THE HIGH COST OF GOVERNANCE DYSFUNCTION IN TEXAS COMMUNITY HOSPITALS

ATLANTA | NASHVILLE | PORTLAND, ME
STROUDWATER
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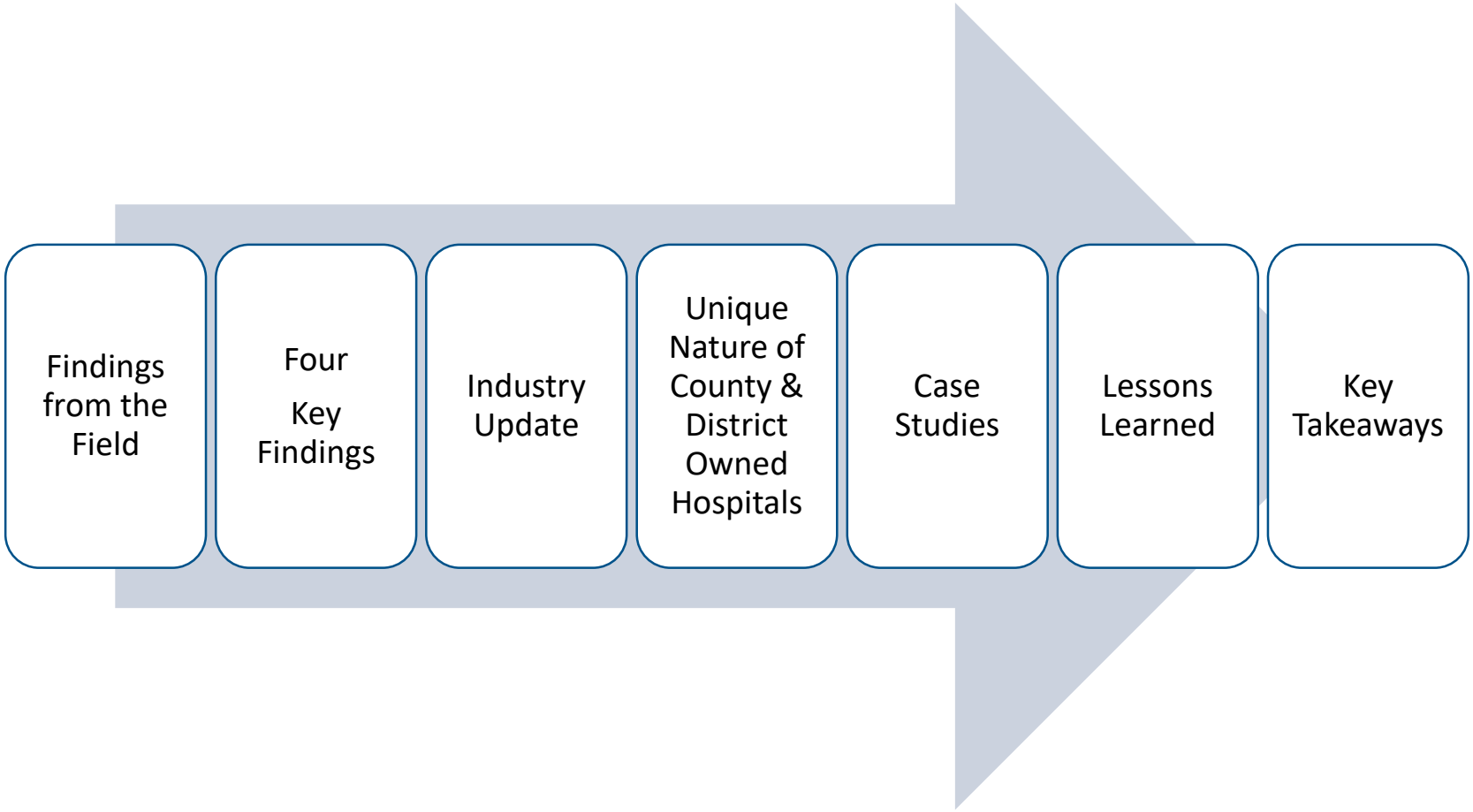
Agenda


Findings from the Field
Four Key Findings
Industry Update
Unique Nature of County & District Owned Hospitals
Case Studies
Lessons Learned
Key Takeaways

Amid the Pleasing Patter of Public Debate…

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Montrose Press

County and hospital to settle beefs

- By Katharhynn Heidelberg, Daily Press Senior Writer
- Feb 7, 2016

Gainesville Daily Register

Taxpayers will pay for hospital board's mistakes

- Jul 11, 2017

OPAQUE LEGAL STRUCTURE INCLUDES TWO BOARDS

http://www.thebanninginformer.com/

Red flag : Grand Jury finds that hospital cannot account for taxpayer dollars

The Hospital District operates in an opaque, difficult to understand legal structure. There is a public district, but also a 501,c, 3 , "Non-Profit" arm. According to the Grand Jury a total of two supervisory boards are exercising "oversight." These two boards and their correlation are difficult to understand, leading to "public confusion."

Heads High, Compassion Intact

A recent article in the Daily Sentinel detailed the "lengthy decline of [Memorial] hospital." A recent Daily Sentinel opinion piece claimed "Memorial Hospital's financial problems had been allowed to fester in the darkness or at least the shadows for far too long. Constituents of the hospital's governing board have the right to know so they can make informed choices at the ballot box."

MESSENGER

Hospital Board Addresses Community Concerns

Posted by Cheril Vernon | Jun 28, 2017 | Local News, News

4 Main Points – 4 Main Findings

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A Very Dynamic Healthcare Environment	• Essential to understand organizational risk profile and manage strategic risks • Risk profile changes have far reaching effects but can also go undiagnosed
Relationship Constraints	• Trust and communication as the essential currency • Develop a mechanism to improve communication and forge trust
Common Fact Base and Shared Vision	• Develop a common fact base to downgrade emotions • Craft a shared vision to unite stakeholders and create common ground
Operating Performance	• Distractions from operating discipline are costly • Cash/cash flow are the lifeblood of any strategic vision

Industry Trends

Consumers Feel the Pain

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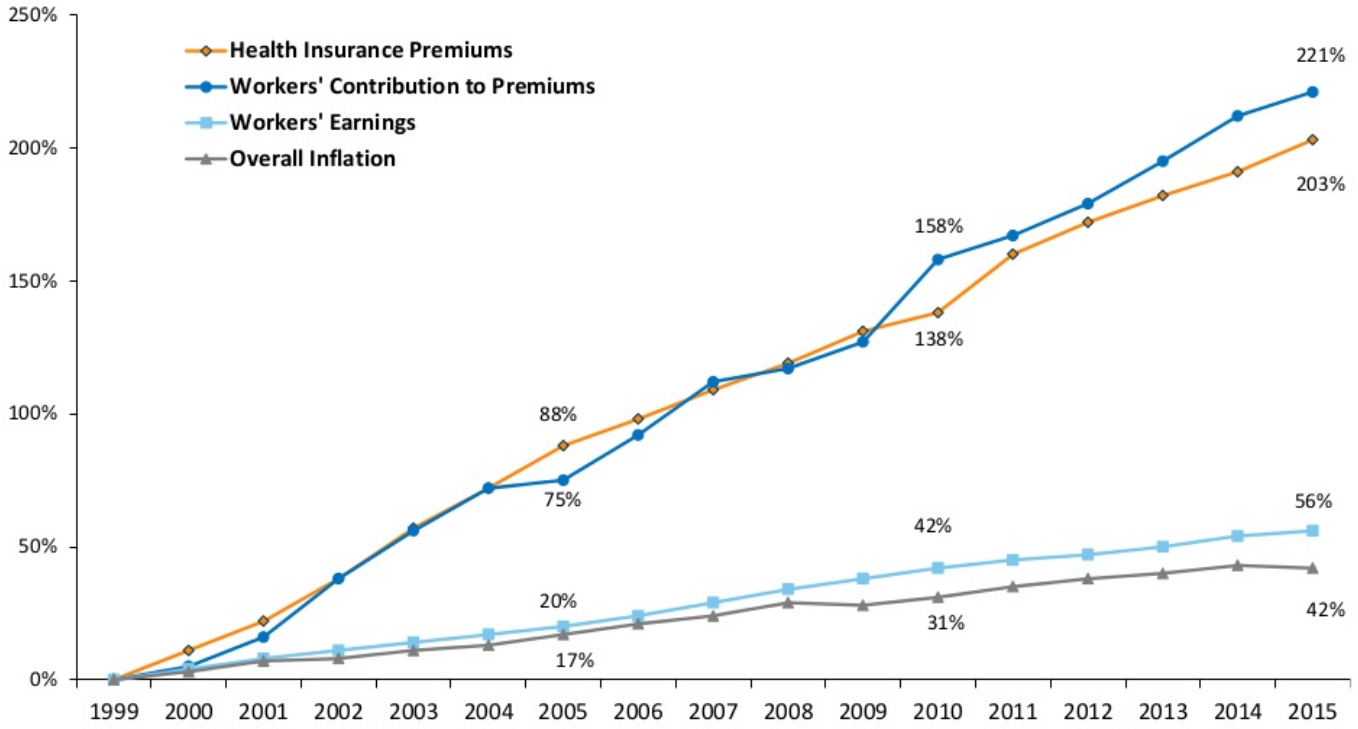
Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).

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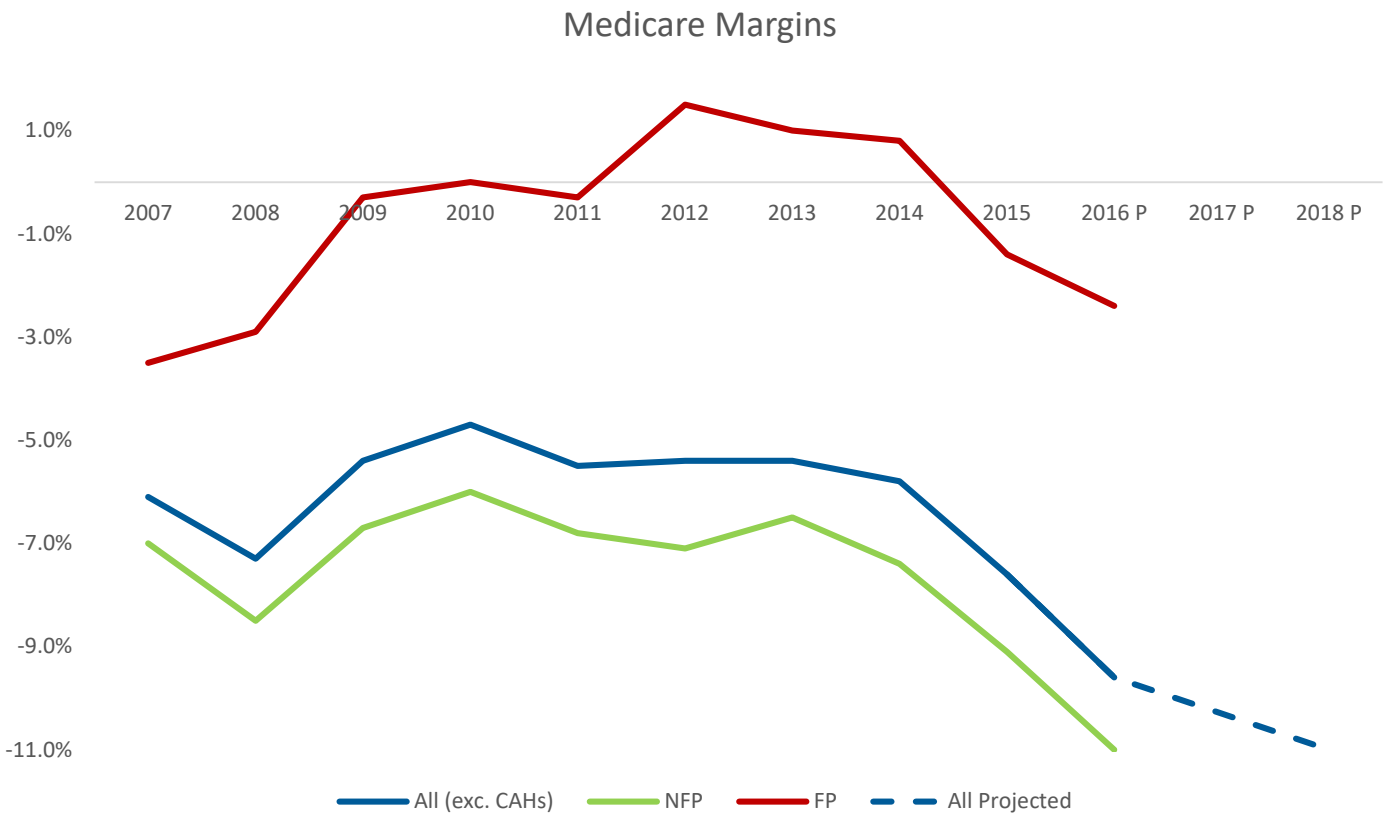
Source: Kaiser Family Foundation kff.org

Medicare Margins: US Hospitals



Medicare margins are expected to decline due to cessation of Meaningful Use funding and decreases in uncompensated care payments due to coverage expansion of ACA.

Source: MEDPAC

August 2018: Per Moody's, Margin Contraction Puts Nonprofit Hospitals on Unsustainable Path

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- According to Moody's, **expense growth for nonprofit and public hospitals outpaced annual revenue growth in FY2017**
  - The median annual expense growth rate was 5.7 percent in FY2017, down from 7.1 percent the previous year
    - The lower expense rate was largely due to better control of supply and labor costs
  - However, the annual revenue growth rate declined faster, falling from 6.1 percent in fiscal 2016 to 4.6 percent in fiscal 2017
    - The **lower revenue growth was attributable to factors including the shift to outpatient care, increased ambulatory competition and lower reimbursement rates**
- Moody's expects **nonprofit hospital margins will continue to be suppressed through 2018** after median operating margins and cash flow margins fell to all-time lows of 1.6 percent and 8.1 percent, respectively, in fiscal 2017
- The medians are based on an analysis of audited fiscal year 2017 financial statements for 303 freestanding hospitals, single-state health systems and multistate healthcare systems, representing 78 percent of all Moody's-rated healthcare entities

MOODY'S

Source: Becker's Hospital Review, *Moody's: Margin contraction puts nonprofit hospitals on unsustainable path, Ayla Ellison, 8/29/18*
https://www.beckershospitalreview.com/finance/moody-s-margin-contraction-puts-nonprofit-hospitals-on-unsustainable-path.html

The Hospital Closure Epidemic

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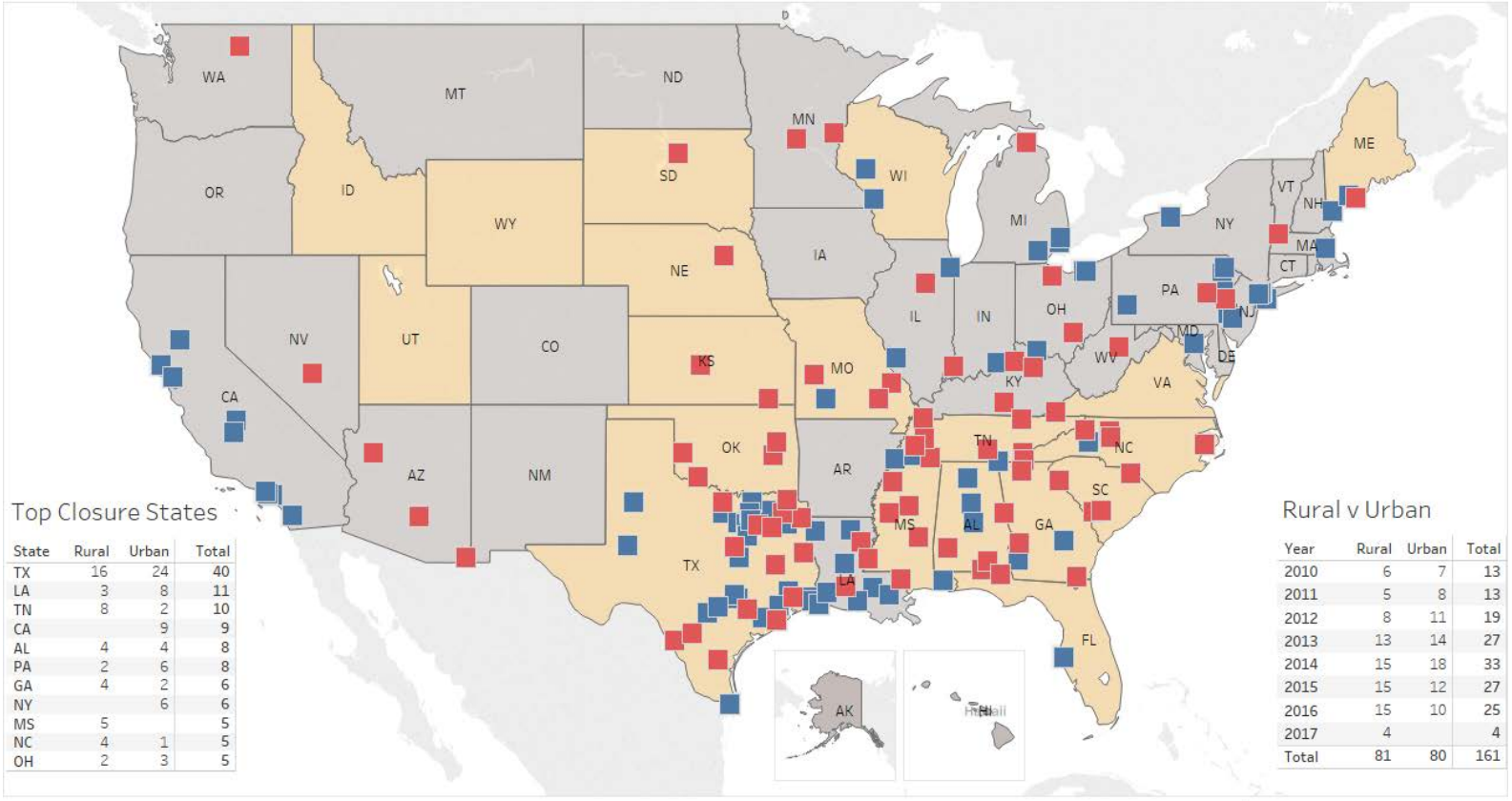
Rural and Urban Hospital Closures since 2010



Top Closure States

State	Rural	Urban	Total
TX	16	24	40
LA	3	8	11
TN	8	2	10
CA		9	9
AL	4	4	8
PA	2	6	8
GA	4	2	6
NY		6	6
MS	5		5
NC	4	1	5
OH	2	3	5

Rural v Urban

Year	Rural	Urban	Total
2010	6	7	13
2011	5	8	13
2012	8	11	19
2013	13	14	27
2014	15	18	33
2015	15	12	27
2016	15	10	25
2017	4		4
Total	81	80	161

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Rural v Urban
- Rural
- Urban

Rural v Urban based on cost report designation

Sources: Cost Report data, The Cecil G. Sheps Center for Health Services Research, KFF.org

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Texas Has Not Escaped The Closure Epidemic

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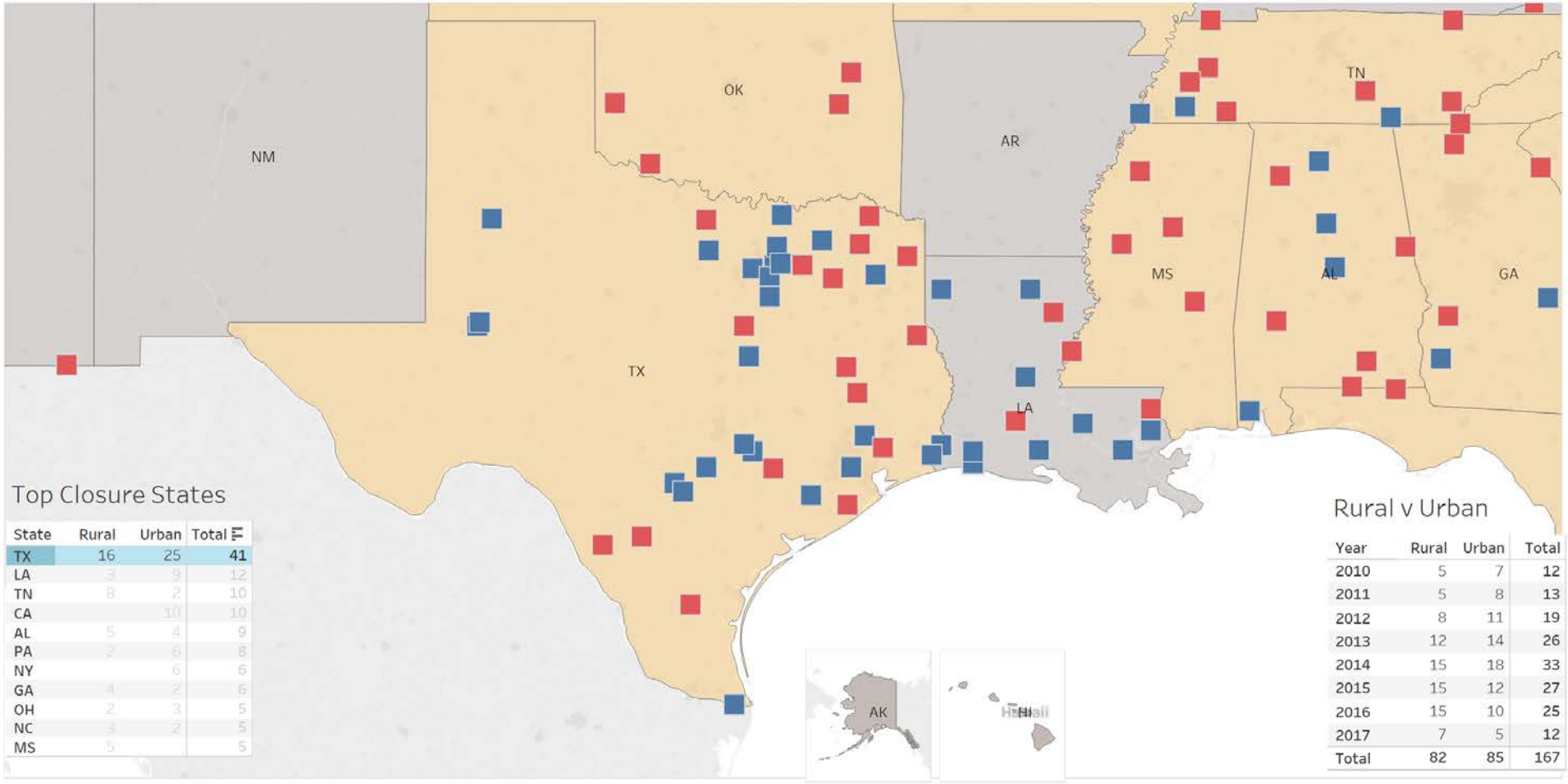
Rural and Urban Hospital Closures since 2010



Top Closure States

State	Rural	Urban	Total
TX	16	25	41
LA	3	9	12
TN	8	2	10
CA		10	10
AL	5	4	9
PA	2	6	8
NY		6	6
GA	4	2	6
OH	2	3	5
NC	3	2	5
MS	5		5

Rural v Urban

Year	Rural	Urban	Total
2010	5	7	12
2011	5	8	13
2012	8	11	19
2013	12	14	26
2014	15	18	33
2015	15	12	27
2016	15	10	25
2017	7	5	12
Total	82	85	167

Current Status of Medicaid Expansion Decision

- Adopted the Medicaid Expansion
- Considering the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Rural v Urban

- Rural
- Urban

Rural v Urban based on cost report designation

Sources: Cost Report data, The Cecil G. Sheps Center for Health Services Research, KFF.org

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Texas Hospitals: CAHs and PPS

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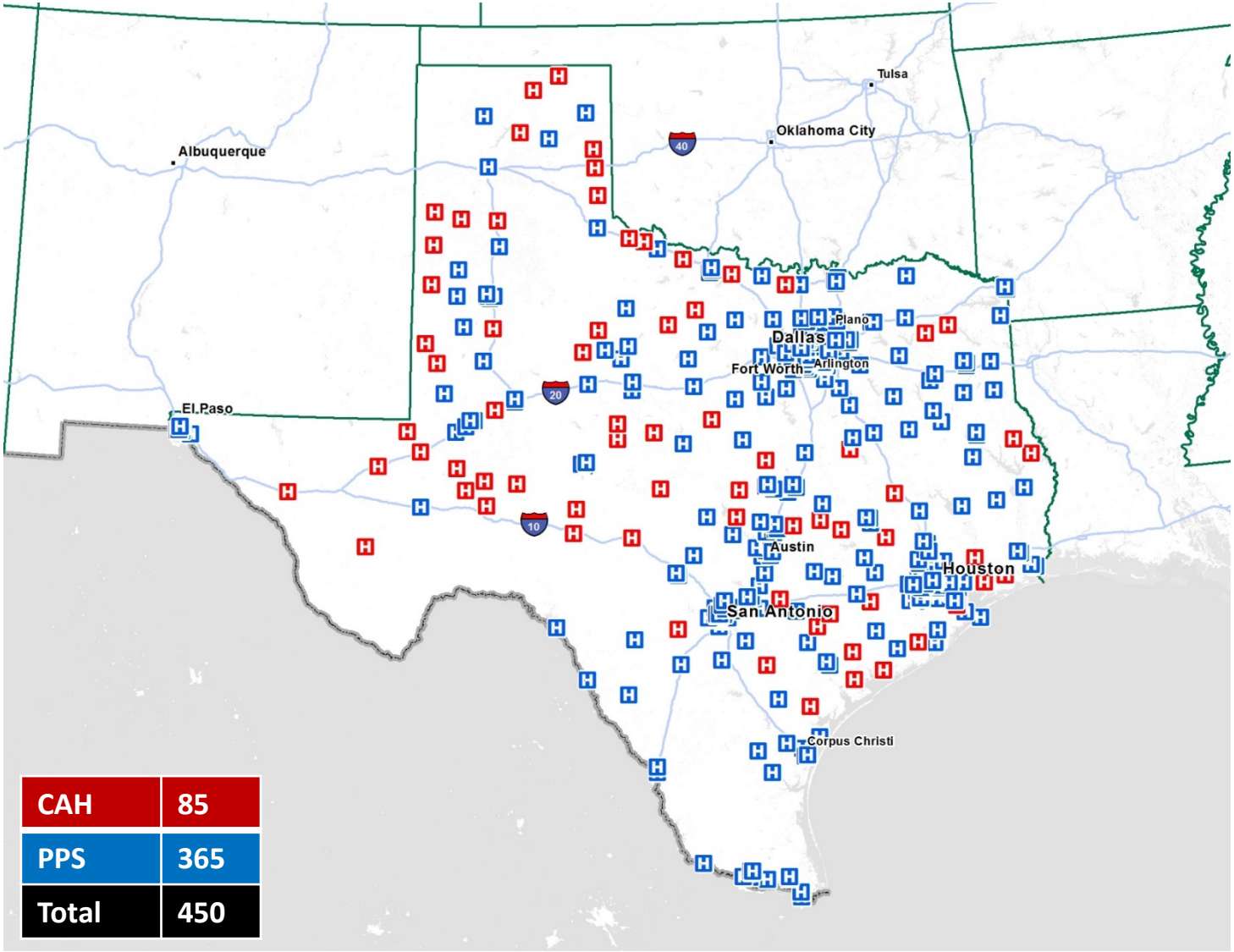
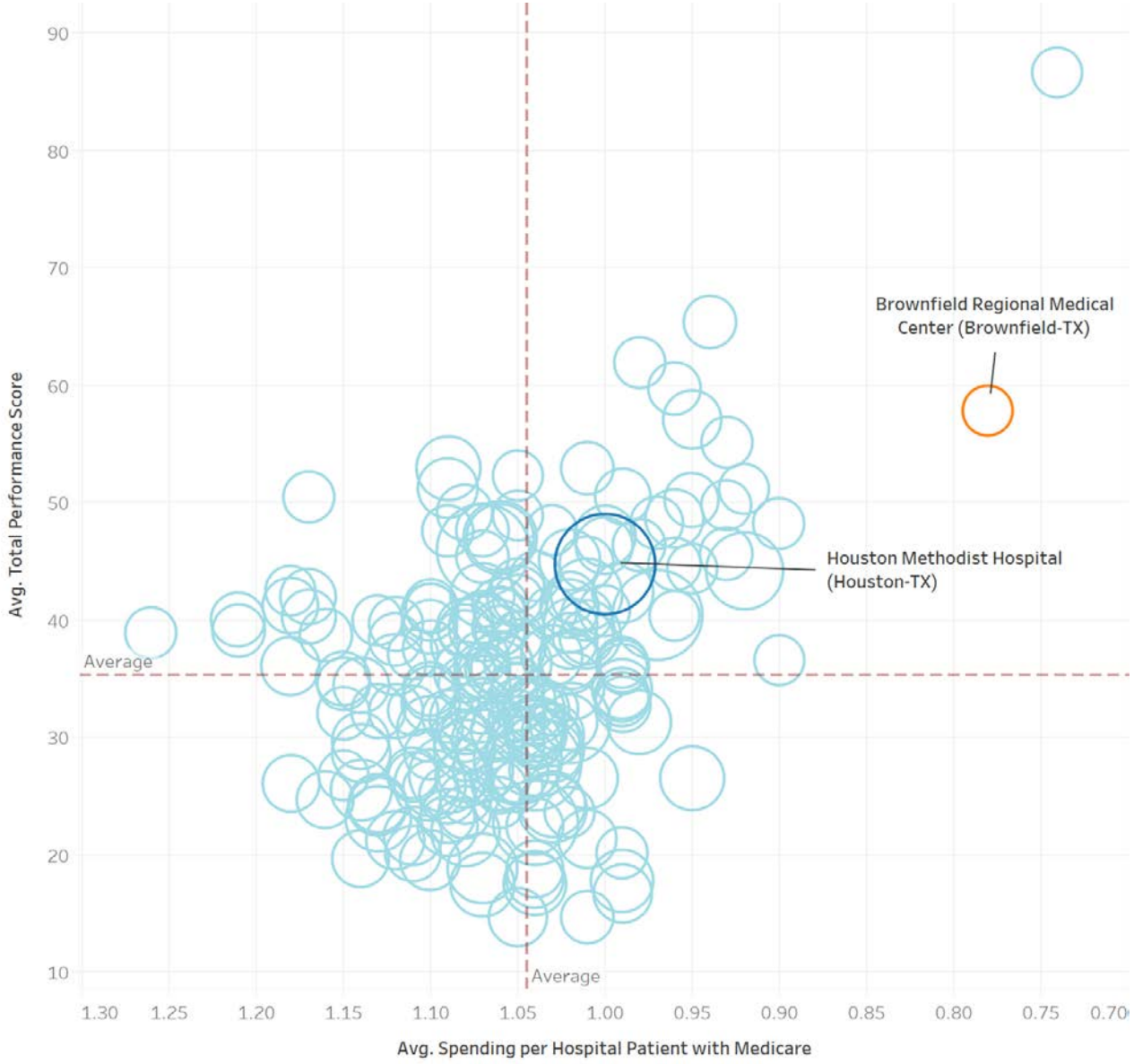


Source: American Hospital Directory (AHD.com)

Value: Essential to Hospital Viability



KEY

High Quality/ High Cost	**High Quality/ Low Cost**
Low Quality/ High Cost	Low Quality/ Low Cost

The value comparison of hospitals is based on CMS Total Performance Score (TPS) and the ratio of Medicare Spending Per Patient for each facility.

The TPS scores are based on the most recent data available from CMS.

The Medicare Spending Per Patient "Efficiency Index" ratio shows whether Medicare spends more, less or about the same per Medicare patient treated in a specific hospital, compared to how much Medicare spends per patient nationally.

The source of these data is CMS.

Note: Only hospitals with both measures are included in the comparison. The size of the mark is relative to the net revenue at each hospital, via the most recent cost report.

Source: CMS

Industry Consolidation

- Providers are aligning into regional hubs that provide scale and significant market presence
  - A common goal: achieving scale and turning it into a financial and competitive advantage
- New disruptive alignments pose new challenges to incumbents/existing business models:
  - CVS-Aetna
  - Optum-DaVita
  - Humana-Wal Mart
- Drivers behind consolidation and new combinations:
  - Financial pressures
  - Heightened competition / new competitors
  - Changing payment models: risk, value and high deductible health plans
  - Technological innovation
  - Declining inpatient admissions
  - Consumerism and value imperatives

Hospital Systems Are Clustered Around Cities

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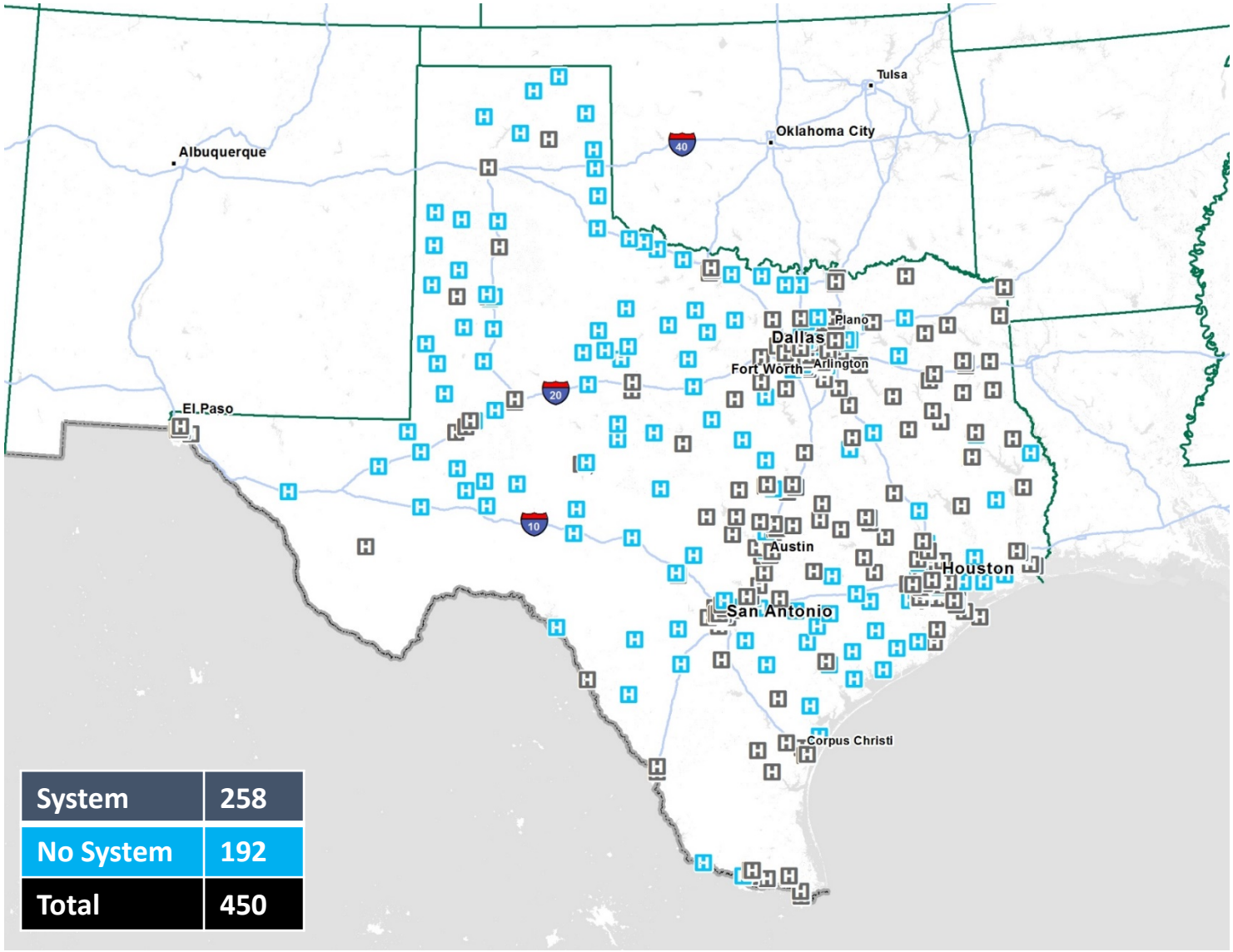

Source: American Hospital Directory (AHD.com)

Unique Nature of County & District Owned Hospitals

Unique Nature of County & District Owned Hospitals

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Multiple layers of governance and responsibility results in blurred lines of accountability

Political agendas, poor communication and lack of transparency can undermine effective board oversight functions

Public conflict dissuades talented and capable board nominees, providers and staff

In some cases a government owned hospital system is not permitted to expand outside of the county/parish/district boundary

In some jurisdictions, authority-owned hospitals cannot file bankruptcy

County & District Owned Hospitals, continued

Subject to open meeting/sunshine laws

Tax support can mask actual financial and operational struggles of the hospital

Eroding operating performance creates financial exposure for tax payers and compromises a public asset

The County/District hospital is everyone's business: a complicated business and critical community resource becomes a source of division

Select Case Studies

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TX Districts and Authorities Experience

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- We have worked with numerous TX Districts and Authorities over the last decade
- These entities include:
  - Struggling entities that have been able to arrive at rational, prudent decisions regarding community assets
  - Highly dysfunctional entities that have not been able to overcome distrust and have destroyed significant community value
- The case studies on the following slides highlight some of the experience we have gleaned nationally from outside TX to illustrate some common themes and pitfalls
  - There are key differentiators between those communities that can work through their differences and those that cannot.

Western Community Hospital

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- 501c3 Board of County-owned hospital plans phased buildout of consolidated campus
- County Commissioners retain SA to assess feasibility of hospital's plan
- Initial phase: lots of infrastructure buildout plus inpatient heart center
    - Result: Hospital incurred additional debt service on necessary but non-revenue generating cap-ex; additional operating costs incurred by 24/7 heart center at new site
    - Depleted debt capacity and weaker than projected debt service coverage mean that hospital was stuck – Yikes!
- Hospital operations deteriorating – 501c3 blamed negative publicity stemming from County's meddling
    - A false narrative
- Hospital downgraded two notches (BBB- to BB+)
- After months long process and compelling evidence, 501c3 board agrees that it lacks resources to execute plan on own but only after divisive, public debate
- The County-owned hospital selected a hospital operator to be its JV partner to fund both the replacement hospital campus and a community foundation

Southeast Community Hospital

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- Exposure to an unfunded long term liability created the need for county assistance
- The county agreed to issue debt on behalf of the hospital to fund the liability, pay off other long term debt and provide funding for needed capital expenditures
- Extensive communication between the county commission and the hospital authority board led to a cooperative initiative to improve the hospital's operating performance
- The hospital authority board and the county commissioners participated in a strategic options exercise that established a well documented common fact base, a path forward and a shared common vision
- The hospital was trending toward closure within six months. Nine months and several significant performance improvement initiatives later the hospital is still operating and turning the corner to positive financial performance
- The hospital is not "out of the woods" but cooperation between the two public entities created needed "run way" for the hospital to reverse its negative operating trends

Southern Coastal Medical Center

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- Relationship between Southern Coastal Hospital District/Southern Coastal Medical Center Board of Directors was historically divisive
- Intrusive and toxic local media where local “rabble rousers” could stir the pot
- After more than a decade of public strife, strong, collaborative leadership at each level initiated the creation of a “Collaborative Committee” consisting of leadership of each board plus the medical center’s foundation board
- With the assistance of Stroudwater, the Collaborative Committee developed a common fact base and shared vision for the future
- Collaborative Committee put aside narrow agendas for a broader vision and solution for the future
- Implemented an effective communications plan and series of public meetings to provide updates and receive comments and feedback

Top 6 Best Practices

For Mitigating Conflict Between Hospitals & District/County Boards

1. Board and stakeholder education	• National, regional and market forces • Organizational constraints and opportunities • Strategic risks facing hospital • Hallmarks of good governance and sound management
2. Develop a common fact base	• Quantify performance gaps • Understand risk factors • Develop strategic objectives
3. Convene a task force involving key leaders from both boards and/or key stakeholder groups	• Provide a format for communication and sharing of perspectives • Engage around key issues and concerns • Remove emotion and make objective data the basis for decisions • Develop working relationships and trust • Seek consensus vs. unanimity
4. Develop a shared vision for the future	• What key attributes do board members and key stakeholders want the organization to have in 5-10 years? • Engage boards and stakeholders around the shared vision
5. Develop and implement a communications strategy	• Develop key messages and talking points • Identify spokespeople • Emphasize the shared vision • Anticipate internal and external communication requirements • Repeat
6. Don't lose sight of the fundamentals	• Sound governance and management • Strategy • Operational performance

Lessons Learned

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Sources of Conflict

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Triggering events that lead to and amplify dysfunction

- Eroding hospital operating performance
- Reductions to hospital services
- Contentious medical staff or employee issues
- Hospital board and management resist questions posed by elected officials
  - Management decisions are debated/second guessed by public officials
- Differing risk tolerances/perceptions of strategic risk held by hospital and county/district officials
- Personal agendas and histories drive board agendas and debate, driving away talented board members, providers and staff
- A lack of transparency, poor communication and personality conflicts all undermine the trust needed for effective county/district and hospital board oversight functions

NFP Board Functions and Blind Spots

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The fiduciary duties of duty of care, duty of loyalty and duty of obedience for NFP boards should be applied to the primary functions below:

- Selecting, monitoring, evaluating, compensating and, if necessary, replacing the CEO
- **Defining, reevaluating and monitoring the long-term strategy by which the organization fulfills its mission**
- Approving budgets, financial plans and financial statements; reviewing and approving material capital allocations and expenditures; ensuring the integrity of the organization's financial reporting and processes; hiring the independent auditor (if any) and assuring itself of the auditor's independence
- ***Understanding the organization's risk profile and reviewing and overseeing the organization's management of risks***
- Ensuring compliance with all applicable laws, regulations, policies and ethical standards of the organization
- Establishing the composition of the board and its committees, and determining governance practices

Source: The Guide to Not-for-Profit Governance, Weil, Gotshal & Manges LLP

Past Operating Results in a Strategic Context

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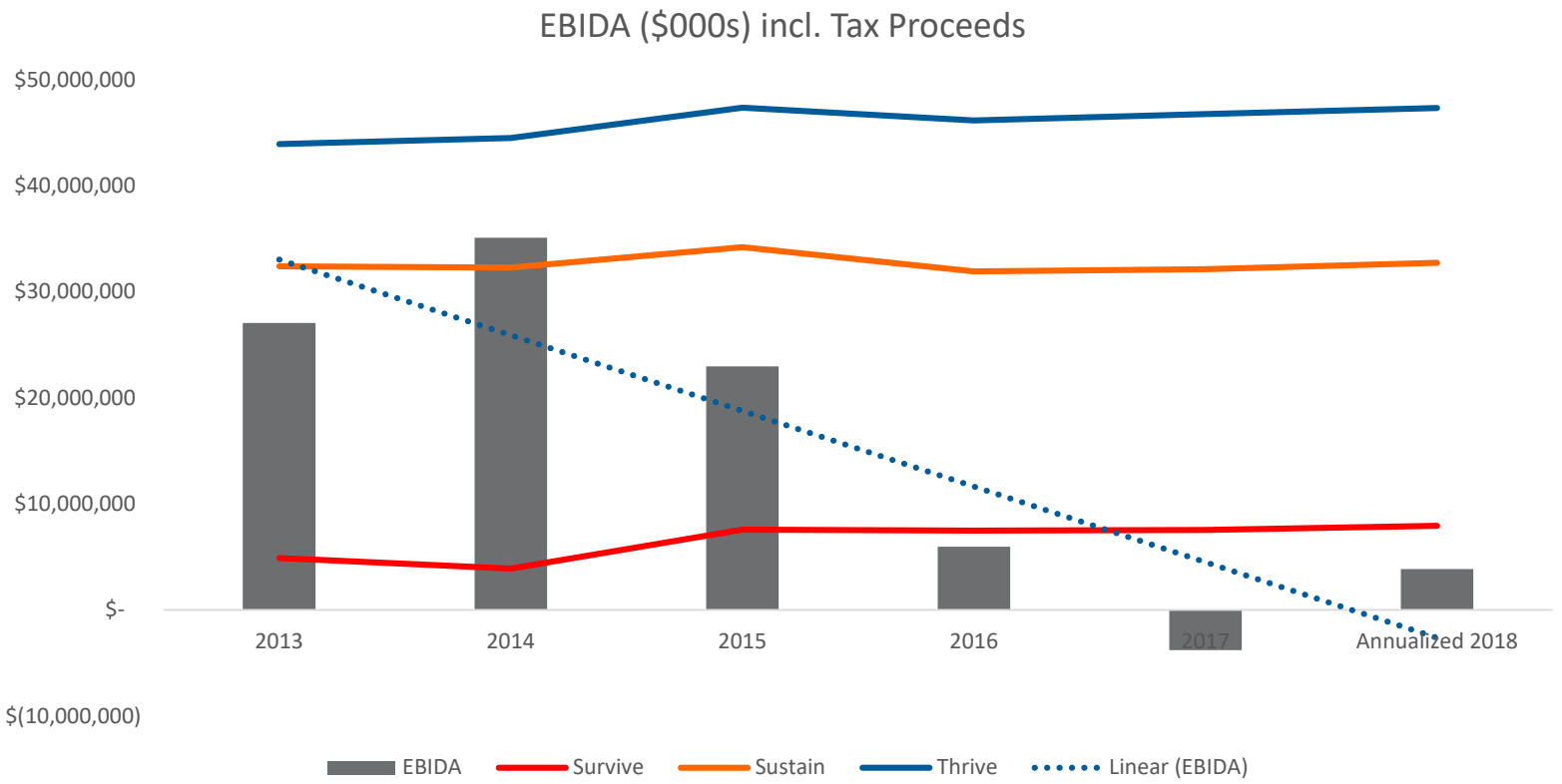

EBIDA = Thrive: 4.0% of operating expenses + 120% of depreciation expense + debt service

EBIDA = Sustain: 120% of depreciation expense + debt service

EBIDA = Survive: debt service

Evaluating & Mitigating Strategic Risk

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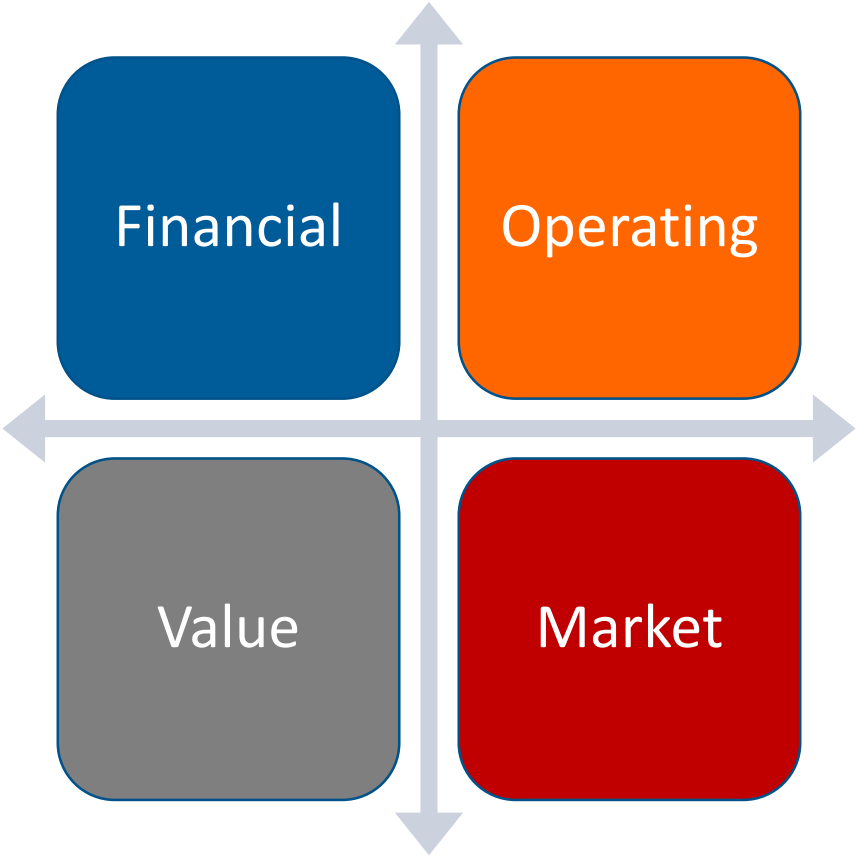

Many boards do not appreciate the cumulative effects of changes in risk factors that can take place over several years.

- The strategic risk profile for most hospitals and health systems is quite dynamic
- The four risk domains depicted to the left describe the major sources of strategic risk in today's environment
- Poor performance in one domain will have collateral or "spill over" effects on one or more of the other domains
- Key trends within each risk category should be monitored annually and long term trends quantified

Key Strategic Risk Indicators

Category	Indicators	Comments
Financial Risk Indicators	• Operating Revenue Trend • Operating Cash Flow & Cash Flow Margin • Debt Service Coverage • Operating Margin • Days Cash on Hand • Days in A/R	• Top line revenue growth is vital to long term health of organization • Operating Cash Flow & Cash Flow Margin are critical for DSCR covenant and investment
Operating Risk Indicators	• FTEs per AOB • Case Mix Index • Payer Mix • Key Volume Trends (O/P and I/P) • Practice Operations, Production and Losses • Revenue and Cost per Adjusted Patient Day	• FTEs per AOB key efficiency metrics • Payer mix and CMI indicate how well the organization is competing for sought after patient populations
Value Risk Indicators	• Cost Position • Attributed Covered Lives • Quality Scores • Performance at Managing Risk for ERISA, ACO and other Population Health vehicles • Retail pricing and charge variability	• Covered lives reflect key population health metric and move from fee for service • What is the organization's ability to manage the health status of populations
Market Risk Indicators	• Market Share Trends • Provider Alignment, Recruitment and Retention (vs. documented need; turnover, productivity) • Consumer Preference Research	• Market share is an indicator of how well the hospital is competing for patients and covered lives • Provider alignment is essential for attribution of covered lives

Four Things to Remember

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- Create a joint committee so key decision makers from the District/Authority/County and hospital Board have a regular venue to communicate and review factual and objective information

- Develop an objective set of analyses, findings and recommendations so decision makers can focus on facts to reduce the role of emotion and perceptions when making critical decisions

- Identify and communicate a thoughtful, shared vision for healthcare services that can unite stakeholders and the community and provide the foundation for moving beyond past grievances

- Know your organizational risk profile and how it is changing

Thank You

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The Stroudwater Difference

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