No Margin for Error

Publication Snapshot

sg2

health care intelligence

PUBLICATION **Snapshot**

No Margin for Error: A Comprehensive Approach to Boost the Bottom Line

Although the past 2 years have been positive financially for many hospitals, trends shaping health care paint a gloomier picture for the future. Inpatient growth is flat. Payer mix is weakening as more patients are covered by government health plans. Private payers are exerting their increasing leverage to demand lower costs. Overhead is burgeoning as organizations add IT staff and other corporate-level employees to support an increasingly complex management model. Credit rating agencies are requiring more stringent financial risk management. The net result: financial uncertainty and margins under threat.

These trends will play out differently in different markets, and organizations will need to adjust their responses accordingly. But many hospitals expect to have to make deep, painful cuts in costs—on the order of 20% to 30%—over the next 5 years, just to stay in business.

Some organizations have begun to address these vulnerabilities with traditional margin management activities aimed at enhancing revenue cycle performance and reducing labor and supply expenses. But these classic measures are not sufficient to meet the complex challenges of tomorrow's health care marketplace. Rather, a comprehensive approach is required—an approach that not only targets both revenue and costs but also encompasses strategy and operations, and utilizes both classic and reform era methods of margin management.

A new Sg2 report, *No Margin for Error: A Comprehensive Approach to Boost the Bottom Line,* is designed to help health care executives prepare a wide-ranging, 2- to 3-year margin management plan to achieve financial health. It offers an extensive menu of revenue and cost initiatives that will be relevant to all provider types under any current or future payment model. Selected initiatives are presented in detail, and case studies highlight organizations that have begun to effectively tackle margin management. An appendix presents rich data to illuminate specific margin and growth opportunities, at the MS-DRG or APC level, in both the inpatient and outpatient settings.

No Margin for Error

- Yesterday's approaches to margin management are not sufficient for tomorrow's financial challenges and marketplace realities.
- A comprehensive approach employing a broad portfolio of initiatives across the enterprise is required to preserve financial viability.

To download the full report, go to members.sg2.com. For multiple copies, email membercenter@sg2.com.

APC = ambulatory payment classification; CMS = Centers for Medicare & Medicaid Services; IP = inpatient; IT = information technology; MS-DRG = Medicare severity diagnosis-related group; OP = outpatient.

Numbers to Know

4%
Median operating margin, US short-term acute care hospitals, 2010

39%
Median gross OP revenue as a percentage of all gross revenues for large community hospitals, 2010

1%
Adult IP discharges, projected 3-year growth*

14%
Adult OP volumes, projected 3-year growth*

*Sg2 Impact of Change® Forecast, 2012–2015. Sources: Impact of Change® v12.0; NIS; PharMetrics; CMS; Sg2 Analysis, 2012; Sg2 Comparative Database, 2012; CMS. Healthcare Cost Report Information System.

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10 Core Concepts in Margin Management

1. There are no silver bullets or quick fixes in tomorrow's margin management journey. Organizations must rely on a portfolio of initiatives that are carefully selected, sequenced and implemented over time.
2. The acute care business model must be redesigned—including everything from streamlining inpatient capacity to reshaping traditional management structures—to drive transformative and sustainable change.
3. While certainly not a panacea (due to competitive and payment pressures), ambulatory sites and services are the growth segment in health care and represent a critical leverage point for care redesign.
4. Individual assets, including hospitals, outpatient sites, post-acute care sites and physician practices, must be optimized from a financial perspective, and synergies across these resources must be leveraged.
5. Organizations must understand the relative value of their services in the marketplace and place a renewed emphasis on partnering with payers on mutually beneficial cost and quality initiatives.
6. The magnitude of cost reduction needed in the industry requires a focus on both direct and indirect costs.
7. While organizations should evaluate their nursing staffing and productivity, leaders should be leery of making reductions beyond recommended ratios.
8. Local market realities will shape which activities organizations take on and define the timing of implementation.
9. Executives must consider management's ability to oversee change and the organization's appetite for change.
10. All organizations will need physician and nursing support to be successful—clinicians must be directly involved in both planning and implementation.

Performance Benchmark

Operating Margin (%), Short-term Acute Care Hospitals, 2010

	Sg2 Performance Categories				
Sg2 Peer Group	Distressed	Lagging	Standard	Leading	Top
Large Community	−2%	1%	5%	10%	17%
Medium Community	−5%	0%	4%	10%	17%
Small Community	−11%	−4%	2%	9%	20%
Teaching/AMC	−18%	−2%	3%	6%	11%
Overall	**−7%**	**−1%**	**4%**	**9%**	**17%**

Note: Operating margin is calculated as the difference between operating revenue (ie, patient and nonpatient revenue less income from philanthropic contributions, investments and governmental appropriations) and operating expenses divided by operating revenue. **Distressed** indicates performance at the 10th percentile; **Lagging** indicates performance at the 25th percentile; **Standard** reflects median performance; **Leading** indicates performance at the 75th percentile; **Top** indicates performance in the 90th percentile. The financial indicators were calculated from a sample size of 3,201 short-term acute care hospitals and include Medicare Cost Report financial data for periods ending in 2010. AMC = academic medical center.
Sources: Sg2 Comparative Database, 2012; CMS. Healthcare Cost Report Information System; Sg2 Analysis, 2012.

$6,700
Average variable direct cost per discharge for a typical large community hospital

$2,000
Reduction required to break even at Medicare rates

37%
Hospitals with IP commercial payment rates more than 1.5 times Medicare rates

56%
Median bed occupancy, US short-term acute care hospitals, 2010

From the Sg2 Centers for Strategic Planning and Performance Strategy

Anticipate the Impact of Change

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