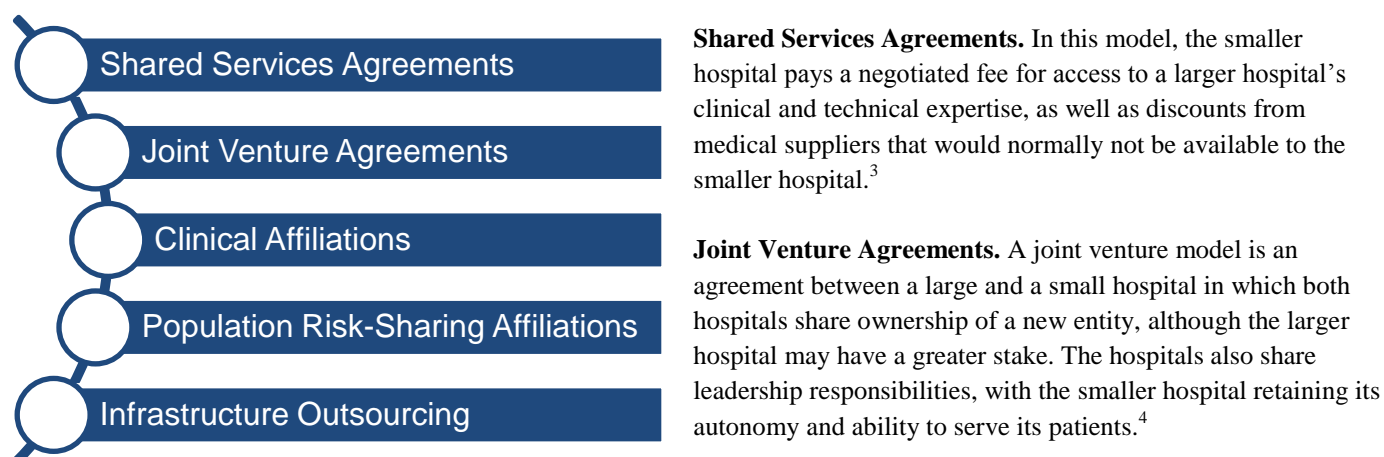
It’s hardly unusual these days for hospitals to be thinking about affiliating or merging: according to one 2012 survey, 87% of hospitals are at least considering an alignment with a larger organization.¹ In fact, more than 3,000 hospitals—just over 50% of the total—are now part of healthcare systems.²

Popular though affiliating may be, the decision to partner with a larger system should still be approached thoughtfully.

A merger with a larger hospital, in which all assets are transferred to the acquiring hospital, is for some stand-alone hospitals the right choice. As a precautionary measure, the merger agreement should include reserve clauses giving the community hospital an opportunity to regain control if the acquiring hospital threatens to reduce or otherwise change the level of healthcare the community hospital provides.

Many hospitals will choose to forego a merger entirely and turn instead to an affiliation model. An affiliate arrangement is designed to meet the needs of both community hospitals and larger hospitals while fully supporting the community hospital’s mission of providing local healthcare.

Here’s a snapshot of five of these affiliation models:



¹ Report: “What Hospital Executives Should be Considering in Hospital Mergers and Acquisitions,” p. 3. DHG Healthcare: Winter 2013. http://www.dhglp.com/res_pubs/Hospital-Mergers-and-Acquisitions.pdf

² “50 Things to Know About the Hospital Industry.” Becker’s Hospital Review: July 23, 2013.

<http://www.beckershospitalreview.com/hospital-management-administration/50-things-to-know-about-the-hospital-industry.html>

³ “Beyond Mergers and Acquisitions.” Hospitals and Health Networks Daily: May 8, 2014.

http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Daily/2014/May/050814-hanlong-mergersandacquisitions

⁴ Ibid.

Clinical Affiliations. Clinical affiliations connect community hospitals with large, well-established providers, but ownership remains unchanged. With clinical affiliation, doctors at community hospitals get access to clinical resources that would otherwise be unavailable, while the larger hospital can gain additional market share without having to invest in completely new facilities or fully acquire other hospitals.⁵

Population Risk-Sharing Affiliations. The goal of population-risk sharing affiliations is for a hospital to partner with other providers and share the risk associated with a given procedure, diagnosis, or overall health management of a particular population. For example, a hospital in a population risk-sharing group might manage hip replacements, but services would be provided and risk assumed by all parties in the group.

Infrastructure Outsourcing. Large healthcare shared-services organizations may offer outsourcing capabilities in areas such as non-clinical revenue cycle, IT, and supply chain. By outsourcing these services, smaller hospitals and systems can gain significant economies of scale—often a 10% to 25% cost advantage—while avoiding giving up governance control or independence. This could be a valuable option for financially sound hospitals or smaller systems looking for a sustainable means of improving their operations without sacrificing their autonomy.

WHAT ABOUT HOSPITALS WHICH ARE ABLE TO REMAIN INDEPENDENT?

Based on their long-term financial projections, some hospitals may find that they can continue serving their communities without affiliating in any way. The challenge for these organizations is to avoid becoming complacent. It won't be sufficient to do long-term forecasts every 10 years. Instead, the hospital should routinely update its projections and model potential changes to determine if, in fact, an affiliation arrangement would be more beneficial to the organization and its patients.

CULTURAL CONSIDERATIONS WHEN AFFILIATING

Hospitals considering affiliation should plan not only for the financial impact—both positive and negative—but also the cultural integration issues that can occur when two systems interact. Indeed, these cultural challenges can be thought of as a cost of the transaction. A successful affiliation or outsourcing model anticipates and addresses change management, employee turnover, and a broad range of potential cultural conflicts.

⁵ “Building Brands and Networks: What Clinical Affiliations Mean for Providers and the Healthcare Industry.” Becker’s Hospital Review: May 1, 2014. <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/building-brands-and-networks-what-clinical-affiliations-mean-for-providers-and-the-healthcare-industry.html>

CONCLUSION

Community hospitals struggling to stay afloat may be unsure of their next move. As this report has suggested, by engaging in a systematic process of long-term planning these hospitals can gain a much clearer picture of the options before them. Whatever path hospitals take—whether they can remain fully independent or, to survive, must affiliate with a larger hospital or provider network—the most important result is that their patients will continue to have a local healthcare provider for years to come.

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