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Hospitals Make Strategic Changes in Response to Flat Revenues

By David A. Williams

Facing flat revenues and uncertainty about the future, two Mississippi hospitals embark on financial strategies to ensure their financial health.

Hospitals across Mississippi, as in many other places in the country, have been looking at flat revenue trends during the current year. Average net income for all hospitals in the state in 2009 was \$3.9 million, average net margin 5.96 percent (American Hospital Directory Incorporated, 2010). With lower reimbursement almost the only sure bet about healthcare reform, controlling or reducing costs is imperative, but each hospital must find its own way to that end.

The two government-sponsored hospitals featured in this article each started their search for cost savings by putting their entire operations under a microscope. Methods employed by the two hospitals in

this article include service line evaluation, eliminating non-essential costs, and product pricing.

Target: LOS and Unprofitable Outpatient Services

Case Study: Memorial Hospital at Gulfport
> 412 beds
> 2,383 employees
> 15,831 discharges
> 79,225 patient days
> \$1.3 billion total patient review

As a city-county organization with one of the largest workforces in Harrison County, Memorial Hospital at Gulfport (MHG) felt it could only sustain its mission in the future if its leaders acted deci-

sively now to secure sufficient financial resources. One of those leaders, CFO Jeff Steiner, explained the immediate factors that drove the hospital to take a proactive approach to controlling costs:

- > The need to shift costs to nongovernmental payers to coverage reimbursement shortages from Medicare and Medicaid
- > Negative margins experienced in governmental programs after Hurricane Katrina
- > Medicare and Medicaid volumes in excess of 60 percent of patients
- > Charges based on acuity of services that exceeded competitive benchmarks

Located less than five blocks from the Gulf of Mexico, MHG was at ground zero when Katrina struck on August 29, 2005; patient demographics changed dramatically in its wake. Harrison County lost 16.5

percent of its population while neighboring Hancock County lost more than 24 percent (Rosenberg, M., "Post-Hurricane Population Data Released." About.com, July 14, 2006).

In light of recent chagemaster rate increases of 15 percent to 17 percent, the hospital's ability to increase charges was minimized. This decrease in patient base and subsequent reduction in government funding prompted MHG to take a new look at its cost structure, said Steiner.

Between 2006 and 2009, MHG had negative margins for Medicare ranging from \$(15.4) million to \$(18.7) million, ending 2009 at \$(13.8) million. Medicaid margins ranged from \$(0.0) in 2006 to \$(4.0) million in 2009. Reimbursements received from the government programs were less than the hospital's costs of operations, which include salaries, benefits, purchased services, supplies, insurance, depreciation, and interest expense. MHG could no longer shift additional costs of services to other payers to stop this downward spiral.

Using accurate data to set inpatient targets.

Beginning in 2006, a work group led by Steiner broke costs down into direct (patient care-related) and indirect (overhead) categories to identify areas for potential cost savings. Understanding that reimbursement will be increasingly tied to quality outcomes, and having previously invested in technology—including a product pricing module—to capture data and develop standardized processes, MHG now invested in a national database to benchmark both cost and quality.

At the same time, the chief medical officer (CMO) established a separate work group to evaluate the clinical effectiveness of selected program offerings, including cardiology, pediatrics, orthopedics,

behavioral health, women's health, and general medical surgical services.

Data analysis pointed to length of stay (LOS), 4.9 percent higher than expected, as the place most likely to yield savings. Given that payroll and benefit costs represented 60 percent of total operating expense, the hospital began a highly detailed review of daily activities and associated labor hours. This led MHG to intensify use of its five-year-old hospitalist program to monitor the care plan of patients and move them to appropriate settings in a more timely fashion. The mindset of offering the most appropriate care became the standard. The CMO, hospitalist, and other physicians worked hand in hand in ensuring the patients were discharged to the level of care necessary as soon as possible.

One year after implementing these changes, LOS had dropped one half day; the associated annual dollar benefit is \$3.2 million (the difference in cost of routine care for adult patients per discharge between FY08 and FY09). An unintended but welcome consequence was the freeing up of 20 beds to accommodate future capacity; this allowed MHG to postpone its planned deployment of approximately \$20 million for a new bed unit until occupancy reaches levels similar to those prior to the drop in LOS.

The hospital continues to pursue a more efficient operation. To achieve additional cost savings, said Steiner, "our organization has to challenge what we have considered good practices and rely on hard data to make informed decisions. Electronic medical records planned for 2011 will further enhance delivery of care to inpatients."

Outpatient changes. Outpatient care at MHG has likewise experienced significant

change since Katrina. As the waters receded so did dozens of physicians looking for a more promising and stable market. Since then, the hospital has increased alignment efforts; today, it employs about half of its current medical staff. The resulting increase in costs has been partially offset by the increased patient volume and corresponding revenue the physicians brought with them.

Overall volume has rebounded to pre-Katrina levels, up 5 percent to 8 percent in both 2008 and 2009—this despite a population that is only 70 percent of its former size. A review of outpatient service levels that focused on shifts in demographics and demand has led MHG to a shift of its own: from an urgent/emergency care model to more coordinated outpatient clinic offerings, including ambulatory surgery, primary care clinics, internal medicine, etc.

The review identified contribution margins (net patient revenue minus direct associated expenses) for service lines that were not contributing to overhead and for those that were at breakeven point or contributing minimally. For example, outpatient rehabilitation services, including speech and occupational therapy, was in the first category, with a negative contribution margin of \$600,000 (\$800,000 in revenue, minus \$1.4 million in direct costs). The hospital determined that the payer mix was unable to sustain that level of expense and decided to discontinue those services, which were available in the market from competitors.

Similarly, outpatient wound management (hyperbaric care) produced a negative margin of \$500,000. After reviewing the payer mix and cost structure based on volume of services offered and care delivery methods used, MHG found that a single payer source was denying a majority of the

patient claims submitted for this service. The problem was that the hospital was offering care that was not covered under the plan. The admissions department immediately implemented a revised admission process for hyperbaric patients based on best practices from the national database, such as investing in technology upgrades and eliminating redundant staff positions. The results: a savings of \$700,000 annually.

Steiner explains that not all decisions are based solely on financial factors. Hospice care services have been offered to MHG patients since the introduction of the program by the Centers for Medicare & Medicaid Services (CMS) in September 1982. "The program has been effective in providing many oncology patients with palliative care on an outpatient basis, reducing MHG's overall LOS but producing a negative contribution of \$950,000. In this case, we elected to continue the service because hospice is an integral part of the hospital's mission."

Open to all opportunities. One of the keys to effective cost control, he says, is being open to all opportunities to reduce expenses. MHG used its two work groups to challenge the status quo, looking for more affordable options. It found three of them in pharmacy, employee benefits, and courier services.

Pharmacy costs represent 5.5 percent of the hospital's total operating costs. After analyzing its system for purchasing drugs, MHG implemented a revised protocol to require first use of formulary or generic drugs, realizing an annual savings of \$200,000.

Employee benefits represent 9.8 percent of total operating costs. After comparing employee benefits against industry peers, the work group determined that MHG's

defined retirement plan was out of line and switched to a more common 403(b) plan, saving the hospital \$1.5 million annually.

One of the side effects of Katrina was the relocation of services. With outpatient services located in several locations off the main campus, courier service costs (i.e., for lab results) were growing dramatically. Using workflow analysis, the hospital was able to align the service in a manner that was more timely, efficient, and less costly. As a result, the hospital was able to save over \$175,000 annually. Even though this initiative was not substantial in the total operation, it served as a model for the mindset of evaluating waste. The CFO is quick to point out that small wins in improving operations make a difference in the success of large efforts.

Using basic economic tools to actively seek out places to reduce operational costs, MHG found approximately \$6 million in total annual savings, allowing the hospital to remain financially viable going forward.

Target: Physician Practices, ED, and Purchased Services

Case Study: Delta Regional Medical Center, Greenville
> 177 beds
> 883 employees
> 8,315 discharges
> 42,014 total patient days
> \$331 million total patient revenue

Delta Regional Medical Center (DRMC) is a county facility located in the heart of the Mississippi Delta region. Like MHG, DRMC is one of the largest employers in Washington County and is currently the sole source of hospital care in its primary service area.

Two developments prompted DRMC to

undertake a review of operational expenses. First, DRMC had undergone an intensive physician recruiting and integrated delivery model process and reaped increased hospital volume as a result, but the practices were not profitable and its subsidies to the recently employed physicians were getting out of control. In addition, its 10 clinic locations (with a total of 26 physicians) were either at breakeven point or losing money. Second, DRMC had just completed the purchase of its only local competitor and discretionary cash was limited.

In addition to evaluating physician practice profitability, the hospital decided to focus its efforts on opportunities for improvement that promised the biggest impact on operating margins, specifically labor costs, purchased services, and bad debts, including charity care, according to CFO Courtney Phillips.

Making primary care pay. The hospital began a policy of evaluating clinic profitability based on production by the physicians. Valuations were performed and productive models were implemented to reflect the workload at each location. This was a culture change from the previous approach of adding physicians sporadically to a more methodical strategy using demographic data based on the patient patterns and utilization.

Tackling bad debt and irrational staffing patterns. In response to an increase in bad debts and charity costs in recent years, DRMC developed and implemented an action plan.

As part of this plan, the admissions policy and process were revised to strengthen upfront collection and review of patient financial resources.

In addition, emergency department (ED)

services were modified to include a triage area staffed by physician extenders, accomplishing two things:

- > A reduction in ED volume, which eased costs and reduced wait times for true ED patients
- > The shifting of patients who had previously used emergency services for clinic purposes to a less expensive and more appropriate environment

The hospital was able to replace one emergency physician with a nurse practitioner, for an annual savings of \$290,000.

DRMC had operated for many years without a formal program to evaluate employee staffing in relation to patient census. Now Phillips and his team developed a policy in which staffing patterns were based on proprietary standards grounded in historical data and responsive to occupancy variances.

"After starting off on a biweekly basis to build professional staff confidence and trust in the staffing process, we implemented a daily matrix," he said. As a result, salary and benefits costs dropped \$6.8 million annually, as the number of full-time equivalents shrank from 4.5 to 3.9 per adjusted occupied bed. The financial result was the \$6.8 million in staffing costs. Other moves under consideration include freezing merit increases and eliminating contract staffing.

Purchased services. Purchased services represent 38 percent of DRMC's operating costs, and the hospital's management team homed in on the largest expenses in this category.

- > DRMC consolidated the professional services rendered by three separate radiologists; using a sole source saved the hospital more than \$800,000 annually
- > The hospital's anesthesia provider assumed responsibility for supplying certified registered nurse anesthetists, for a net savings of \$400,000 annually
- > Centralization of insurance services—that is, placing all insurance under the management of one broker responsible for risk management—produced an annual savings of \$300,000; this arrangement will, ultimately, include DRMC's malpractice insurance
- > Applying a space planner to the management of the hospital's voluminous real estate and rental agreements allowed DRMC to consolidate and eliminate duplicate space (e.g., family clinics in same community, diagnostic and lab services) along with \$270,000 annually in costs
- > After careful review of the professional management services provided to various departments (e.g., intensive outpatient program, biomedical services, rehabilitation services, housekeeping), the hospital was able to identify managers and team members on its own staff that could perform the same services without increasing costs; discontinuing outside services saved \$1 million annually

Echoing Steiner at MHG, Phillips pointed out that the primary reason DRMC was able to accrue \$8 million to \$10 million in savings overall was because the management team refused to accept the status quo—even though previous operations had been satisfactory.

Now Is the Time to Cut

Memorial Hospital at Gulfport and DRMC both reviewed their operations with a sharp eye and a skeptical mind in an effort to reap savings needed to maintain financial viability in a future of diminishing reimbursement. They used basic economic tools to pinpoint promising areas to cut costs and boost efficiencies while sustaining or improving quality of care. And they have proved that even modest savings resulting from sometimes modest moves can add up.

It behooves individual hospitals elsewhere in Mississippi and in the rest of the country to do likewise. Not because controlling costs will be enough to ensure success under healthcare reform—whatever its ultimate shape. It will also be necessary to fully understand, to measure and closely monitor, the economic drivers at work in the industry at large and in their individual organizations; to find ways to stand out in an increasingly competitive environment; to move toward cooperative arrangements with physicians and other providers; and to reach out to consumers in new and creative ways. But without being able to rein in costs, none of this will be possible.

Hospitals cannot afford to stand still, even if the ground under them feels solid at the moment. Like the status quo, the landscape can be deceiving. The bedrock of the industry is moving, and hospitals must move, too.

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