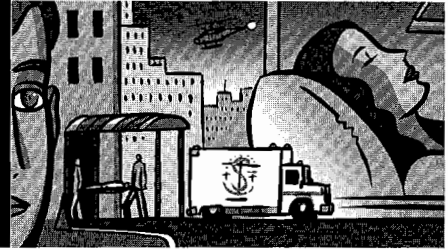


A B O V E B O A R D



FINANCE

Getting Back to Basics: Restoring Financial Health through Divestiture

by Alan M. Zuckerman

What goes up must come down. After a decade of frenzied mergers, affiliations, and system and network building, health care systems and integrated delivery networks are reassessing their holdings. For many organizations, selective divestiture is a logical next step for maintaining or improving their financial health.

Certainly, the financial pressures from managed care's growing presence and the recent effects of the Balanced Budget Act add to the urgency to reassess operations and trim underperforming businesses. But as those familiar with business cycles probably know, divestiture is a natural consequence of rapid growth, when organizations have a tendency to overextend their reach and tax their abilities to manage the significantly larger enterprises that result.

Addressing Financial Distress

In this cycle, divestiture is once again a potential solution to hospital and health system financial distress. In most cases, organizations have first tried to deal with financial underperformance through less dramatic approaches.

Typically, the first initiative they take is to reduce overhead in nonrevenue-producing areas. Next, and sometimes concurrently, managers conduct productivity benchmarking. Most health care organizations have either made cuts and included benchmarking as an ongoing component of budget preparation and financial management or are in their second, third, or fourth wave of cost reductions.

Moving past productivity benchmarking and improvement, the next step is often to reengineer part or all of the organization.

After this, organizations may look at revenue enhancement. Techniques include complete and accurate coding and billing, better and higher yielding collections systems, and managed care contract compliance. Many health care organizations have begun to take a more aggressive approach to managed care contract (re)negotiation to gain higher rates and better terms.

Finally, some innovative organizations believe that the answer to today's financial dilemmas lies in revenue expansion. Those organizations are increasingly emphasizing service and market expansion, new service development, and better penetration of existing markets.

Typically, divestiture is only considered once all of these other approaches have been exhausted.

Divestiture Options

The overwhelming majority of hospitals and health care systems today take one of two approaches to divestiture:

1. In a crisis mindset, leaders downsize and excise operations in order to stem the red ink, with little regard for the coherence and viability of what will remain.

2. Management implements slow, deliberate, and cautious change in severely underperforming business units.

Clearly, there is a large middle ground between these extremes, especially for

hospitals and systems that are not facing a financial crisis. Divestiture should be openly discussed and debated during strategic planning or as part of a financial and operational review.

Divestiture in Action

Several examples clarify some of the issues and options facing trustees. In two cases this year, I have been asked to evaluate whether a system of multiple hospitals and other enterprises should divest itself of a small, financially distressed hospital. In one case, the system had the opportunity to partner with another health care organization to develop significant new business at the underperforming hospital. In the other, no feasible prospects surfaced for adding significant business or revenue, or for dramatically reducing costs.

The decision to terminate acute care operations and sell the plant, while painful, was obviously prudent in the latter situation. In both cases, financial performance improvement for the system is expected to be dramatic. In closing the small hospital, system operating margins will grow by \$10 million annually, while the partnering arrangement at the other small hospital is expected to turn a \$2 million annual operating deficit into a \$2 million operating margin.

Many hospitals and health care systems are struggling with poorly performing primary care practices. In a few cases, we have been successful in restructuring employment arrangements to put the physicians at risk for a significant portion of their compensation, thus

restoring the entrepreneurial "edge" to these practices. In other cases, however, this approach has been impossible, and divestiture has been the only reasonable course of action.

Most health care organizations developed wellness and prevention activities in the mid to late 1990s. Few of these ventures were grounded in solid business plans or financial projections. In many cases, the programs were never projected to yield direct financial benefits. Instead, these "loss leaders" were expected to enhance the organization's marketing image and generate other indirect goodwill.

In addition, cost and revenue accounting for wellness and prevention programs is highly variable, making it difficult to get a good picture of their actual financial performance. I have been involved in four situations in the past year where senior management or the board asked for a review and assessment of prevention and wellness activities. After each evaluation, leaders significantly reduced or redirected these activities. In every case, they eliminated more than \$1 million annually (and up to \$3 million to \$4 million in one situation) of expenses without affecting related revenue streams.

On the farthest end of the divestiture scale, one large health care system experienced such great operating losses in fiscal years 1998 and 1999 that it has had to completely restructure its entire operation and adopt a multidimensional approach to divestiture. Unfortunately, this organization is probably not unique. With an operating budget of \$500

million in fiscal 1999 and operating losses in excess of \$30 million, system leadership has undertaken the following initiatives:

- One of its four hospitals will convert to a non-acute care role in fiscal year 2000. This small hospital has an average daily census of about 50 patients and operates in a severely overbedded market. A number of repositioning options are being considered, including ambulatory care, senior services, and assisted living. Depending on the alternative chosen, the fiscal year 2000 projected operating loss of \$5 million will be, at a minimum, cut in half for fiscal year 2001, and the contribution margin (i.e., profit before overhead is charged against it) at other nearby system hospitals should increase by \$1 million to \$2 million annually through patient transfers. Three- to five-year financial projections for the converted facility range from breaking even to a modest operating margin.

- All physician practices will be divested in fiscal year 2000. In fiscal year 1998, the system owned approximately 30 practices employing 50 physicians each at a total loss exceeding \$7.5 million. By the end of fiscal year 2000, all physician practices will be privatized. In fiscal years 1999 and 2000, the system will have incurred restructuring costs of \$2 million each year, but the operating deficit from the physician practices will be eliminated, and all but a few of these physicians will have been successfully transitioned into affiliated, private practices.

- Late in 1999, the system conducted a full review of its wellness and prevention activities. As with many other large, complex organizations, it was difficult and time-consuming to inventory, account for, and

assess the cost and benefits of the system's extensive and diverse wellness and prevention activities.

Total system expenditures were about \$3 million in fiscal year 1999, with associated revenue of approximately \$150,000. Eliminating the department responsible for many of these activities should reduce costs by \$1 million, while cutting many of its activities, redistributing others to their related operating units, and eliminating those activities outside the central coordinating department should result in a net operating improvement of another \$1 million annually. Although the system is still providing wellness and prevention services, it is doing so on a much smaller scale than it had previously.

These initiatives are only part of the overall scheme to turn this system's negative operating margin into a positive one, but they illustrate a financial turnaround in process.

As most hospitals and systems scrutinize their financial performance and face further cost-cutting, it may be time to completely reassess the size and scope of most of our health care organizations. In many cases, it is time to get back to basics through selective divestiture and downsizing. Trustees need to actively bring the divestiture discussion to the boardroom table, preferably during the course of ongoing strategic planning and prudent stewardship of their organizations, rather than when the organization is in crisis. **T**

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