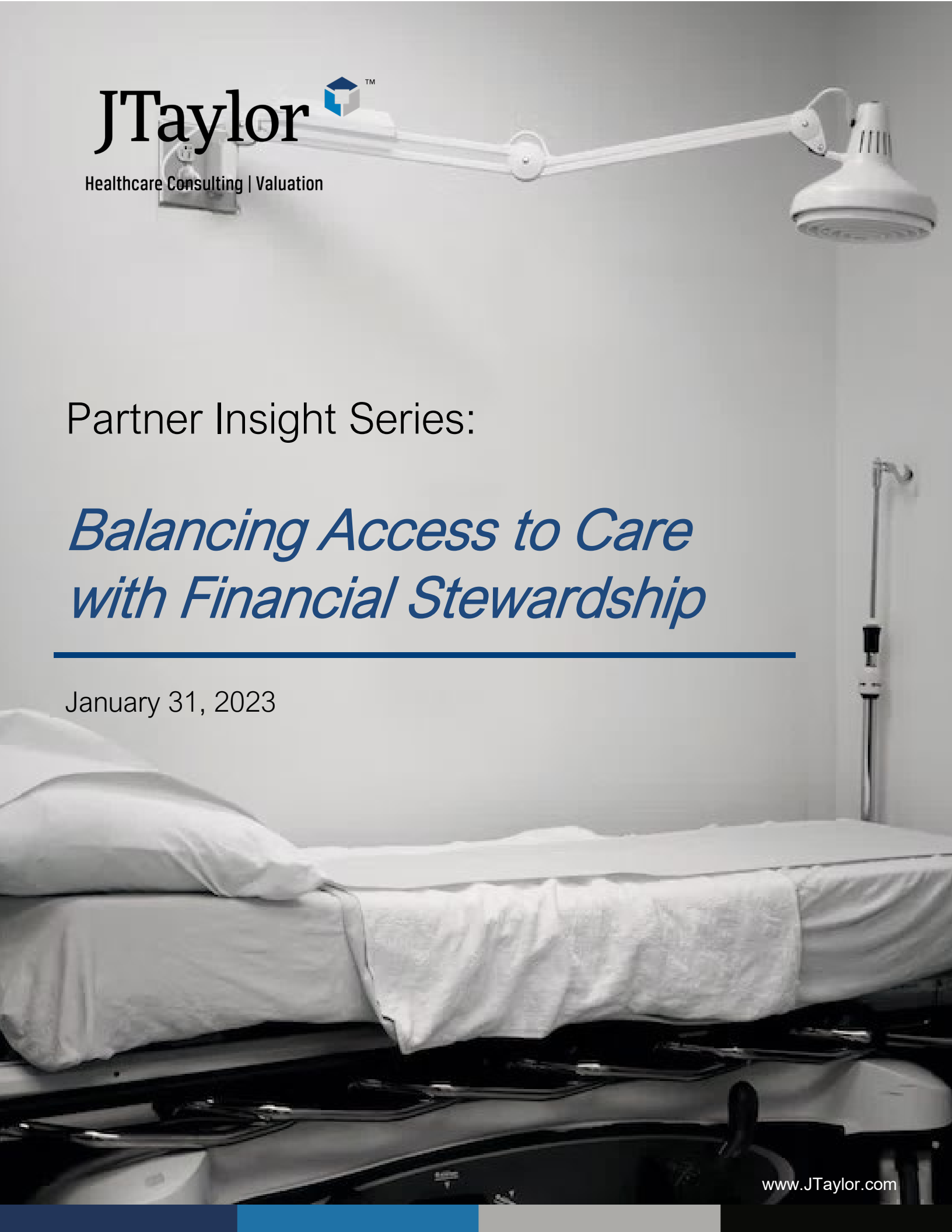
JTaylor™

Healthcare Consulting | Valuation

Partner Insight Series:

Balancing Access to Care with Financial Stewardship

January 31, 2023



www.JTaylor.com

In Today's Economy, Can Access to Care and Financial Stewardship Coexist?

For healthcare providers and their governing boards, access to care is a fundamental concern and a part of every hospital's charge. Philosophically, all providers desire to provide open access to all who need medical care. Further, there is an increasing awareness nationally of the need to improve health equity. However, financial and operational realities exist now more than ever that require providers to choose how, where, and when to provide access to healthcare services.

In today's world, we are seeing more and more rural hospitals close. Hospitals are closing obstetrical units and other less profitable but important service lines due to poor ongoing financial performance. Safety net providers are continuing to utilize funding from taxes and other governmental sources to fortify losses, but not without tension. Providers are struggling to keep up with patient demand as high costs and labor shortages continue. Financial pressures are leading to gaps in patient access, particularly in rural areas.

Financial Pressures

- The biggest driver of costs associated with patient care is labor. While providers are utilizing fewer high-cost travelling nurses now than at the height of the pandemic, the shortage of nurses and other clinical and non-clinical support staff has led to higher labor costs than existed prior to the pandemic.
- Supply costs have escalated as a result of both limited availability and inflation. This includes everything from medical supplies and equipment to medications to food and dietary supplies.
- Most commercial payer contracts have multi-year terms. Therefore, although costs of providing care have been rapidly increasing, commercial reimbursement has not. Likewise, reimbursement from government payers has not kept pace with cost increases.
- Hospitals are seeing more high-acuity patients, often because of delays in diagnosis. This can lead to longer inpatient stays, which may not yield increased reimbursement. Additionally, staffing shortages for post-acute settings mean that inpatient stays are sometimes extended while suitable post-acute care can be coordinated, if at all. Again, this increases the cost of care without a corresponding increase in reimbursement.

Gaps in Access

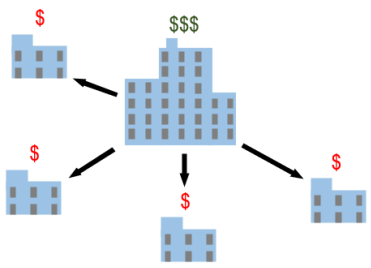
- Rural areas are experiencing the most acute provider shortages. In the tight labor market, physicians and other providers have leverage in salary negotiations. However, rural areas may not have sufficient volume to support high-cost specialty providers. This can lead to patients having to travel long distances to receive the care they need.
- The service lines that have historically

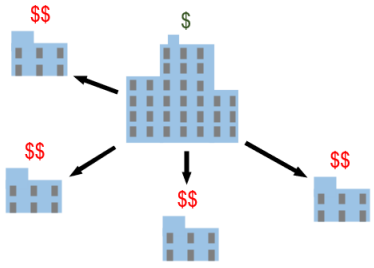
been most profitable, and therefore could subsidize lower-margin services, have experienced declines in volume and profitability. This is the result of a combination of factors, including Covid-related mandates to suspend elective procedures for a period of time to preserve resources, patients deferring care due to fears of going to the hospital during the pandemic, and the shift of certain profitable procedures such as orthopedic cases to outpatient surgery centers.

- As the cost of health insurance rises, many employers have shifted to high-deductible health plans in an effort to reduce premiums. This leads to a higher out-of-pocket cost for routine medical care for plan participants, who may decide to delay or forego care due to financial constraints.
- The traditional relationship between patient and primary care provider is weakening. Patients are becoming episodic, seeking care only to address acute medical issues as they arise rather than maintaining an ongoing relationship with their physician. While patients today enjoy the convenience of urgent care or retail clinics, this can lead to more serious cases down the road if they do not receive appropriate preventive care and screenings. We are now seeing the impact of delayed care during the Covid pandemic, which has led to serious conditions being more advanced when they are identified.

The Hub and Spoke Mentality

Historically, large hospital systems rooted in urban centers were able to provide care to those in less accessible areas through the hub and spoke model. This system consisted of a large main facility that provided a wide range of surgeries and other profitable services. To continue the mission of providing accessible care to patients, smaller facilities are constructed within the hospital system for suburban or rural areas. These arms many times operate as loss leaders, as the main facility could typically support their losses. As we see costs rise without additional reimbursement, the system's main facility can no longer support the losses of ancillary facilities, leading to loss of access for some patients.





Although brick and mortar facilities in rural areas are reducing specialty services or closing altogether, post-pandemic telehealth technology allows patients to access the care they need without a face-to-face encounter with a provider. Implementing a telehealth option for patients not only allows greater access to care, but has also proven to be more efficient and cost-effective

than traditional, in-person visits for some specialties. It also allows providers at rural "spoke" hospitals to consult with specialists in urban hubs to supplement locally available expertise and utilize those resources most efficiently.

Rural Emergency Hospitals

Another option for rural communities to consider is the Rural Emergency Hospital designation, which was recently established to address the growing concern regarding the closure of rural hospitals. This designation allows eligible hospitals to receive a 5% increase in Medicare reimbursement for outpatient services as well as a facility fee payment of around $3.3 million annually, in exchange for eliminating inpatient beds. The idea is to preserve access to emergency care in these communities while consolidating inpatient resources in areas with a higher volume of patients. However, the loss of inpatient services in local communities is a steep hurdle that is meeting significant resistance. Additionally, the facilities that choose this option would also lose funding from the 340B drug discount program and the ability to utilize "swing beds" to provide acute or skilled nursing care as needed to adapt to the needs of patients. Many are concerned that the overall financial impact of converting to a Rural Emergency Hospital will not be adequate to overcome these obstacles.

Final Thoughts

Today's hospital and health system governing boards and leaders face a dilemma of providing equitable access to the underserved while maintaining financial viability. It requires strong financial diligence, focused attention on revenue optimization, excellence in resource optimization, and shrewd operators and providers. The "good old days" of having "cash cow" high-end profitable services offset underperforming mission-oriented care centers is at a turning point where all fronts need to be closely managed to maintain sufficient margins to preserve access over the long term.

Kyle W. Kirkpatrick, FACHE
Partner – Director of Consulting Services
817.502.7731 | kkirkpaatrick@jtaylor.com

Kyle has over 25 years of consulting and operational experience working in healthcare and life sciences with public and private organizations across the nation. He is a former hospital CEO with experience running hospital groups, managing joint ventures, implementing new strategies, driving EBITDA enhancements, and creating positive organizational cultures. He has worked as a consultant within Big 4 firms focused on strategic planning, M&A, and operational improvements. He has strong project management experience to coordinate complex initiatives among multiple stakeholder groups.