

# managing the margin

...strategies for generating new revenue and controlling costs

APRIL 2005

## FEATURED FOCUS

### Is a Joint Venture Right for You?

Craig E. Holm, D. Louis Glaser, and Alan M. Zuckerman

"Given the current revenue and cost pressures in the healthcare industry, joint ventures are more important than ever." This statement by John R. Boettinger, Jr., and Teresa Young was written in 2003, but it could just as easily apply to 1993 or 2005.

As healthcare providers have struggled with intense financial pressures over the past 15 years, efforts to grow and meet market demand have been consistently stymied by uncertain revenue streams and scarce capital.

Joint ventures have been viewed as an attractive approach for lowering upfront investments by individual parties in new services or facilities. These arrangements also provide valuable opportunities to solidify cooperative

relationships with other providers who could become competitors rather than partners.

#### Why Now?

Although joint ventures have been a part of the healthcare landscape for several decades, several market and environmental developments have made joint ventures of particular interest these days.

## BENCHMARKING IN BRIEF

### Staffing Cost Management

Labor costs typically account for more than 50 percent of a hospital's expenses. When managing this important area, it can be particularly useful to compare facility staffing, worked hours per discharge, and contract labor use with peers. Consider the chart discussing median and average information for these measures, which were obtained from 475 hospitals between the second quarter of 2003 and the second quarter of 2004.

**Facility staffing.** One of the broadest measures of facility productivity is the ratio of full-time staff to facility volume, or adjusted occupied beds. Paid FTEs are defined to include employed staff and contract service paid hours. The charts on page 4 discuss current paid FTEs per

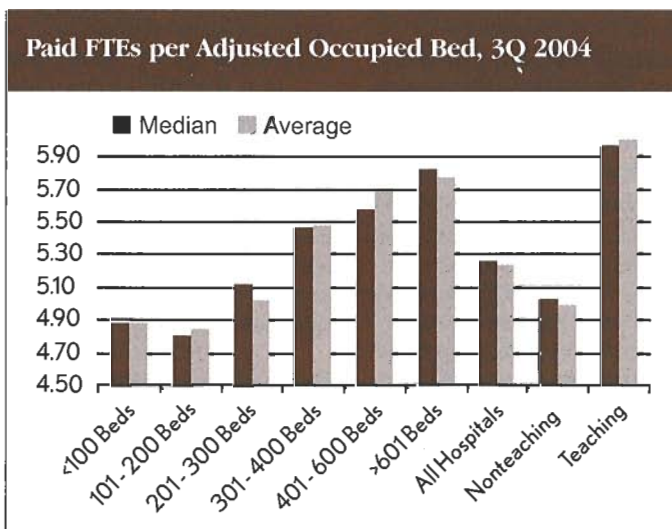
adjusted occupied bed for various comparative groups.

**Patient care staffing and case mix.** Patient care staff represents the largest group of employees and the largest number of worked and paid hours

within the average hospital. Over the past six quarters, the case mix index for the average hospital has declined slightly from 1.2348 during the second quarter of 2003 to 1.2233 during the third quarter of

*continued on page 4*

**Hospital retention of ancillary services.** Physicians are working increasingly long hours and struggling with rapidly escalating expenses to achieve stable or declining practice revenues. Ancillary services can represent a lucrative means of supplementing declining professional income for physicians. Joint ventures represent a compromise for physicians and hospitals: physicians can add ancillary services and hospitals can retain some portion of ancillary services, many of which are likely to shift out of the hospital setting.



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**Relaxed regulatory environment.** Federal and state laws and regulations render many joint ventures between hospitals and physician practices permissible.

**Physician motivation.** Ownership of healthcare services, independently or through a joint venture, represents an attractive option for physicians who are now more willing to take risks on ventures where the returns can be substantial. By partnering with a hospital, competition can be reduced and physicians can benefit from a known provider of services being included in the joint venture. In some cases, the payment levels can be two to three times higher through hospital affiliation.

**Potential for high-margin returns.** Pursuing a joint venture for ancillary services can yield returns far exceeding other investment options.

### Three Categories

Joint ventures fall in three categories: offensive, defensive, or a combination of these two.

**Offensive** joint ventures involve either the creation of a new service or the expansion of an existing service into a new market. Purely offensive joint ventures also tend to be proactive, meaning that they are pursued in the absence of a competitive response or threat.

**Defensive** joint ventures typically involve a reaction to a competitive threat. They are designed to protect a service or market by legally preventing a competitive threat or by preventing an erosion of an existing business or service.

**Combination** joint ventures involve both offensive measures, such as creation of a new service and entry into new market, and defensive measures, such as protection of services or market by legally joining together with a potential competitor.

Potential joint ventures should be considered based on which category they best characterize and the presence or absence of a competitive threat from a potential partner.

### Evaluation Criteria

Once a potential joint venture arrangement is ready for more than casual discussion, organizations should proceed with applying formal, widely communicated evaluation criteria. If possible, to ensure objectivity, it is best to develop broad evaluation criteria when no specific joint venture is being considered. A tertiary care hospital in the Mid-Atlantic developed the following evaluation criteria:

**Strategic alignment.** Does the joint venture further the hospital's mission, vision, and goals? Is there a shared vision?

**Precedent.** Will forming this joint venture be an acceptable precedent in working with any physician practice in a similar arrangement in the future?

**Market position.** Do market conditions support the pursuit of the joint venture? A joint venture should improve quality and/or increase volume or market share, and/or decrease a competitor's market position.

**Return on investment.** Will the joint venture provide adequate return in

time, effort, and money? The joint venture should be financially beneficial to each investor.

**Realistic physician partners.** Are physician leaders trustworthy, do they have realistic expectations, and are they considerate of the hospital's goals and concerns? In the planning process for the joint venture, information should be shared openly. "Outside of service area" parties are viewed negatively. (Author note: In this instance, an independent, publicly funded niche provider was the main competitor.)

**Magnitude of threat.** Is there significant potential for erosion of hospital ambulatory services volumes, market share, and/or financial viability if physicians or other parties develop services independent of the hospital?

**Likelihood of threat.** Is there high probability that physicians or other parties will develop services independent of the hospital?

**Potential consequences.** Are political (or other) barriers to implementation and success manageable? If collaborative relationships are dissolved, consequences to the hospital should be tolerable.

### Lessons Learned

In addition to applying appropriate evaluation criteria, it's also important to consider the following lessons based on several decades of experiences.

**Joint ventures are not the only means of collaboration between hospitals and physicians.** If a goal is to build an

ambulatory surgery center with surgeon investors and then share technical revenue, there may be other less onerous means to accomplish the same objective without proceeding into a joint venture.

For example, a hospital operating room could segregate ambulatory surgery to significantly improve throughput and efficiency. Other options include a management contract (with compensation to surgeons for help with improving the efficiency of services) or the lease of existing operating room space. Although these approaches can be complex, each represents other avenues that may help accomplish the overall objective without adding duplicative capacity.

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## What Makes a Joint Venture?

Joint ventures represent an opportunity for two or more parties to collaborate to pursue the growth and development of healthcare services and facilities. In this *Managing the Margin* series, affiliations will be considered joint ventures if they:

- Involve the delivery of healthcare services
- Include two or more partners such as one or more hospitals or healthcare systems, physicians, and other investors
- Require shared ownership and control of healthcare services
- Involve funds flow between and among the parties

A more formal definition of a joint venture articulated by HFMA's Board of Examiners is "an arrangement involving risk and benefit sharing between a hospital and one or more other entities, with rights and obligations specified in contractual terms for a specific purpose."

### **"Backfill" opportunities should be considered.**

Most ambulatory joint ventures, if carefully planned, achieve favorable financial performance. Annual pretax returns on capital investment can be as high as 30 percent or more, compared with returns far inferior from other investments, such as real estate investments with 8 percent to 10 percent returns or CDs with 3 percent to 4 percent returns.

But a more significant issue for a hospital is not the financial return from a joint venture; it is the concern about the erosion of high-margin services from the hospital.

Is there "backfill" opportunity? For one hospital in the Southwest, the development of a joint venture ambulatory care center in a growing market enabled it to decompress capacity constrained services and add new surgical and imaging services to its main location.

### **Physicians who partner with a hospital may**

### **benefit from favorable, provider-based**

**payment.** In August 2002, the Centers for Medicare & Medicaid Services revised the provider-based regulations to permit joint ventures to obtain provider-based status if they meet certain requirements. The revised regulation became effective October 1, 2002. As a result, technical fee payment can be more favorable. In a recent cardiac services joint venture in the upper Midwest, the provider-based technical fee payment was two and a half to three times the payment garnered by the physician practice outside of the joint venture.

### **Providers should be selective when choosing**

**investors.** Each investor should have a purpose for participating in the venture and should bring capital and business acumen to the deal. For example, physician investors should bring efficient, high-volume practices to the arrangement. Hospital investors, at a minimum, should bring management and operational expertise and bargaining power with payers. Passive investors,

meaning investors who are not in a potential position to influence referral relationships, are legally permissible but will dilute the earnings potential of the joint venture.

**Joint ventures will not work without compatibility and trust.** The environment in which the joint venture occurs must be one where trust and compatibility are evident and former hostilities and resentment have dissipated.

### **Hospitals should not fight the inevitable out-migration of services.**

Examples of services that rarely remain entirely within a hospital setting include ambulatory surgery, imaging, cardiac diagnostics, physical therapy, and endoscopy. Hospital leaders that prohibit outmigration or affiliations with physicians for these services are doomed to lose volume and physician goodwill.

### **Percentage of ownership should always be negotiable.**

Often a hotly contested issue is the eventual percentage ownership by each of the parties of the joint venture. The perception exists that a minority ownership position will result in a loss of all control. Most successful joint ventures with a high degree of compatibility and trust need not vote on contentious issues based on ownership, but will come to mutually agreeable decisions based on a desire to be fair to all parties. Also, supermajority protection can be built into the shareholders' agreement for the most important issues, such as the sale of the joint venture, inclusion of new investors, and major capital purchases.

**Planned expansion is best.** If the joint venture is a success, expansion in the present location(s) or to new locations may be necessary. Discussions about level of comfort with expansion opportunities should be discussed before the joint venture is finalized.

### **Exit strategies should be clear from the outset.**

Most joint ventures mature about 10 to 15 years after physician practices mature. An exit strategy from the original joint venture formation, such as resyndication and buy out/in provisions, can help reduce the likelihood that the joint venture will deteriorate.

As providers become more aggressive and creative with their approaches to revenue enhancement, joint ventures offer valuable opportunities to enhance competitive positioning and increase market share, and may be less risky than some options since multiple investors are involved. But joint ventures must be thoroughly researched, evaluated, implemented, and monitored to ensure that expectations are met and benefits realized for all parties with a stake in the joint venture's success. ■

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## Staffing Cost Management

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2004. During that same time period, nursing worked hours per patient day (adjusted for case mix) have increased from 10.3 to 10.9.

Worked hours per discharge (weighted for case mix) show a similar trend during the past two quarters. An examination of two specific patient care units—medical/surgical and medical/surgical intensive care—shows

that worked hours per day (inpatient days and equivalent days for outpatient observation patients) have increased in both patient care units. Worked hours in the medical/surgical unit have increased from 9.6 to 9.9 hours per day, and worked hours in the intensive care unit have increased from 19.8 to 20.2.

### Using the Data

This information represents the experience of the “average” hospital between the second quarter of 2003 and the third quarter of 2004. As such, it represents comparative industry information.

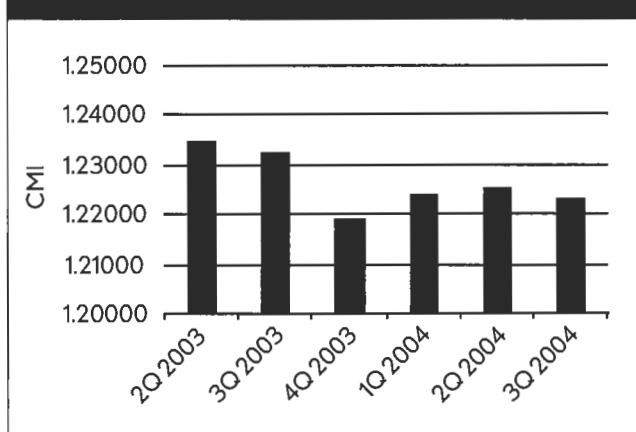
To refine this information to create benchmarks, it would be important to create a comparative group that reflects the volumes, service mix, and case mix of your organization.

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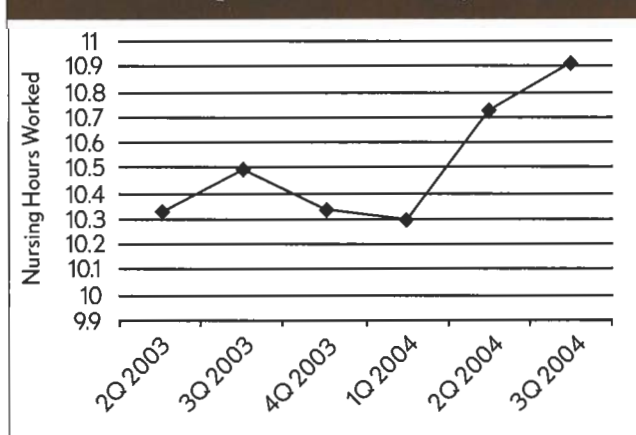
### Use of contract labor.

Nursing use of contract labor declined from 1.97 percent of all nursing paid hours to 1.37 percent during the six quarters. This decline may be an indication that hospitals have been more successful in recruiting for employed staff and have reduced their dependence on contract labor.

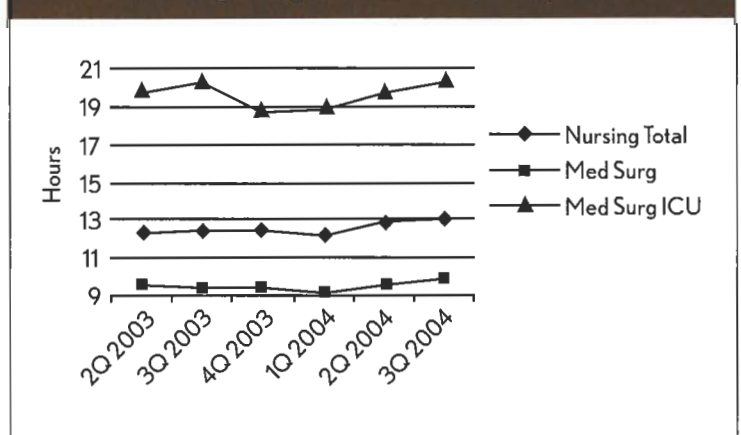
Case Mix Index—All Patients



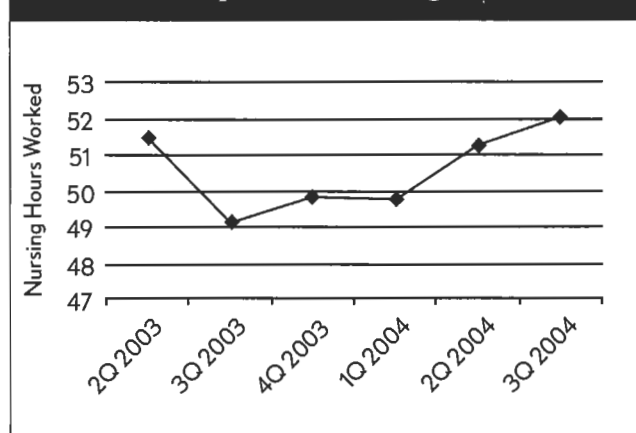
Worked Hours per CMI Patient Day



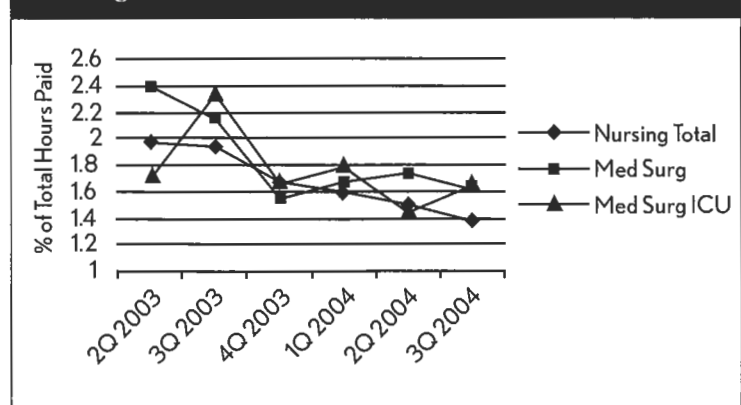
Hours Worked per Equivalent Patient Day



Worked Hours per CMI Discharge



Non-Payroll Paid Hours as a Percentage of Total Nursing Paid Hours



# Supply Chain Savings: Dos and Don'ts

David Kaczmarek

The supply chain consumes a substantial portion of a hospital's budget, with supplies, services, and the labor

involved in this function composing about 40 percent of all expenses. Yet skepticism persists about whether

this area can be streamlined for true savings. Too often, healthcare providers fail to realize the opportunities

that exist. To optimize your supply chain processes, consider the following list of "Dos and Don'ts."

## Do

- **Make nonsalary expense management a cultural imperative.** Reducing nonsalary expenses must be a major component of any supply chain improvement effort. It must be viewed as a long-term effort, recognizing that cultural changes typically take five to eight years for full effectiveness.
- **Pay attention to total costs, not just the acquisition price.** Often a more expensive up-front cost will result in a lower overall cost, particularly when a product or service involves multiple departments.
- **Seek true partnerships with selected suppliers.** You cannot streamline the supply chain on your own. Optimal efficiency and effectiveness will only come when the various stakeholders—manufacturers, distributors, providers, and users—work together in concert. Vendors cannot be viewed as adversaries.
- **Implement true value analysis.** There is no more effective tool for managing and reducing the supply and service component of the supply chain than a comprehensive value analysis program. Product standardization called value analysis is not effective.
- **Set administrative-level supply chain policies.** Doing so sets a cultural imperative for savings and ensures all parties play by the same rules.
- **Limit and designate official hospital agents.** Only official agents of the hospital should be able to commit hospital funds. Having agents commit funds that others (administrators and department managers) have authorized is a prudent check and balance. Typically, department managers and administrators should not be agents except in limited instances.
- **Implement a technology assessment program.** Avoid costly purchases of supplies and equipment that may not advance your strategic position. Use value analysis principles to guide the team.
- **Involve the clinical staff in all supply chain initiatives.** Physicians should be a part of your technology assessment programs and included in the value analysis process. Without these stakeholders' involvement, most programs will be doomed to fail.
- **Maximize supply chain technology.** You don't have to purchase newer or additional software necessarily. However, all aspects of the current software should be used and new or additional software should be evaluated for current and future efficiencies. For example, operating room and materials information systems are rarely interfaced. Linking the two often produces process efficiencies and savings.

- **Reexamine your group purchasing organization relationship.** The GPO field has changed recently. The older, more established organizations are evolving, and newer players with different business models have emerged. Your current GPO may still be a good fit for your organization. However, if you don't at least question the relationship, you may be missing a chance at a much better fit.
- **Maximize your GPO.** Once you have validated or changed your GPO, you must get the most you can from the relationship. Investigate all the contracts and use as many as feasible. Make sure your GPO is treating you like a customer.
- **Consolidate all of your contracting and contracts in materials management.** These functions need to be centralized to avoid costly mistakes and optimize savings. Without consolidation, you're at greater risk for disadvantageous language and inappropriate renewal.
- **Communicate frequently with all stakeholders regarding supply chain issues and successes.** Frequent supply chain communications will reinforce the cultural imperative for savings and keep the organization focused.
- **Reward departments and individuals who contribute to supply chain savings.** Rewards do not have to be monetary. In fact, praise and recognition will normally be more effective over time.
- **Create a supply chain executive position to replace the materials manager.** If you are serious about optimizing your supply chain and reaping all the benefits of a best practice operation, you need a materials professional that has gone beyond purchasing and inventory control. In addition to possessing the required technical skills, this person should be a win-win negotiator, project planner, and visionary for the supply chain.

### What Makes a Supply Chain?

The supply chain includes all activities from manufacturer to provider that involve getting supplies as well as the costs of the supplies themselves, including:

- Internal processes from identification of need through disposal
- External processes from manufacturer through distributor to payment
- Product selection and utilization
- Services as well as supplies and equipment
- The labor that is used to make it all happen

## Supply Chain Savings: Dos and Don'ts

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### Don't

- **Expect significant supply chain savings from old sources.** These include searching for lower prices, reducing storeroom inventory, using product review committees, standardizing basic medical/surgical products, and generally beating up on vendors. These strategies worked 10 years ago, but have largely been played out.
- **Look for most supply chain savings to come from the materials management budget.** Only a small portion of actual supply chain costs is in the materials budget. Most is in the supply and service budgets of the other departments and spread throughout the various departments' labor budgets.
- **Allow a silo mentality.** Supply chain savings come from a collaborative effort among all hospital departments. Organizational interests must take precedence over departmental interests.
- **Make exceptions for administration.** If you want to make cost management a cultural imperative, administration must "walk the talk".
- **Be fooled by false claims of labor savings.** Cost analyses of expected savings from labor reduction can be misleading. Labor savings are only real when there is a commensurate reduction in FTEs.
- **Make changes without looking at all the alternatives first.** This value analysis principle is especially noteworthy for supply chain issues. All too frequently, an alternative to a problem is proposed and blindly pursued when other, more cost-effective alternatives are available.
- **Allow physicians or clinicians to "coerce" you into overspending.** Data and a consistent value analysis process should always drive decision making, rather than personal preference.

- **Allow materials management and accounts payable to work at cross-purposes.** These departments need to have a great working relationship to realize all of the negotiated benefits and to keep vendor relationships positive. Organizations should consider placing their accounts payable department under the authority of materials management.

There are real savings in the supply chain and adhering to these dos and don'ts will help to realize them. It is not a quick fix, but an optimal supply chain can ultimately result in as much as a 12 percent total reduction in the hospital budget without any decrease in quality.

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