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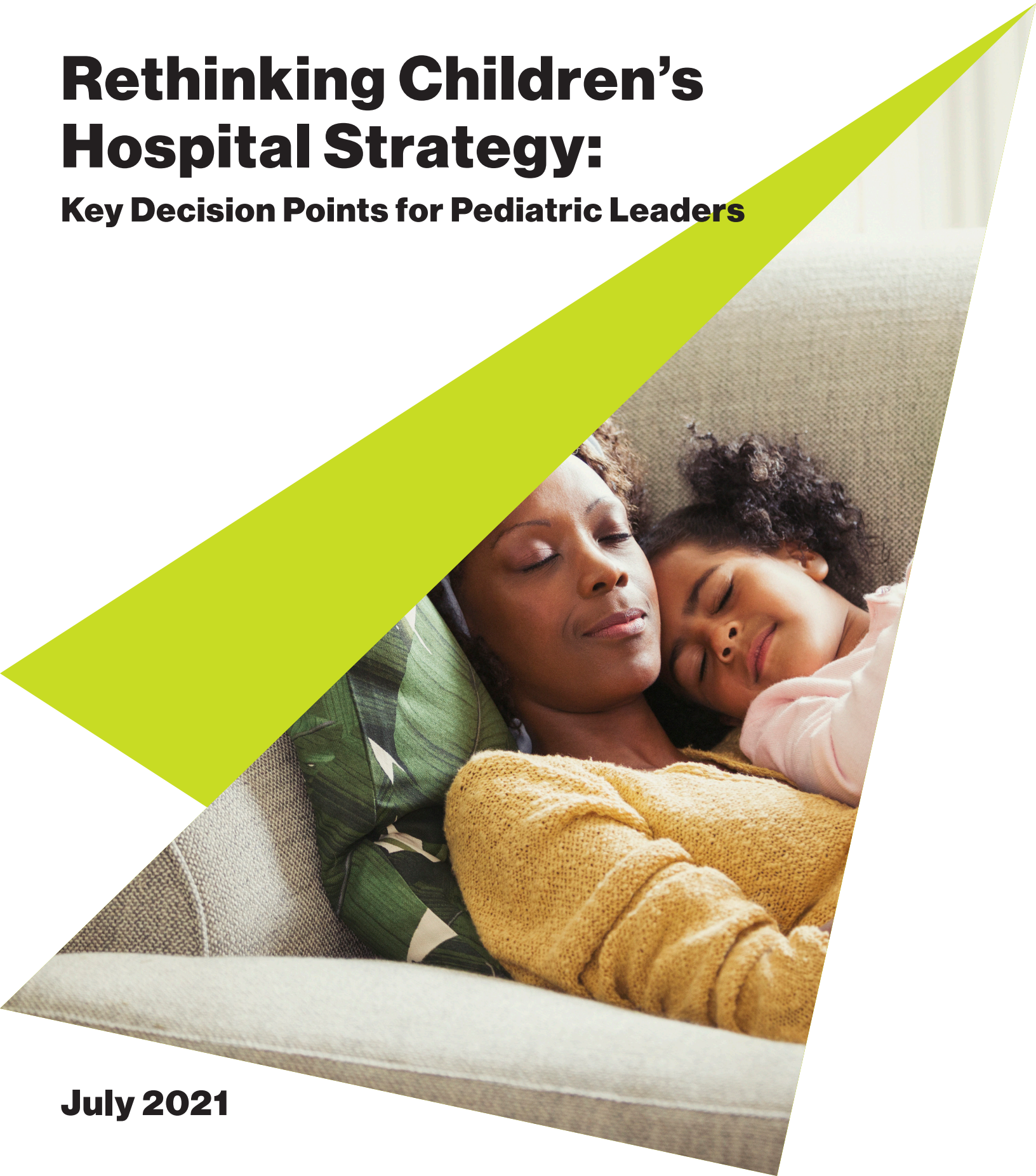
Key Decision Points for Pediatric Leaders



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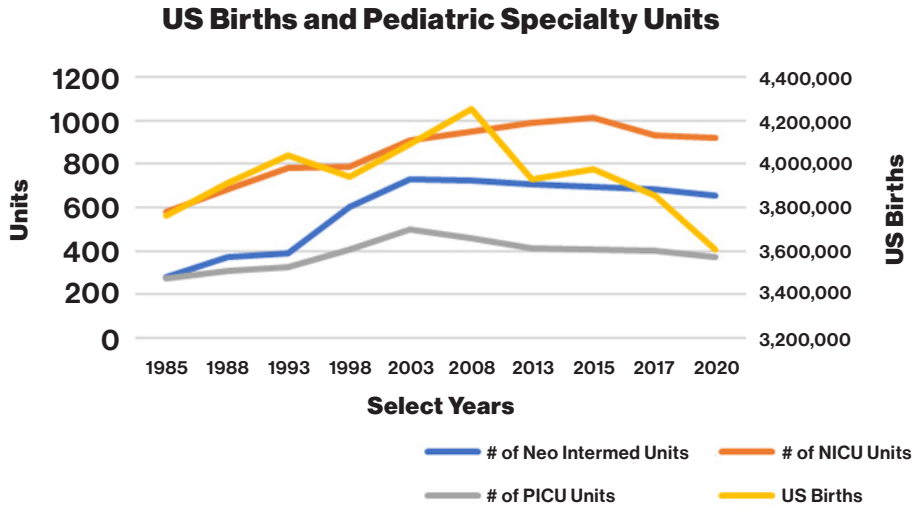
Children's hospitals took a financial hit during the COVID-19 pandemic, and many—especially those outside major metropolitan areas—are showing signs of stress. But there were indications that children's hospitals were struggling before the pandemic. Now, children's hospital leaders face an urgent need to assess their risk and determine next steps to protect their futures.

A Now-or-Never Moment for Children's Hospitals

In May 2020, **75 children's hospital leaders** submitted a letter to the US Department of Health and Human Services, stating revenues had fallen 40%, with losses of $2 billion per month, largely due to delayed surgeries and a plunge in emergency department (ED) volumes. A year after the pandemic began, the acuity levels of children who visit the ED are higher, likely due to reduced access to in-person care during the height of the pandemic. Further, more pediatric patients face behavioral health issues due to pandemic-related stress.

On paper, children's hospitals had healthy operating margins and strong market platform a year before the pandemic. However, the potential for operational stress remained, according to a **Fitch Ratings** Report. Competition for pediatric patients was fierce: In the area of neonatal intensive care alone, the total number of bassinets in neonatal intensive care units (NICUs) **had risen 240%** since 1985 with 22,000 NICU bassinets in service. Meanwhile, birth rates dropped to a record low, **decreasing 4% in 2020 alone**. As a result, children comprise just 22% of the nation's population, **also a record low**.



Source: AHA Hospital Statistics (1985-2021), Health Forum LLC, an affiliate of the American Hospital Association, the Centers for Disease Control and Prevention, and the National Center for Health Statistics.

Pediatric subspecialists practice best in groups of three to four subspecialists due to today's coverage and lifestyle factors. Depending on the specialty, pediatric population estimates range from 50,000 to 100,000 lives to support a single pediatric subspecialist. Therefore, the market to support a full complement of pediatric subspecialists is several hundred thousand children at a minimum.

Operating challenges for children's hospitals have been building for three decades, as community health systems bolstered their pediatric service lines, developing or expanding freestanding, free-leaning, or hospital-within-a-hospital specialty pediatric services. This is due in large part to the economic advantages of operating an NICU. In this environment, the number of newborn intensive care, pediatric intensive care, and neonatal intermediate care units has doubled. For urban general hospitals that care for Medicaid-covered babies and high-acuity children's cases—neither of which generate significant revenue—NICUs provide an economic lifeline.

The shift toward delivery of pediatric care in outpatient settings—such as ear tube insertion procedures, which can be performed in outpatient centers for commercially insured children with little capital investment—also has tightened revenue-generating opportunities for children's hospitals, which are left to care for disadvantaged children and those with medically complex conditions. Many markets have seen increased fragmentation of low-acute, commercially reimbursed services such as general surgery, orthopedics, plastics, and urology for children. At the same time, new payment arrangements and new care delivery models made the provision of pediatric hospital care more complex for legacy specialty pediatric providers.

Meanwhile, delivery of pediatric care has been severely affected by the maldistribution of pediatric specialists across specialties and regionally. This leaves some areas of the country with limited or very distant coverage: A 2020 **JAMA study** indicated that children residing in some geographical areas had limited or no access to certain specialized care within an 80-mile driving distance.

Further, if Medicaid funding were to be **capped for children with special healthcare needs**, such policies could have dire financial repercussions for children's hospitals in some states. In this scenario, the strategies of years past likely have not prepared children's hospitals to manage care on a per member per month basis.

Future-Proofing Children's Hospital Operations

The factors described above create a classic conflict in healthcare: that of mission ("What's best for kids?") versus stewardship ("How do we protect this asset?").

How can children's hospital leaders safeguard their organization's legacy and endowment from qualitative and quantitative erosion? The first step is to understand how many children, in terms of captured population, are required to sustain a full-service children's hospital with a full complement of subspecialty services. While the answer is complicated, a Guidehouse actuarial and Medicaid claims analysis suggests that for most pediatric subspecialties, one to two subspecialty full-time equivalent employees are needed for every 100,000 patients.

However, as noted above, pediatric subspecialists are not likely to commit long term to solo practice. As a result, for many pediatric subspecialties, ***it takes a substantial number of dedicated pediatric lives*** to sustain a group of at least three to four subspecialists in a market, depending on the subspecialty. This does not include additional tertiary and quaternary referral reach for certain specialties.

The rise in specialty pediatric units (pediatric intensive, neonatal intensive, and cardiac intensive care) requiring expanded physician coverage has fueled demand for many pediatric subspecialists. For example, neonatologists generally provide coverage across multiple NICUs in a market.

In 2005, there were approximately 3,000 neonatologists under age 70; by 2018, **5,400 neonatologists under the age of 70** provided care, even as the total number of births became stagnant or decreased. This macroeconomic paradox means that neonatologists' control over referrals to pediatric providers and other subspecialists has taken on new importance. As NICUs struggle to maintain volumes to support appropriate subspecialty coverage, aligned and dedicated neonatologists with firm ties to OB/GYNs will be increasingly important for children's providers.

Key Actions for Children's Hospital Leaders

What are the key questions that leaders of legacy pediatric organizations should ask in determining their path forward? If an organization is not a market leader, how might leaders improve its chances for sustainability and long-term community relevance? And, how will the importance of scale play out going forward, especially amid unprecedented shifts in care and volume due to the pandemic?

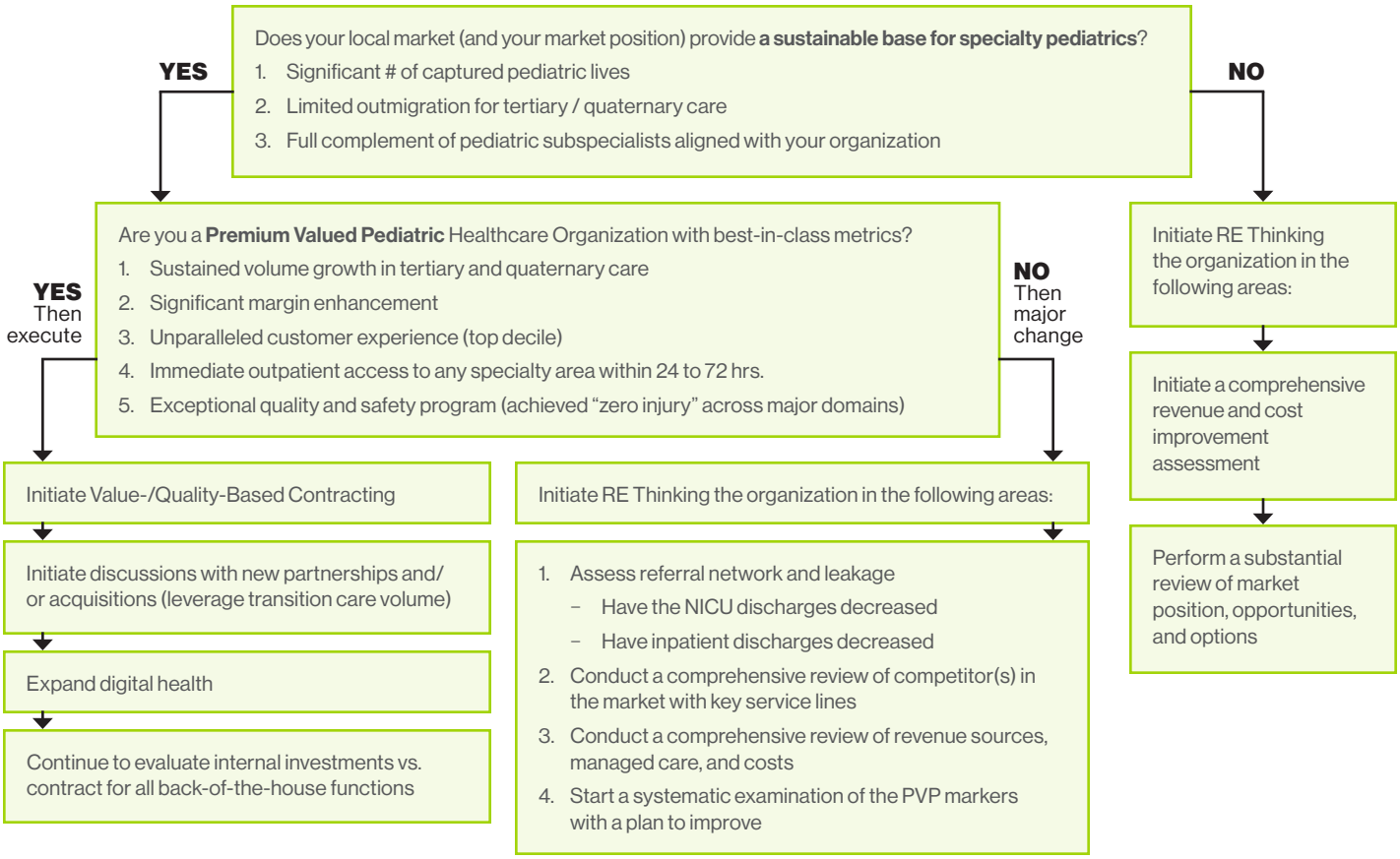
The decision tree model located below enables children's hospital leaders to quickly gauge their organization's level of vulnerability. From there, leaders can assess the steps needed to align their organization's strategic and operational planning to support long-term viability and success. (See the exhibit below.)

Efforts to turn around a children's hospital's financial performance and reposition the organization for the future typically focus on five areas.

No. 1: Margin enhancement. Aligning quality metrics, financial incentives, and other components of value-based payment models across payers can accelerate the transition to value-based care. It simplifies implementation and reduces the administrative burden of implementing more complex payment models. It also supports participation in multiple value-based payment contracts, which amplifies the impact of these models and drives care transformation across the healthcare system.

Leaders also should develop a cost roadmap, looking for opportunities to leverage scale in shared services, revenue cycle, and other areas. Today, innovative leaders are taking steps to safeguard their organization's legacy and endowment by developing new models for collaboration around administrative functions, such as revenue cycle. These models empower leaders to share best practices and take advantage of shared resources, reducing costs while protecting quality of care.

Rethinking Children's Hospitals 2021: Key Initiatives for Sustained Growth and Margin



Also crucial: "Owning" delivery of NICU staffing (e.g., neonatologists, advanced practice practitioners) in the region. If a traditional children's hospital NICU is unable to control NICU services across its market, it can quickly become a destination for a large proportion of Medicaid and high-intensity pediatric cases—with generally unfavorable economic results. A strong focus on capturing commercial pediatric procedures also is key to an children's hospital's long-term financial health.

No. 2: Volume growth. This is essential to support inpatient volumes in the tertiary and quaternary service areas. To achieve the volume needed to support value-based contracting, leaders should explore collaborative relationships that drive expansion in both primary and secondary service areas.

No. 3: Patient and family experience. The ease with which patients and their families can access services and the quality of the experience they encounter are key factors in market-area loyalty. Coupled with an outstanding experience, "immediate" access to primary and specialty care drives volume and reduces network or system leakage. It also helps to align primary care providers with the hospital. Also critical: a strong care continuum, with support for one-stop encounters within the service line or clinical program.

No. 4: Efforts to reduce clinical variation. These efforts are critical to achieving high-quality care. They include work toward achieving zero readmissions, hospital-acquired infections, and medication errors, such as through mandated implementation of protocols, order sets, and algorithms. They also involve the use of predictive analytics to identify patients with high risk of complications and others who would benefit from additional support. These efforts improve health outcomes while reducing costs of care.

No. 5: Innovative partnerships or acquisitions. These can involve organizations within the same geographic area or even in other states—and they aren't limited to partnerships with other providers. For example, in July 2020, Connecticut Children's partnered with Guidehouse to develop the **Children's Health Consortium**, a national alliance of independent children's hospitals and industry experts. Its focus: to strengthen revenue cycle operations in children's hospitals, a move designed to reduce cost and increase efficiency while enabling hospitals to devote more time and resources toward clinical care and the patient and family experience.

For Connecticut Children's, the ability to partner with other children's hospitals that have skin in the game holds strong appeal. It ensures that these entities remain focused on patient and family satisfaction and care quality, even as they seek to improve their bottom line. Further, by easing oversight for administrative functions such as revenue cycle, children's hospital leaders can center their attention on initiatives that directly support their mission. They also gain a funding mechanism for advanced treatment and an avenue for redirecting scarce IT resources to meet clinical and operational needs. Early wins from the Children's Health Consortium include a 14% decrease in days in accounts receivable and a $7.6 million boost in cash collections—revenue that Connecticut Children's reinvests in care delivery.

Determining the Right Path Forward

COVID-19 exposed a variety of pressure points that impact children's hospital performance, but signs of stress existed long before the pandemic. By reevaluating their operational model and repositioning for the future, children's hospital leaders can protect their organization's long-term health and remain a vital resource for the communities they serve.

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