



Navigating the Gap Between Volume and Value

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Navigating the Gap Between Volume and Value: Assessing the Financial Impact of Proposed Health Care Initiatives and Reform-Related Changes

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Executive Summary

The nation's health care delivery system is in the midst of a transition from a fee-for-service approach to one based on value. This transition poses numerous challenges for hospitals and health care systems, including declining utilization and the need to invest significant capital in new infrastructure and competencies. Organizations seeking to effectively navigate these challenges must be proactive in developing and implementing a comprehensive financial plan based on traditional corporate planning principles.

This guide offers hospital leadership step-by-step advice and information on the financial planning process and how it can help organizations plan for value-based care and payment.

The first step of the financial planning process **establishes the foundation** by identifying existing sources and uses of capital within an appropriate credit and risk context. A comprehensive capital position analysis includes five key assessments:

- Review of historical financial performance
- Quantification of current debt capacity
- Definition of capital requirements
- Identification of expected liquidity needs
- Determination of other key areas of cash uses and sources

The capital position analysis quantifies how much operating cash flow will be needed to maintain financial equilibrium while also supporting strategic capital needs.

The next step, preparation of sound **baseline financial projections**, allows executives to predict the organization's financial trajectory over the plan period, before factoring in major initiatives. "Status quo" baseline projections are no longer sufficient in the current health care environment. Hospital and health system leaders should be conservative in their projections, incorporating known and expected challenges.

In setting the *revenue side of the equation*, for example, health care leaders should factor in slow revenue growth, declining inpatient use rates, and flattening outpatient use rates. It is important to have a clear understanding of the organization's market position and specify realistic projected revenue increases or decreases by payer. Executives also should include both the known and unknown effects of health care reform, such as fluctuations in payment rates from different payers.

Building the *expense side of the equation* requires executives to define fixed versus variable expenses and account for inflation. Costs associated with various planned initiatives—such as acquiring physician practices and resulting operating losses—should be included. Through this process, organizations can identify the level of cost management that will be needed going forward.

To define *balance sheet and cash flow requirements*, hospital leaders need to develop assumptions for each of the major balance sheet components, including working capital, ongoing capital needs exclusive of major strategic investments, debt and/or lease financings, and pension obligations.

Finally, hospitals and health care systems should *consider risk* as a factor in developing baseline financial projections. This requires identifying strategic, financial and operational risks and quantifying the impact of various risk scenarios on organizational capital capacity over time. Sensitivities should be calculated both independently and in combination.

With a realistic baseline plan in place, organizations can incrementally **test the impact of major strategies**. These may include cost management initiatives in areas such as labor and nonlabor savings, facilities planning and information technology, cost restructuring through business/service line rationalization, and/or potential partnerships. By quantifying the implications of each initiative independently and in various groupings and timelines, hospital and health care system leaders can define an optimal portfolio of strategies for sustainable financial performance that will enable the organization to provide high-quality care to the community on a continuing basis.

After a preferred set of strategic initiatives is identified, the final and perhaps most important analytic stage of the financial planning process is **understanding and testing the impact of planned strategies** through the evaluation of risk—including conducting sensitivity and scenario analyses. Such analyses involve projecting a range of possible outcomes in order to examine the risk parameters related to assumptions. Health care leaders who understand the risks associated with their strategic financial plan can establish appropriate key performance indicators to monitor performance, as well as specific action plans to address any deviations in performance related to that risk in years to come.

Having a robust strategic financial plan is critical in ensuring high-value care in today's health care environment. By walking readers through the stages of the financial planning process, this guide demonstrates the importance of developing organizational strategies within the context of realistic projections of financial and capital capacity.

Once a solid plan is in place, executives should ensure it is routinely monitored and updated as strategies are implemented and markets shift. Hospital and health care system leaders also should use the plan as a communication tool to educate key constituents as to the expected outlook for the organization and, importantly, the range of potential outcomes given the inherent risk in the field. The numerous uncertainties facing health care require a disciplined planning process that provides a framework for flexibility and ensures long-term success in the new health care era, and thus continued delivery of critical services to patients.

Introduction

As a value-based business model replaces the volume-based model, the issues confronting hospitals and health care systems are rapidly evolving, making it difficult for their leaders to plan with any level of certainty. To succeed in the new health care era, executives must rethink how, where and to whom their organizations provide services—and which services are most appropriate—under a delivery model that focuses on consumer-focused *health* care as distinct from provider-focused *sick* care.

Health care organizations face significant challenges during the transition, including declining commercial and government payments, rising supply and service costs, increasing price sensitivity from consumers and other health care purchasers, decreasing demand for inpatient services, and a shift in focus to care provided in ambulatory and home settings. These challenges create operating pressures that are expected to intensify as the field continues to move toward value-based payment and population health management. The speed of change will vary from market to market, but hospitals and health care systems that wish to serve their communities over the long term must develop realistic plans for making the transition, and navigating the gap in between.

Because the environment in which health care organizations operate is changing (Sidebar 1), robust and disciplined financial planning must guide organizations during this transition.

Using a Back-to-Basics Plan

Developing and implementing a comprehensive financial plan are critical to ensuring long-term sustainability and success. A back-to-basics approach—one founded in traditional corporate financial planning principles, as described fully in other publications¹—is strongly recommended. With such an approach, a health care leader can gain a deep understanding of the current position of the organization and its likely trajectory over the next five to 10 years. A disciplined process (Sidebar 2) allows leaders to re-examine their existing strategies, quantify current and future strategic initiatives, and rigorously test alternative “portfolios” of initiatives using sensitivity analysis.

Once the desired and achievable portfolio aimed at maximizing value for patients is defined, executives should use the financial plan to set expectations, assign responsibilities and establish accountability during the annual budget process and on an ongoing basis.

Sidebar 1. Characteristics of the Changing Environment for Hospitals and Health Care Systems

1. Provider revenues will be under severe pressure as payment mechanisms migrate toward value-based approaches; organizations need to do less with less.
2. Inpatient use rates are declining, and certain outpatient use rates are likely to decline as well.
3. Continuing to compete on volume and rate will be a riskier strategy than shifting to value-based reimbursement; being a rate-taker in a shrinking market is not a viable strategy.
4. A new set of core competencies will be required for success.
5. Providers will consolidate at an accelerated pace, horizontally and vertically.
6. The competitive landscape will be reshaped by existing and new competitors.
7. Regardless of what happens at any regulatory level, improving care quality and efficiency is the right thing to do.
8. Providers need to determine how they will participate in the future health care delivery system and prepare for that transformation.

Source: Kaufman, Hall & Associates, Inc., 2014.

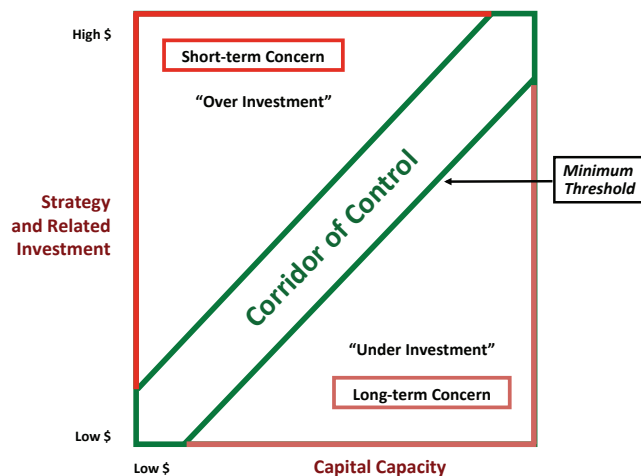
Sidebar 2. Observations on the Current Financial Planning Environment

- The basic components remain the same:
 - Sufficient cash flow to meet strategic capital needs (within an acceptable risk tolerance)
 - Credit and capital position, financial projections, and sensitivity analysis
 - Net capital capacity
- Status quo is no longer baseline; typical baseline financial projections include:
 - Challenges to utilization and revenue streams
 - Significant investment around core competencies
 - Deteriorating financial performance
- Analytics are advancing along critical dimensions:
 - Exchange exposure (opportunity)
 - Evolving reimbursement models
 - Physician alignment
 - Strategic cost management

Source: Kaufman, Hall & Associates, Inc., 2014.

Finally, the financial plan provides a means to communicate the impact of desired strategies and objectives to key constituencies. A sound financial planning process and the resultant plan will enable executive teams and boards to evaluate whether or not the hospital or health care system will remain within its “Corridor of Control.” A concept conceived by Kaufman Hall more than two decades ago, the Corridor of Control represents the equilibrium point between strategic investment of capital and commitment of operating dollars, *and* protection of the organization’s long-term financial integrity as measured by continued, effective access to capital.

Figure 1. Corridor of Control: Finding the Balance of Strategic Requirements and Capital Capacity



Source: Kaufman, Hall & Associates, Inc., 2014.

Figure 1 illustrates this concept. An organization whose position appears below the Corridor of Control in the “long-term concern” area may be at risk of losing market share because it is not investing sufficient capital to build new competencies required to succeed in a value-based business environment. If an organization is positioned above the Corridor of Control in the area labeled “short-term concern,” its financial need or strategic capital appetite exceeds its current financial capability. In the extreme, this can cause a liquidity crisis and trigger a default on debt. More commonly, this capital position reflects an organization that—given levels of performance—is unable to respond to market opportunities and threats.

Although the current planning environment has new variables and uncertainties, the need for the time-honored, fundamental financial planning approach remains unchanged. This approach is grounded on the guiding principle that cash flow must be sufficient to meet the strategic capital needs of an organization within an acceptable risk tolerance. To provide high-value care into the future, health care organizations must establish parameters of financial performance, balance their sources and uses of capital, estimate their future financial trajectory, and assess how changes to assumptions will affect the organization’s financial position. Sidebar 3 outlines key questions that should be asked as part of this planning process.

This guide describes each process component in depth. It also provides numerous examples describing the experiences of hospitals and health care systems in the current health care environment. The names of individual organizations have been blinded.

Sidebar 3. Strategic Financial Planning Must-Ask and Answer Questions

1. What must we do to ensure we remain relevant in our local health care market? Can we stand alone in the new business model? Are we big enough to handle the intellectual demands of reform and the new business model?
2. Do we have a carefully constructed physician alignment strategy that will meet reform era requirements?
3. Do we have the required infrastructure and culture to effectively manage cost and utilization? Are we making a real effort to bend the cost curve?
4. Do we have a quality initiative that recognizes the principles of care coordination, evidence-based medicine and comparative effectiveness?
5. At what level of risk are we able to participate now and at what level do we want to participate in the future?
6. Is our existing portfolio of services and locations the right portfolio for changing competitive conditions?

Source: Kaufman, Hall & Associates, Inc., 2014.

Establishing the Foundation

The guiding principle described earlier requires hospital leadership to balance the organization's funding equation—with variables including cash, capital, debt, and operating profitability—through use of a rigorous financial planning process. Each element must be optimized within an appropriate credit and risk framework that supports ongoing organizational access to external capital. No major organization can fund the full range of its capital needs solely from internally generated cash flow and remain financially viable. Capital access is a critical organizational asset and competitive differentiator in ensuring ongoing health care in communities.

In developing a realistic financial plan, health care organizations must quantify any gap that may exist between their current position and the amount of capital capacity it requires to remain fiscally stable (at a minimum) and achieve long-term capital access objectives. To do so, the organization first must define its usual sources and uses of capital within an appropriate credit and risk context. This process involves the five analyses described next.

Reviewing the Organization's Historical Financial Performance

A financial assessment establishes the context for how the health care organization has performed relative to desired credit rating medians for profitability, debt position and liquidity. As the credit medians are expanded to include assessment of volume and quality trends, objective evaluation of these aspects of the organization's operating and competitive position also should be included. This analysis should provide the foundation for the health care organization's ongoing performance targets.

Targets commonly are based on industry benchmarks and/or organizational performance to date. The organization in Figure 2 used current-year performance and rating agency medians to define targets related to key financial indicators, including liquidity (days cash on hand) and operating margin. These "minimum thresholds" reflect the level of financial performance necessary to meet the organization's ongoing strategic requirements.

Figure 2. Target Setting: Establishing the Framework for Evaluating the Organization's Expected/Required Performance

Metric	XYZ 2013	XYZ Budget 2014	'A3' Medians	XYZ Targets	XYZ Minimum Threshold
Days Cash on Hand	185.0	185.7	175.9	200.0	175.0
Operating Margin	-3.1%	0.0%	1.6%	5.0%	2.0%
Operating EBIDA Margin	5.1%	7.6%	10.0%	12.0%	10.0%
Debt Service Coverage	4.3x	6.2x	4.2x	4.5x	3.5x
Debt to Capitalization	31.7%	30.7%	41.0%	35.0%	45.0%
Cash to Debt	179.7%	181.5%	112.7%	150.0%	110.0%
Capital Expenditure Ratio	120.1%	133.0%	113.6%	120.0%	100.0%

Source: Kaufman, Hall & Associates, Inc., 2014.

Quantifying the Organization's Current Debt Capacity

Debt capacity can represent a significant source of capital to support an organization's strategic investment needs. As such, developing a thorough understanding of the magnitude of the organization's debt capacity, as well as the underlying makeup of that capacity, will directly impact the magnitude and timing of strategic initiative implementation. Debt capacity analysis should reflect the integration of three industry-standard approaches that evaluate an organization's: 1) cash flow relative to its current debt levels; 2) debt-to-total capitalization/leverage level; and 3) cash-to-debt/liquidity level. The analysis will determine the extent to which the health care organization has access to additional external capital (i.e., debt) at desired levels of risk to fund future strategic initiatives without compromising its financial goals. The debt capacity analysis should consider the organization's ability to generate not only the cash flow necessary to support additional debt, but also to avoid dilution of its balance sheet through excessive leverage and/or diminished liquidity relative to its total debt.

Defining the Organization's Capital Requirements

Development of a comprehensive inventory of capital requirements is a cornerstone to quantifying an organization's position within or outside the Corridor of Control. The identified capital requirements used in this analysis should include all ongoing facility expansion and maintenance plans, information technology (IT) needs and any costs associated with ongoing and planned strategic initiatives. To the extent that identified capital requirements are understated, the financial plan targets established will result in long-term undercapitalization of the organization. One means by which to test the relative reasonableness of an organization's capital inventory is to calculate and compare the resulting capital spending ratio to industry medians.

Establishing Expected Liquidity Needs

Establishing a liquidity target using days cash on hand as the key measure should reflect both the organization's current position and the liquidity level associated with a desired rating level (a proxy for both risk and ease of capital access). The related analysis will estimate the minimum unrestricted cash balances required to retain appropriate capital access and organizational liquidity strength. When comparing projected liquidity needs to current levels, the health care organization can effectively quantify the portion of future cash flow it will need to allocate to its balance sheet as reserves to preserve its capital access. These reserved future cash flows, which otherwise would be used to fund strategic capital expenditures and other cash needs, essentially become a use of cash rather than a source.

Determining Other Key Areas of Cash Uses and Sources

This step identifies other existing and future sources and uses of cash that should be considered as part of the financial equilibrium equation. Examples of other key impacts on a health care organization's sources and uses of capital include additional pension funding requirements, working capital needs, payment of debt principal, asset monetization and potential philanthropic dollars (e.g., capital campaigns).

By combining the results of these five analyses, an organization can complete a comprehensive capital position analysis (Figure 3). This quantifies the level of future operating cash flow necessary to support the organization's strategic capital needs to maintain high-value care for patients, while maintaining its financial equilibrium (i.e., keeping it within the Corridor of Control).

Example: Capital Position Analysis Uncovers One Organization's Need for Change

To maintain 225 days cash and implement its identified capital investment plan, the health care organization whose capital position or “gap analysis” appears in Figure 3 will need to generate approximately \$1 billion in cash flow over the next five years (approximately \$200 million annually). This annual level of cash-flow generation is well above its historical average performance, indicating that, at current levels of performance, the health care organization will not generate sufficient cash flow to meet its strategic needs over five years and maintain its financial position.

Figure 3. Projected Capital Position

Uses of Cash	2014 - 2018	Sources of Cash	2014 - 2018
Capital Investment			
Routine/ Ongoing	\$593.3	Unrestricted Cash (2013 End Balance)	\$890.5
IT Capital	149.0		
Known Strategic Initiatives	130.0		
Total Capital Investment	\$872.3		
Funding of Minimum Cash Position (End Balance, 225 days cash)	1,157.2	New Debt (Net Proceeds)	100.0
Pension Funding	50.0		
Principal Payments on Existing Debt	32.2	Monetization, Philanthropy, Other	100.0
Working Capital (estimated)	10.0		
Total Capital Uses	\$2,121.7	Total Capital Sources	\$1,090.5
Cumulative 5-year Cash Flow Requirement :		\$1,031.2	(\$206.2 annually)
Historical Cash Flow:		2013 ACTUAL: \$153.3	
		2012 ACTUAL: \$91.5	
		2011 ACTUAL: \$219.0	
		2010 ACTUAL: \$178.1	

Source: Kaufman, Hall & Associates, Inc., 2014.

Developing Baseline Projections in Uncertain Times

Once the financial framework, operational performance targets and targeted annual cash flow required to generate financial sustainability have been established, sound baseline financial projections for the health care organization should be prepared. Whereas the capital position analysis helps quantify the gap between cash flow targets and historical performance, this step is designed to develop initial estimates of the projected gap between the baseline financial results and the capital capacity generation required to remain fiscally stable *and* achieve long-term capital access. The baseline projection depicts the organization's financial trajectory over the plan period, absent major management interventions such as the cost-restructuring or strategic-repositioning initiatives described later.

The business model change puts even more emphasis on the need for objective, conservative baseline modeling to create a valid foundation for the more uncertain modeling needed to evaluate impacts of the shift to value-based payment. Certain aspects of value-based payment are readily definable with specific expectations relative to the timing in which they will occur. Other changes, such as shifts to private exchanges, bundled payments and types of payment-for-quality arrangements, are more of a moving target. In their modeling, health care organizations should clearly identify what they “know” and what they do not know. At this time, financial modeling is more about ranges of outcomes and probabilities than it is about absolutes.

In establishing baseline financial projections, hospital and health care system executives should be aware that “status quo” baselines are no longer appropriate, especially as those projections relate to future inpatient and outpatient volumes. Initial projections must be developed conservatively, incorporating currently known values and assumptions. In today's health care environment, typical baseline financial projections should include challenges to utilization and revenue streams, and significant investment in core competencies—the result often is deteriorating financial performance.

Since fee-for-service payment continues to constitute a large portion of provider revenue, maintaining that payment structure in the baseline projections makes sense. At the same time, the projections also must incorporate anticipated changes to utilization and revenue streams, as well as necessary investment related to physician integration, sophisticated IT, care coordination, and other new, required competencies² that likely will challenge and diminish financial performance. Revenues and expenses should be projected using inputs from across the health care organization, including finance, strategy, clinical operations and executive management.

Setting the Revenue Side of the Equation

Hospital revenue growth has slowed considerably and is projected to continue to be very modest.³ Inpatient use rates are declining significantly in many areas of the country and outpatient use rate growth is diminishing and is projected to flatten.⁴

Conservative revenue projections are especially essential given the impending shift to value-based payment. A realistic understanding of the health care organization's current market position is critical. Local, state and national patient utilization, as well as other patient volume-related data sources, should be accessed to determine how the organization compares to other hospitals and health care systems. Such data can provide valuable information on whether projected revenue and utilization from select payers and patient classifications should be higher or lower.

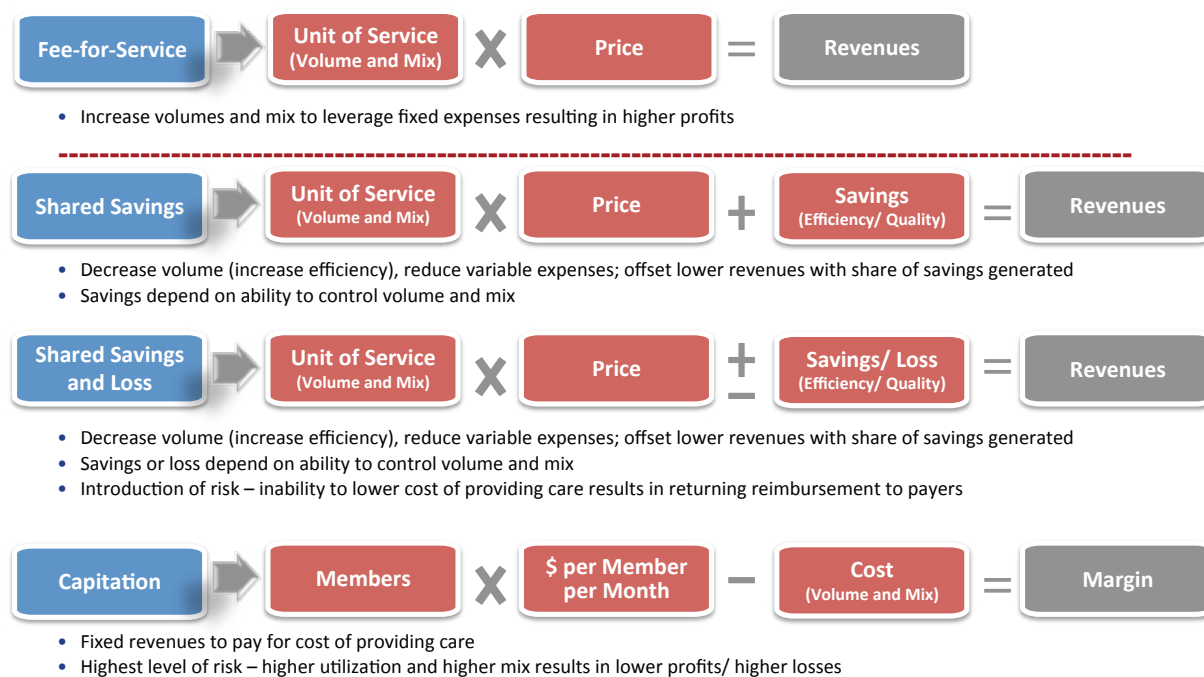
Projected revenue increases or decreases must be specified by payer. Some payers may aggressively shift to value-based payments, either in the form of lump sum or bundled payments, or percentage increases (“inflation kickers”) tied to quality metrics. This “new math” for payment arrangements could have

significant implications for organizations (Figure 4) and will vary significantly by payer and by market.⁵ Maintaining specificity in payer revenues will support the vital revenue-related sensitivity analysis described later.

Health care leaders also should incorporate both the known and unknown revenue effects of health care reform. These include, but are not limited to:

- Pressures on payment rates, such as a recent slowing in Medicare rate increases to about 1 percent per year, compared to approximately 3 percent per year historically
- The impact of having a larger Medicaid population in states that are expanding coverage, and the lack of Medicaid expansion in states that are not
- Changes in payer mix from public and private exchanges, accounting for uninsured individuals who may gain coverage and for the increasing number of people insured through traditional commercial plans who are anticipated to move to exchange plans
- The impact on bad debt and uncompensated care as a result of the aforementioned shifts in coverage

Figure 4. The New Math for Payment Arrangements



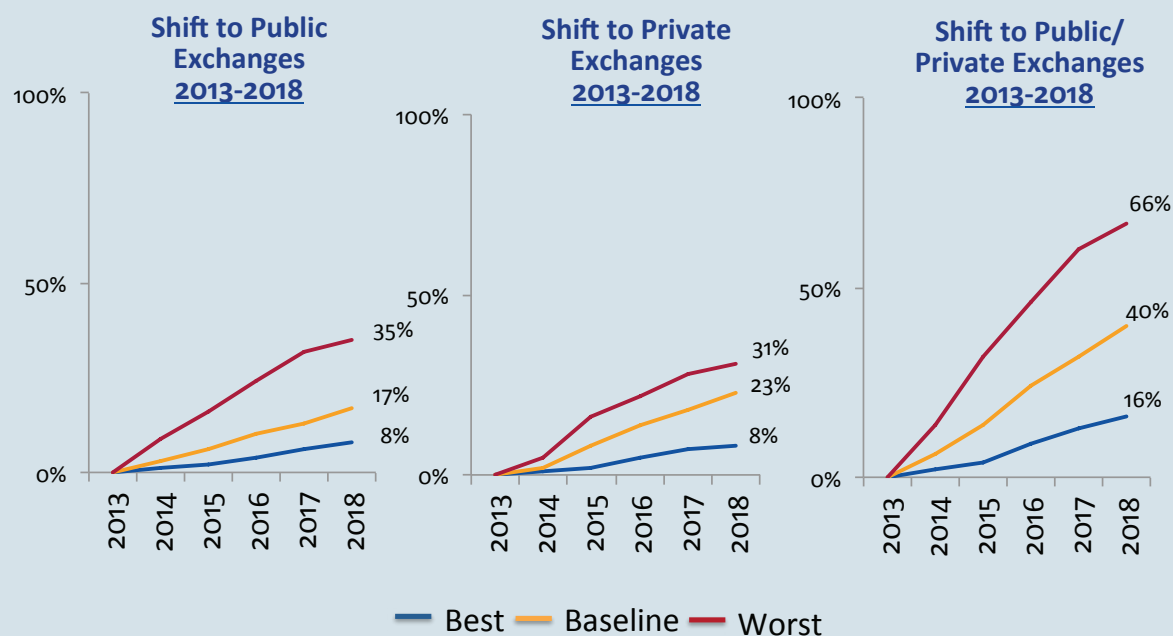
Source: Kaufman, Hall & Associates, Inc., 2014.

Example: Identifying Best- and Worst-Case Scenarios

Figure 5 shows the baseline, best-case and worst-case projected impact on a sample hospital of a range of assumed changes in payer mix, resulting from a projected shift of commercially insured patients into public and private exchanges. The underlying analysis that created the range of scenarios incorporated the health care organization's specific market dynamics, including employer profiles, likelihood of employers moving employees into exchanges, and the relative sizes of the commercial and noncommercial markets. Although the impact of the shift will vary based on exchange uptake rates, market share, and contract rates for individual exchange products, this type of analysis provides a good "order of magnitude" assessment.

In this example, the best-case scenario for the hospital would result in a 16 percent shift of its commercial lives to exchange products; in the worst case, the shift would be 66 percent. Using these scenarios as bookends, the health care organization was able to evaluate the potential timing for such shifts and the impact on its payer mix. A final analysis applied a range of payment levels to the exchange-covered population to quantify the potential impact on financial performance and capital capacity. The focus of this analysis was not on a single projection, but rather on a range of potential outcomes around which proactive initiatives could be developed and implemented to address the financial impacts.

Figure 5. Anticipated Shift of Commercial Lives to Public and Private Exchanges



Source: Analysis by Kaufman, Hall & Associates, Inc., 2014.

Many organizations may see fluctuations in volume-based payment rates from public and private health insurance exchanges and government payers. Declines in commercial revenue likely will be particularly significant, as employers and payers negotiate and test new plan models designed to lower health care costs. In markets with more managed care penetration, volumes of emergency visits and utilization of other higher cost facilities and procedures may be expected to decline as a result of more effective population health management.

Walmart, Lowe's and other large employers joined an alliance to launch a "centers of excellence network" for employers. The network has contracted with four leading health care systems for knee- and hip-replacement surgeries for more than 1.5 million employees and their dependents. Walmart also has bundled-fee arrangements with six leading hospitals and health care systems to provide heart, spine and transplant surgeries to its employees, and Lowe's has similar arrangements with the Cleveland Clinic for employees' cardiac and spine-related surgeries.⁶

The potential impact of these types of national initiatives on an individual organization that does or does not participate in such arrangements must be fully evaluated, factoring in employers in the market area and the organization's service-line focus.

Building the Expense Side of the Equation

Building expense assumptions into the baseline projections is the foundation upon which health care leaders can identify the level of ongoing cost management necessary to maintain competitive financial performance. This process includes defining appropriate assumptions related to the fixed versus variable component of each expense category and applying inflation assumptions to the underlying unit costs.

For example, an organization would want to create separate assumptions for merit and cost-of-living increases in its salary and wage assumptions, the rising cost of benefits such as health insurance, or decreased maintenance costs from an ongoing initiative to lower energy expenses. This in-depth exercise allows executives to develop a clearer picture of the effect of cost pressures on the organization's ability to operate at sustainable financial levels. A more specific assumption set also supports more directed quantification of organizational expense reduction targets—a current management imperative.

To position themselves for managing the health of a specific population, many organizations are employing physicians and acquiring physician practices.⁷ Many of those organizations also are experiencing substantial operating losses associated with these physician strategies. Losses may result from poor contract terms, disproportionately high compensation or practice expenses, decreasing payment for physician services, insufficient provider productivity or rising technology costs. According to data from the Medical Group Management Association, the median loss to a health system per full-time equivalent employed physician is about \$176,000 per year.⁸

As hospitals and health care systems plan for future growth and move toward population health management for their communities, the effect on revenue of a shift to value-based payment under partial or full capitation arrangements must be an area of financial planning focus. As such arrangements are undertaken, services provided will represent an expense rather than revenue. Major strategic initiatives related to cost restructuring are described later.

Building the Balance Sheet and Cash Flow Requirements

To develop balance sheet and other cash flow requirement projections, finance executives at hospitals and health care systems need to develop different assumptions for the major components of the balance sheet. For the working capital components, specific historic ratios—which describe the timing for the organization to convert its working capital into revenue or expense—can be applied and ongoing or planned initiatives incorporated (i.e., revenue cycle improvement) to reflect how those efforts may affect these ratios. For instance, a hospital may anticipate that its days in accounts receivable will decline in future years due to an initiative to speed up collections by offering patients multiple payment options. To reflect this initiative, a specific change to assumed levels of days in accounts receivable can be made.

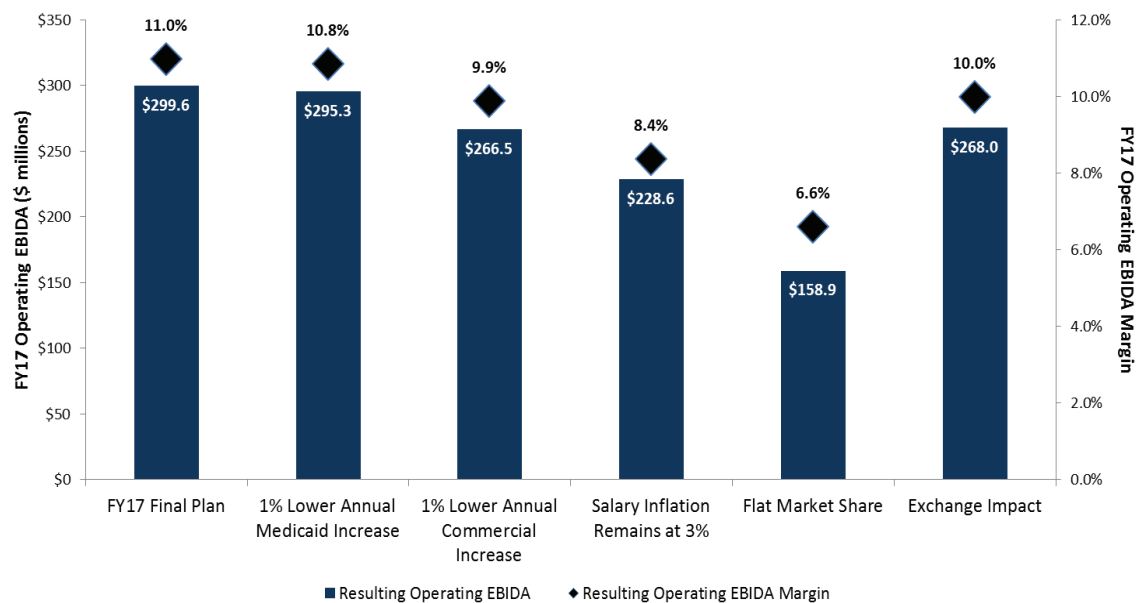
The baseline projections also should incorporate basic, ongoing capital needs exclusive of major strategic investments (which will be quantified and built into the financial plan in a later phase), and include the cash flow and balance sheet effects of known debt and/or lease financings. Many health care organizations also need to account for additional pension obligations not already included in benefits expenses. Other known factors that could impact the balance sheet moving forward, such as pending legal or transaction costs or use of restricted assets, also should be integrated.

Considering Risk

Given high uncertainty in the field, health care executives should comprehensively identify elements of strategic, financial and operational risk, and incorporate in their planning risk scenarios related to alternative income statement, balance sheet and cash flow metrics. This will allow them to quantify the impact each risk scenario would have on organizational capital capacity over time, and further support development of contingency plans to address the identified risks and ensure continued high-value patient care.

Figure 6 illustrates the results of scenario testing at one health care organization showing the impact on EBIDA (Earnings Before Interest, Depreciation and Amortization) dollars and margin, and on days cash on hand, of alternative assumptions including lower Medicaid and commercial payment increases, stable salary inflation, flat market share, and revenue from exchanges. Each of these sensitivities is calculated independently of the others, so additional scenario testing that combines variables might be valuable as well.

Figure 6. Scenario Analysis with Independent Variables



FY2017

Days Cash	179.5	177.6	164.5	144.5	137.6	165.3
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Note^(A): All sensitives are calculated independently of each other.

Source: Analysis by Kaufman, Hall & Associates, Inc., 2014.

Sidebar 4. Scenario/Sensitivity Checklist Related to Health Reform

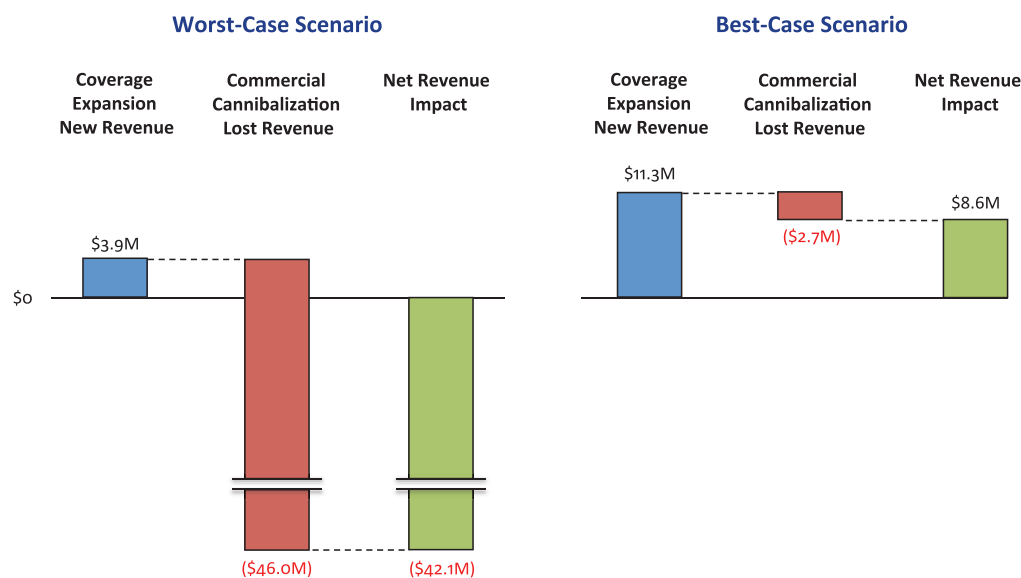
Scenario and sensitivity analyses of the following factors can help hospitals and health care systems better gauge the impact of health reform:

- Inpatient admissions trends
- Outpatient visits trends
- Emergency department visits trends
- Impact of private exchanges on payer mix
- Impact of public exchanges on payer mix
- Impact of Medicaid expansion
- Annual commercial insurance rates
- Inclusion/exclusion from narrow networks
- Medicare payment rates (market basket factor, disproportionate share payments, penalties)
- Medicaid payment rates
- Market share increases/decreases
- Increase/decrease in bad debt and uncompensated care (expanded coverage, but higher co-pays and deductibles)

Source: Kaufman, Hall & Associates, Inc., 2014.

Figure 7 illustrates worst- and best-case scenarios related to the net revenue impact of a projected shift of commercial lives to health care exchanges, as shown in Figure 5. After completing the steps outlined here, most organizational analyses indicate that the baseline is indeed no longer status quo and that any solution set must include some or all of the types of major strategic initiatives described next to create long-term sustainability.

Figure 7. 2018 Net Revenue Impact by Scenario



Source: Analysis by Kaufman, Hall & Associates, Inc., 2014.

Sidebar 5. Sources of Risk

Hospitals and health care systems face four key sources of risk in preparing for a value-based business model. Descriptions of each category and examples follow.

Strategic and operational risk involves an organization's ability to build the competencies for the new business model, such as a robust and high-performing delivery network for patients and risk-management infrastructure. The ability to generate sufficient capital and effectively manage risk allocation is critical.

Examples:

- Unexpected competition from new market entrants
- Performance of care-continuum partners
- Known and unknown impacts of health care reform

Actuarial or insurance risk is the ability to properly estimate use rates and costs for serving a defined population under a value-based contract, and mitigating risk of inaccurate projections. Health care organizations should be able to meet capital reserve requirements for assuming risk.

Examples:

- Fluctuations in patient utilization
- Impact of public and private health insurance exchanges (i.e., changes in payer mix and/or shift in composition of patient population)

Financial/asset and liability risk is incurred due to the significant capital required to build the infrastructure for value-based care, including technology, physician networks and care-management resources. As health care organizations invest in such areas, their ability to invest in other traditional uses is restricted.

Examples:

- Cost of building capital structure
- Credit-enhancement initiatives

Comprehensive risk refers to the combination of all the component risks listed here, and their aggregate effect on the organization. Such risk can undermine a hospital or health care system's strategies, market position, financial performance and, ultimately, its ability to serve its community.

Examples:

- Declining or flat market share
- Failure to make appropriate investments in needed competencies/resources

Health care leaders must understand how their organization's single and comprehensive risk profiles stack up to its ability to handle that risk, and make necessary adjustments to balance these components.

Source: Kaufman, Hall & Associates, Inc., 2014.

Incorporating the Impact of Cost Restructuring and Other Major Strategic Repositioning Initiatives

Baseline projections typically reveal sizable performance gaps relative to an organization's strategic capital requirements. Working from a realistic baseline plan, leaders therefore must incrementally test the impact of specific major strategies or changes on the organization's ability to bridge the gap between projected results and target performance goals. This iterative process quantifies the implications of each strategy or combination of strategies, ultimately enabling executives to define an optimal portfolio of strategies that moves from baseline projections to a sustainable financial plan.

To continue meeting community health care needs in the new delivery and payment environment, hospital and health care system leaders will need to think and act strategically about managing cost. A completely new cost curve will be required of hospitals in the rapidly developing environment of lower utilization, payment and revenue.⁹ Bending the cost curve through traditional cost management approaches that remove 5 to 10 percent of costs likely will not suffice. Substantially more operating costs must be removed and removed permanently, driving down present and future expenditures to lower health care spending. This will require identification, quantification and implementation of much broader and more difficult operating initiatives affecting service offerings and market positioning.

To close the gap identified through the analyses described up to this point, health care leaders should focus on a potential solution set that includes:

1. Traditional cost management initiatives, plus:
2. Facilities planning and IT initiatives
3. Business/service line rationalization
4. Potential partnership synergies

A description of each follows.

Cost Management Initiatives

A first step in addressing the performance gap should focus on opportunities to improve the efficiency of existing operations or services, including both labor and nonlabor expenses. While these areas historically have been the emphasis of performance improvement efforts, health care organizations must continue to engage in regular evaluation and monitoring of these costs.

Labor Savings

Labor costs typically constitute more than half of a hospital or health care system's operating expenses. Benchmarking against both external sources and internal historical data provides a valid starting point for health care leaders to identify opportunities to reduce labor expenses. This type of evaluation is especially effective using compensation ratios, staffing metrics and productivity drivers. In addition to benchmarking to other organizations, it is important that a health care organization benchmark against itself as a means to maintain its highest levels of productivity.

Staffing metrics can be evaluated to identify opportunities to reduce labor costs in multiple areas. Measuring the difference between operating efficiency at peak patient volumes versus average volumes often leads to a finding of excess staff capacity. Significant savings can be realized by realigning staffing to better correspond to patient demand, thereby ensuring maximum efficiencies at various volume levels.

Another area of frequently identified cost-reduction opportunity is excessive or duplicative departmental overhead. Health care organizations may reduce labor expenses through initiatives to better target workloads and assignments, minimize the use of overtime and premium labor through cross-training, or reduce functional redundancies across facilities.

Example: Regional Health System Eliminates HR Redundancies

As part of its cost management efforts, a five-hospital health care system evaluated administrative services systemwide and found significant duplication within its human resources functions. By eliminating such duplication and reducing excess capacity, including relocating several human resources functions to regional or system-level offices, the health care system realized full-time equivalent savings of \$6 million.

Source: Kaufman, Hall & Associates, Inc., 2014.

Nonlabor Savings

Initiatives to improve nonlabor costs should include goods, supplies, physician preference items, purchased services and logistics, among other items. Again, benchmarks can be used to compare costs as a percentage of revenues to standards in the field. Health care organizations can analyze their purchase order and accounts payable files to assess where and how money is being spent and identify potential savings. This might indicate opportunities to renegotiate a food or cleaning service contract, for example, or eliminate costly physician preference items. In one case, a southeastern academic medical center saved enough money by addressing usage of contrast media to buy a new MRI every other year.

Engaging clinicians in product and service line decisions is essential. Using solid outcomes research to guide the decision-making process also is helpful, as the case for making a change in products and services should be based on both financial and clinical outcomes criteria and data.

Example: Community Hospital Cuts Cost by Reducing Device Variation

Based on a review of its cardiac surgery program, a Midwestern community hospital identified wide variations in the costs of devices preferred by different cardiologists for electrophysiology tracking. By getting the cardiologists to agree to use a common device, the hospital was able to save an estimated \$665,000 annually.

Source: Kaufman, Hall & Associates, Inc., 2014.

Facilities Planning and IT Initiatives

Operating and functional inefficiencies commonly exist due to age and design of facilities. Once facility deficits are identified, the strategic focus should be on quantifying the costs associated with improving the existing space, converting unneeded capacity to new functions, and/or creating new space to allow the health care organization to meet new patient needs.

IT initiatives, which can require significant capital, also should be scrutinized to ensure that assumed or proposed levels of expenditures are appropriate. Each proposed project should undergo standardized and thorough business planning analyses and then be evaluated comparatively as part of a portfolio through a comprehensive capital allocation process.

Example: Opportunity Found in Converting Old Facility to Meet New Needs

In evaluating its facilities, one health care system determined that it could save at least \$6 million annually in fixed costs by converting an aged, under-used inpatient facility into an ambulatory surgery center with an emergency department and some observation beds.

The facility was located relatively close to the health care system's tertiary hospital, so there was some concern that the converted facility would draw patients away from the main hospital. But additional scenario modeling showed that repurposing the facility would benefit the organization and the community overall. A negative impact would occur only if the outpatient center drew more than 50 percent of the hospital's patient volumes—a scenario that was deemed highly unlikely.

Source: Kaufman, Hall & Associates, Inc., 2014.

Cost Restructuring Through Business/Service Line Rationalization

With an increasing emphasis on value versus volume, a health care organization's inpatient and outpatient service delivery network must be much more efficient and effective, and its cost platform much lower.

To generate viable bottom-line results and competitive financial performance, health care organizations must reassess the scope of their businesses and services to determine how best to distribute them to meet community needs. Within the strategic financial planning process, this involves quantifying the impact of strategies related to maintaining or divesting of noncore businesses—including the associated savings or costs (both direct and indirect) and the incremental effect on operations.

Applying a standard and rigorous framework is helpful in analyzing how each business or service line fits into the organization's overall mission, operations and future strategic needs. Health care leaders must consider the total value of the business or service line, whether it represents the best use of resources, and how it effects the organization's competitive position and financial performance.

Health care organizations also should thoroughly evaluate potential investments in specific services, quantifying the net incremental impact of hiring more physicians in order to capture additional market share. One health care organization assessed the net operating impact of each of its service lines, quantifying the expense and revenue effect of achieving increased market share through defined strategies over a five-year period. Figure 8 indicates the high degree of variation in net operating impact by service line.

Figure 8. Quantifying the Financial Impact of Service Line Strategies (millions)

Service Line Analysis	Total Market Cases	Current Market Share	Contribution Margin Impact of 1% Move in Market Share	Expected increase in share over 5 yrs in %	Estimated Contribution Margin (Incremental to Baseline)	New Physicians Needed to Support Case Growth	Annual Subsidy Per Doc	Total Annual New Physician Cost to Support	Net Operating Impact
	A	B	C	D	F (QdX100)	H	I	J(HxI)	(F-J)
Interventional Cardiology	890	64.2%	\$ 61,989	6%	\$ 371,931	-	\$ -	\$ -	\$ 371,931
Cardiology Medical	5,153	73.2%	\$ 137,585	7%	\$ 963,096	-	\$ -	\$ -	\$ 963,096
General Medicine	3,384	68.0%	\$ 132,484	7%	\$ 927,385	-	\$ -	\$ -	\$ 927,385
Vascular Surgery	1,117	61.6%	\$ 63,032	14%	\$ 857,239	2	\$ 200,000	\$ 400,000	\$ 457,239
Cardiac Electrophysiology	517	52.0%	\$ 26,439	18%	\$ 475,909	1	\$ 100,000	\$ 100,000	\$ 375,909
Psychiatry	3,176	59.6%	\$ 67,490	10%	\$ 701,896	1	\$ 50,000	\$ 50,000	\$ 651,896
Urology	739	60.4%	\$ 31,873	10%	\$ 318,731	1	\$ 100,000	\$ 100,000	\$ 218,731
Otolaryngology	562	56.6%	\$ 14,230	13%	\$ 190,680	1	\$ 100,000	\$ 100,000	\$ 90,680
General Surgery	3,028	50.8%	\$ 205,753	19%	\$ 3,909,299	2	\$ 150,000	\$ 300,000	\$ 3,609,299
Cardiac Surgery	514	41.1%	\$ 87,401	29%	\$ 2,525,876	1	\$ 100,000	\$ 100,000	\$ 2,425,876
Orthopedic Surgery	3,305	49.7%	\$ 224,905	20%	\$ 4,498,105	1	\$ 200,000	\$ 200,000	\$ 4,298,105
Gynecology	884	46.6%	\$ 28,624	15%	\$ 429,359	1	\$ 100,000	\$ 100,000	\$ 329,359
Thoracic Surgery	624	48.6%	\$ 73,869	21%	\$ 1,551,252	1	\$ 100,000	\$ 100,000	\$ 1,451,252
Spine	1,031	28.1%	\$ 72,768	42%	\$ 3,056,255	2	\$ 200,000	\$ 400,000	\$ 2,656,255
Neurosurgery	292	6.5%	\$ 33,113	23%	\$ 761,594	1	\$ 200,000	\$ 200,000	\$ 561,594
Total Estimated Annualized Impact of Strategy									\$ 19,388,607

Source: Kaufman, Hall & Associates, Inc., 2014.

Hospitals play a critical role in providing a variety of services for communities that other entities cannot, but finding the best balance of services for the organization and access for patients is essential. Strategies to redistribute existing services and evaluate a health care organization's overall assets portfolio are increasingly important elements of comprehensive financial planning. In both cases, the analytics should be targeted at quantifying the impact of consolidating services and/or establishing centers of excellence meant to generate increased efficiency (lower cost) and more appropriate care access (improved quality).

Example: Divestitures Allow AMC to Refocus on Primary Goals

An academic medical center evaluated the financial performance of each of its service lines and business units, including projections of volumes, revenue, expenses and contribution margins. Sensitivity and scenario analyses, which were focused on identifying and evaluating the key performance drivers, generated a range of possible future trajectories.

Through this process, the academic medical center determined that it could not sustain high service quality at its home health business given the economics of the business as operated under its auspices. Management decided to divest the home health business to a specialty company that could maintain quality service on a profitable basis, allowing the academic medical center to redirect capital capacity to other vital initiatives.

Source: Kaufman, Hall & Associates, Inc., 2014.

Identifying and Quantifying the Impact of Potential Partnership Synergies

For many health care organizations, the financial planning process also should include evaluation of the impact of alternative strategic affiliation options, including acquisitions, mergers, divestitures, shared-service arrangements or partnering with a payer to move toward value-based payment. This additional layer of analysis typically is necessary when an organization has analyzed all scenarios and initiatives aimed at “navigating the gap” on its own, and determined that it cannot resolve the challenges without strategic and/or financial assistance.

Identifying the appropriate affiliation strategy is an in-depth process that must be grounded in traditional strategic and financial planning principles. Careful and comprehensive evaluation and execution planning are required to ensure realization of anticipated benefits and synergies. Synergies can include operating cost savings, improved capital access, enhanced clinical alignment, improved market position, and the ability to share best practices to improve quality metrics.

A high-level assessment of the benefits offered by multiple potential partnerships (Figure 9) can provide a good starting point.

Figure 9. A High-Level Assessment of Partnership Options

Key Success Requirements	Strategic Alternatives				
	Stand Alone	Option 1	Option 2	Option 3	Option 4
Integrated service delivery and care coordination	○	●	○	●	●
Risk sharing and management	○	●	○	○	●
Physician engagement and leadership	●	●	○	●	●
Primary care network development	●	●	○	○	●
Process re-engineering and sustainable cost structure	●	●	○	○	●
IT connectivity and platform development	●	●	○	○	●
Sustainable financial performance and access to capital	○	●	○	○	●

Ability to advance critical success factor: ○ Limited ● Fair ● Good

Source: Kaufman, Hall & Associates, Inc., 2014.

If a preferred potential partner is identified, the organization(s) can pursue more detailed analyses and develop a business case for the partnership. This typically will include:

- A thorough analysis of each organization’s current financial position based on market and industry realities
- The pro forma financial and market impacts of a combined, new entity
- Quantification of the potential incremental improvement to be achieved by a combined organization

For example, a small stand-alone hospital in the Northeast developed an integrated strategic-financial plan that indicated that remaining independent was not a sustainable option due to the magnitude of cost reductions required and lack of available, realistic strategies to support long-term financial strength. As a result, the hospital sought a partnership with a larger health care organization that would provide the necessary capital and cost infrastructure support, putting it on solid footing to continue serving the community through various joint strategic initiatives.

Alternatively, one health care system's strategic financial plan indicated significant challenges related to retaining market share and growing volume. While the financial planning analytics clearly indicated that the system did not require capital support, it would benefit significantly from an affiliation that could enhance public perception of the value and quality it provided to the community. As a result, the organization sought a partner with a strong clinical brand to bolster its market position.

By conducting multiple analyses incorporating different variables, potential partners can begin to quantify the anticipated pros and cons of the proposed combination. From that point, baseline projected performance for each organization—including creditworthiness and debt capacity—on an independent basis can be developed to assess the long-term financial trajectory of the combined entity. Finally, the potential for improved performance and capital access as a combined system can be quantified and assessed to ensure the highest value care, and access to services for the communities they serve.

Example: Projecting Financial Synergies of a Proposed Merger

Figure 10 illustrates the potential synergies that could be achieved through the merger of two health care systems. Independently, each health system was projected in fiscal year (FY) 2016 to achieve operating margins of only 2.2 percent and 2.0 percent, resulting in capital access of \$299 million and \$40 million, respectively.

Under a merged scenario in which targeted baseline savings of \$83 million were achieved, the combined, pro forma operating margin would increase to 3.7 percent, and capital access would increase significantly to \$864.1 million. If the newly joined organization met higher identified savings, its operating margin and capital access would increase further.

Figure 10. Financial Impact of Potential Merger

Key Target	Fiscal Year 2016				Moody's 'A2' Level
	System #1 Independent	System #2 Independent	Combined Systems at Baseline Savings (\$83M)	Combined Systems at High Savings (\$147M)	
Operating Margin	2.2%	2.0%	3.7%	5.5%	3.1%
Op. EBIDA Margin	9.9%	10.1%	12.1%	13.9%	9.7%
Days Cash on Hand	172.6	151.8	201.6	222.4	168.8
Debt to Capitalization	38.5%	45.9%	40.6%	38.7%	37.9%
Capital Access	\$299M	\$40M	\$864.1M	\$1.2B	----

Source: Kaufman, Hall & Associates, Inc., 2014.

Understanding and Testing the Impact of Planned Strategies

The financial planning process next should shift focus to assess the impact of alternative portfolios of the identified strategic initiatives on the organization's financial outlook. This is accomplished by integrating the strategies—both one at a time and in a number of groupings and timelines—to test whether the projected net impact would create sufficient incremental financial benefit to support organizational sustainability. Health care leaders should be mindful that there may be some overlap in the benefits of alternative strategies and strive not to double-count such benefits.

This planning process enables health care leaders to determine the risks associated with moving to strategies at various levels and speeds. The timing of when to move forward with a specific initiative will be based on numerous factors, including the organization's capabilities, priorities, financial position and risk tolerance, and what is happening in its respective market. The faster the market is moving toward value-based care, the faster health care organizations will want to implement initiatives aimed at adapting to the new business model. Figure 11 summarizes, in credit profile format, one health care organization's consolidated outlook with the inclusion of its preferred strategic portfolio.

Once the organization settles on its preferred strategic solution set (including operating, capital and market initiatives) designed to ensure sustainability and high-value patient care, the final and perhaps most important analytic component of the financial planning process begins—evaluation of risk. Thorough risk evaluation requires developing analyses to identify “vulnerable variables” driving projected outcomes, and to inform the various constituencies of the quantified risk parameters inherent in the plan.

Figure 11. Financial Profile Incorporating Major Strategic Initiatives

Ratio / Statistic	Moody's ^(A)			Historical			Projected				
	A3	Target	Minimum	2012	2013P	2014B	2015	2016	2017	2018	2019
Net Patient Service Revenue	\$391.9	---	---	\$456.0	\$441.3	\$449.3	\$456.1	\$464.7	\$473.2	\$481.7	\$490.2
Cash Operating Expenses*	---	---	---	\$441.4	\$447.3	\$454.5	\$453.1	\$457.1	\$463.3	\$469.6	\$476.1
Operating Income	\$8.2	---	---	\$3.5	(\$14.5)	(\$0.0)	\$4.5	\$4.9	\$6.0	\$6.9	\$8.0
Operating EBIDA	\$41.2	---	---	\$37.5	\$23.8	\$37.0	\$44.0	\$45.7	\$48.5	\$51.0	\$53.4
Net Income	\$17.7	---	---	\$7.9	(\$9.2)	\$16.1	\$16.7	\$16.3	\$17.1	\$17.8	\$19.4
Cash Flow (Net Inc + Depr)	\$40.5	---	---	\$38.6	\$25.7	\$49.8	\$51.5	\$52.5	\$55.1	\$57.7	\$60.8
Unrestricted Cash	\$194.2	---	---	\$234.1	\$226.1	\$231.3	\$198.2	\$200.2	\$186.2	\$194.1	\$204.4
Total Debt	\$158.3	---	---	\$114.7	\$125.8	\$127.4	\$83.7	\$79.9	\$75.9	\$71.7	\$67.3
Capital Expenditures	\$29.1	---	---	\$58.3	\$41.3	\$44.7	\$38.0	\$44.0	\$60.0	\$40.0	\$42.0
Profitability											
Operating Margin	1.9%	5.0%	2.0%	0.7%	(3.1%)	(0.0%)	0.9%	1.0%	1.2%	1.3%	1.5%
Operating EBIDA Margin	10.0%	12.0%	10.0%	7.9%	5.1%	7.6%	8.9%	9.2%	9.6%	9.9%	10.2%
Debt Position											
Debt Service Coverage (x)	4.2	4.5	3.5	12.8	4.3	6.2	1.2	6.7	7.0	7.3	7.6
Total Debt to Capitalization	41.0%	35.0%	45.0%	31.7%	31.7%	30.7%	21.6%	20.0%	18.4%	16.8%	15.2%
Liquidity											
Cash to Total Debt	112.7%	150.0%	110.0%	204.1%	179.7%	181.5%	236.8%	250.7%	245.4%	270.8%	303.6%
Days Cash on Hand (days)	175.9	200.0	175.0	193.6	185.0	185.7	159.7	159.9	147.1	150.9	156.7
Other											
Capital Spending Ratio	113.6%	120.0%	100.0%	189.6%	120.1%	133.0%	109.0%	121.6%	157.9%	100.4%	101.5%
Compensation Ratio	---	---	---	59.7%	63.2%	62.7%	61.4%	60.9%	60.8%	60.8%	60.8%

Source: Kaufman, Hall & Associates, Inc., 2014.

The foundation for the risk assessment is sensitivity and scenario analyses, performed to generate results—including impacts on the organization’s ability to achieve targets—that can be compared directly to the plan results. Figure 12 indicates the potential risks over a three-year period under different scenarios assuming that the health care organization achieved only 50 percent of the desired benefits of its cost management, facility reconfiguration, service line redistribution and affiliation strategies. Clearly, this represents broad-brush sensitivity, but it is indicative of the range, specificity and intensity of risk analysis that can be performed. Even this high-level approach to risk analysis provides important and actionable information for management decision making. Given these results, management likely will want to focus the analysis more specifically on individual aspects of the plan.

Understanding the risk associated with a strategic financial plan enables leadership to establish appropriate key performance indicators and develop specific action plans to mitigate the impact of actual performance that is materially different than has been projected.

Figure 12. Testing the Strategies Through Risk Analysis

Sensitivity/Risk Analysis	Target Goal	Minimum Threshold	Year 1	Year 2	Year 3	Variance from Year 3
Strategic Plan						
Operating Margin	5.0%	2.0%	0.9%	1.0%	1.2%	N/A
Operating EBIDA Margin	12.0%	10.0%	8.9%	9.2%	9.6%	N/A
Debt to Capitalization	35.0%	45.0%	21.6%	20.0%	18.4%	N/A
Days Cash on Hand	200.0	175.0	159.7	159.9	147.1	N/A
Cost Management Initiative at 50%						
Operating Margin	5.0%	2.0%	0.7%	0.8%	0.9%	(0.3%)
Operating EBIDA Margin	12.0%	10.0%	8.5%	8.7%	8.9%	(0.7%)
Debt to Capitalization	35.0%	45.0%	21.7%	20.1%	18.5%	0.1%
Days Cash on Hand	200.0	175.0	155.7	155.9	143.1	(4.0)
Facility Reconfiguration at 50%						
Operating Margin	5.0%	2.0%	(1.1%)	(1.0%)	(0.8%)	(2.0%)
Operating EBIDA Margin	12.0%	10.0%	6.4%	6.7%	7.1%	(2.5%)
Debt to Capitalization	35.0%	45.0%	24.6%	23.0%	21.4%	3.0%
Days Cash on Hand	200.0	175.0	139.7	139.9	127.1	(20.0)
Service Line Strategy at 50%						
Operating Margin	5.0%	2.0%	(0.1%)	(0.0%)	0.2%	(0.7%)
Operating EBIDA Margin	12.0%	10.0%	7.4%	7.7%	8.1%	(0.8%)
Debt to Capitalization	35.0%	45.0%	22.1%	20.5%	18.9%	0.5%
Days Cash on Hand	200.0	175.0	149.7	149.9	137.1	(6.0)
Partnership Evaluation at 50%						
Operating Margin	5.0%	2.0%	0.8%	0.9%	1.1%	(0.1%)
Operating EBIDA Margin	12.0%	10.0%	8.9%	9.2%	9.6%	0.0%
Debt to Capitalization	35.0%	45.0%	27.5%	25.9%	24.3%	5.9%
Days Cash on Hand	200.0	175.0	185.4	185.6	172.8	25.7

Source: Kaufman, Hall & Associates, Inc., 2014.

Conclusion

A robust strategic financial planning process is imperative for hospitals and health care systems in the current environment. The planning process links operational strategies to the reality of organizational financial and capital capacity. Identifying a baseline financial trajectory and layering on the projected impacts of core strategies provides leadership with an objective means to determine the most fiscally responsible approach going forward. Strategies and results, performance targets and risk analyses developed as part of the financial plan enable health care organizations to maximize strategic and financial goals within the context of maintaining ongoing access to external capital and ensuring the continued provision of high-value care to the communities they serve.

Developing a strategic financial plan is not a “one-and-done” process. The process requires vigilant monitoring, flexibility and updating as markets evolve and strategies are implemented. To support this organic process, health care organizations should develop mechanisms to continually revisit and monitor performance compared to plan projections. Monthly or quarterly review is recommended to keep pace with changes in the field.

Uncertainty is prevalent in the current environment, and unforeseen circumstances—such as the emergence of a new market competitor or an economic downturn—may intervene to disrupt even the best laid plans. As outlined in this guide, using a disciplined decision-making platform that applies core corporate planning fundamentals provides hospitals and health care systems with the ability to measure continuing performance, anticipate potential problem areas, and make informed decisions to change course as needed to ensure sustainability and success into the future.

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Mr. Sussman is the author of *The Healthcare Executive's Guide to Allocating Capital*, which was published in 2007 by Health Administration Press, the publishing arm of the American College of Healthcare Executives (ACHE). In addition, he has authored articles for various industry periodicals, including *hfm* magazine, *Strategic Financial Planning*, and others, and was a contributing author to *Best Practice Financial Management: Six Key Concepts for Healthcare Leaders, Third Edition* and *The Financially Competitive Healthcare Organization*. Mr. Sussman received a Helen Yerger/L. Vann Seawell Best Article Award from the Healthcare Financial Management Association (HFMA) for "Ensuring Affordability of Your Hospital's Strategies." He co-authored this article, which appeared in the May 2009 issue of *hfm* magazine.

Mr. Sussman is a frequent presenter at national and regional seminars sponsored by the HFMA and its chapters, ACHE, the American Hospital Association, numerous state hospital associations, the National Association of Children's Hospitals and Related Institutions, and other industry organizations.

Mr. Sussman received an MBA in finance and accounting with a specialization in health care management from Northwestern University's J.L. Kellogg Graduate School of Management and a BA from the Johns Hopkins University. He holds a CPA certificate in Illinois.

Brian R. Kelly is the executive vice president and chief financial officer at Excelsa Health in Greensburg, Pa. His responsibilities include overseeing the health system's financial operations, including evaluating, planning, and implementing financial strategies to ensure the long-term fiscal health of the organization.

Before joining Excelsa, Mr. Kelly was a senior vice president of Kaufman Hall and a member of the firm's Strategic Financial and Capital Planning practice. In that role, he worked with dozens of health care systems in developing financial, strategic, and capital plans, assessing joint venture, partnership, and affiliation options, and advising on merger, acquisition, and divestiture transactions.

Prior to Kaufman Hall, Mr. Kelly was a director of finance and business development at the University of Pittsburgh Medical Center, where he focused on the evaluation and execution of strategic business initiatives. Prior to this, he held positions at Arthur Andersen and Huron Consulting Group.

Mr. Kelly is a regular speaker at health care industry conferences, including those sponsored by the Healthcare Financial Management Association (HFMA) and state hospital associations. He has presented on numerous topics ranging from the changing health care industry to the challenges of financial planning in distressed economic environments. Mr. Kelly also has been a contributing author for several industry thought leadership pieces in publications including HFMA's *Healthcare Cost Containment*, *Healthcare Finance Blog*, and *Strategic Financial Planning*.

Mr. Kelly holds an MBA, with a concentration in corporate finance, and a BS in business administration from Robert Morris University in Pittsburgh.

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Kaufman Hall provides strategic advisory services; physician advisory services; financial advisory services to debt and derivative transactions; strategic, financial and capital planning services; capital allocation design and implementation services; and merger, acquisition, partnership, real estate and divestiture advisory services. In addition, Kaufman Hall developed and markets the ENUFF Software Suite®.

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Hospitals in Pursuit of Excellence is the American Hospital Association's strategic platform to accelerate performance improvement and support delivery system transformation in the nation's hospitals and health care systems. Working in collaboration with allied hospital associations and national partners, HPOE synthesizes and disseminates knowledge, shares proven practices, and spreads innovation to support care improvement at the local level. For further information, visit www.hpoe.org.