HEALTHCARE FINANCE

Hospitals in Financial Straits Due to Difficult Market Conditions, Poor Cash Management Practices

Economies of scale and long-term cash forecasts are essential, especially for smaller hospitals that are feeling the pressure from payers.

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Hospitals are struggling financially, especially smaller hospitals that operate independently or are part of smaller health systems. The reasons for this are varied, encompassing both internal and external factors.

Internally, poor cash management may be dooming these facilities to underperformance. Externally, there are some difficult market conditions that make it more challenging to maintain a sustainable level of revenue.

Hospitals, by and large, make money when patients come to the facility. Areas in which healthcare organizations typically make the most money -- such as the emergency room, diagnostic imaging, and big-ticket items such as heart surgery -- have come under some pretty aggressive pressure from payers, according to Greg Hagood, president and senior managing director at SOLIC Capital.

"It's actually a transition of those services," said Hagood. "With the ER, if you look at what Anthem and the Blues have done, they've put out an edict that basically says, 'We're not going to pay emergency room rates for non-emergency conditions.' So if you've got strep throat, you're actually advised that you can go down to the urgent care clinic, but your visit there won't be reimbursed."

A CHALLENGING MARKET

There's another level to the payer challenge. Let's say someone injures themselves playing softball. If they go to a hospital and require an MRI on their knee, it runs about $2,000. At a clinic, it costs about $500. Payers have stated they won't pay ER rates for these MRIs, putting another big hospital moneymaker under pressure.

On a larger scale, a similar thing can happen with revenue sources like orthopedic surgery. Such procedures can be done in ambulatory surgery centers, and it cost perhaps $15,000 to $20,000, as opposed to $25,000 or $30,000 in a hospital.

"Hospitals get hit two ways," said Hagood. "They get lower reimbursement, but if you go to a surgery center, they're getting paid less and they have to share that revenue with another party. And similarly, there's the whole idea that people are staying in the hospital less. Starting with the (Affordable Care Act), they're pushing for home care and other services, so they'd rather have you for a day and then put you in home care for three days.

"It hits mostly small hospitals," he said. "If you're a big system you can capture a lot of that. You own the surgery center, you own the outpatient clinics."

The successful players have found ways to compete by partnering with larger systems to offer more of those types of services in outpatient settings. Being part of a larger system means the resources are already there; it's hard for a smaller hospital to compete in that type of environment otherwise.

"They are being hit by reimbursements or lower revenues that ultimately puts them in financial distress," said Matt Rubin, senior managing director at SOLIC. "They didn't plan for that appropriately, so they're in a freefall and something needs to happen, whether in court or out of court. We're typically seeing these situations where they didn't plan ahead or couldn't plan ahead, and now something needs to happen."

Going into default is a risk in these situations, Rubin said. Some will be forced to sell their hospital out of court, but the preferred situation is usually to have them file bankruptcy. Whoever buys the hospitals would rather buy them in an asset sale, free of the risks or liabilities associated with it, or they could end up in liquidation.

Hospitals that have seen a decline are typically going to have a very difficult time raising new capital from donors and existing funds, so the appropriate strategy for many in this boat is to identify the core services a community, and who the strategic partners might be. Usually it's another regional health system in an adjacent market.

Sometimes these hospitals will be converted into long-term facilities or some other type of service -- it depends on how badly the community needs a particular service and whether there's a large regional system present that would support it. An example would be Atrium Health, formerly Carolinas Healthcare system, which owns, manages and provides financial support to large networks of hospitals.

THE IMPORTANCE OF CASH MANAGEMENT

Some hospitals that are in distress find themselves in that position due to poor cash management practices, said Hagood.

"The biggest one we see is the conversion of their accounting system," he said. "Many of those systems were encouraged to adopt new electronic health records, and as we've seen hospitals do that -- even very big systems -- when they converted over they couldn't get the new patient data to talk to the old patient data. That led to delays getting out bills, and in some cases if you don't get bills out with a big system like that, you have a liquidity crisis."

In most cases an organization can fix those issues once they've got the system back up and running, but if they've wiped out their capital cushion in the process they can make themselves very vulnerable.

"Further compounding the issue," said Rubin, is that "in most cases these hospitals don't have dedicated resources for cash management, or if they do, they're probably the lowest-level resource they have, where they're just tracking the cash on a daily basis rather than managing the cash."

The best scenario is to have seasoned veterans conducting 14-day cash forecasts, outlining a forecast of receipts and disbursements, which is generally enough to keep an organization out of trouble.

The best way to improve liquidity, said Hagood, is through the discharge-to-bill cycle.

"How many days does it take for the hospital to get the doctor's notes in the system? The faster you drop that bill, particularly to someone like Medicare, the better," he said. "With physician services, the hospital waits for the doctor to close out their notes and you end up extending that cycle too many weeks, and that builds up. You have to be careful. You have to bill within 90 days."

There's no escaping the fact that larger systems have more resources to spend on personnel, which means the quality of cash management practices tends to be higher. Theoretically, regional health systems with billing centers in major metropolitan areas are able to recruit more qualified applicants; outsourcing to third-party billers has elicited a mixed response due to the expense.

There are a few things hospitals can do to turn the tide.

"Certainly having a 13-week cash flow forecast, or even a longer-term forecast, can help," said Rubin. "Whether you call it a cash plan or even a strategic plan, it helps you determine how to staff and operate your company for the short- and long-term. And I feel a lot of these hospitals aren't making the difficult decisions in order to cut costs."

And then there are the services a hospital offers. Many are necessary, no matter how financially difficult they can be to sustain. Others may need to go altogether, and hospital leaders have to be honest about whether retaining those services is ultimately worth it.

"Some services will always lose money that you have to provide -- your loss leaders," said Hagood. "Others just require some difficult decisions. Being proactive rather than reactive is important there."

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