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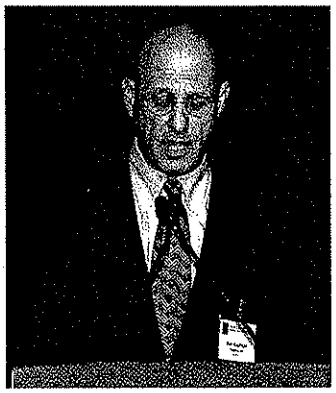
A New Business Model for the Hospital Industry



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The following is based on Ken Kaufman's Leadership Issues for CFOs presentation at the 2009 Kaufman Hall Financial Leadership Conference in Chicago.

> Creative destruction: "...(A) process of industrial mutation that incessantly revolutionizes the economic structure from within, incessantly destroying the old business model and incessantly creating a new business model." –Joseph Schumpeter

Healthcare reform has captured the nation's attention during the past year. Hospitals and health systems have been focusing on how the legislation might impact their strategic, competitive, and financial positions. While the reform legislation is critically important, we believe that healthcare may be experiencing a bigger and more profound change—that change involves the emergence of a new business model.

Since Medicare was introduced in 1966, the hospital industry has operated under one continuous business model, which has been driven by the fee-for-service payment system. The system generally rewarded a business model that encouraged growth in both total services provided and market share in general. This article will suggest that the twin impacts of the financial crisis and the principles of healthcare reform are likely eroding this current business model, and the hospital industry may now, in fact, be experiencing what Joseph Schumpeter described as "creative destruction."

Austrian-born economist Schumpeter described this process in 1942. Then teaching at Harvard University, Schumpeter used "creative destruction" to explain how change occurs in a capitalistic economy through a process of destroying old models and creating new ones.[1] According to Schumpeter, the genius of capitalism is that it incentivizes people in the business world to identify what's old and not working well and to replace it with something new that works better. Continuous replacement of models that have become stale gives capitalism its ongoing vibrancy, he noted.

Examples of this process in business are both plentiful and increasingly significant. Bill Gates' invention of the PC operating system substantially impacted the mainframe computer business. Apple's iPod both destroyed the CD business and permanently damaged the music business revenue model. Google's recent addition of free GPS software to cell phones will create an unexpected competitive threat to the GPS device industry. The examples go on and on.

In the healthcare business, a similar change is likely underway with ever-louder calls for a new model that asks hospitals to work with physicians, patients, and other constituents in a very different way. Passage of healthcare reform legislation, consistent with the principles articulated by the Administration, may not be required to drive this transition, but would serve as an accelerant to the change process.

New Model Overview

With the new business model, strategic and financial success for hospitals and health systems would likely *not* be achieved through the volume of services provided. Rather, success would be attained through positive patient outcomes at acceptable "value," defined with quality and cost dimensions, across the continuum of care.

The hospitals likely to be most successful in delivering services under this new model are those with highly integrated arrangements with physicians, sophisticated information technology, efficient use of capital, the ability to direct patients to the lowest-possible cost setting consistent with quality and patient care best practices, and command and control of the care delivery process from start to finish. More details on these follow later.

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TABLE 1. FINANCIAL DETERIORATION OF THE HOSPITAL INDUSTRY
Source: Data from Moody's Investors Service: "Not-for-Profit Healthcare Medians for Fiscal Year 2008 Show Weakening Across All Major Ratios and All Rating Categories." New York, Aug. 2009.

	2007 Median	2008 Median	Deterioration Measure
Operating margin	2.1%	1.5%	40%
Median rate of revenue growth	7.2%	7.1%	1%
Days cash on hand	160 days	140 days	14%
Cash to debt	111.5%	100%	11%
Debt to capitalization	38.5%	42.1%	9%
Maximum annual debt service coverage	4.0x	3.6x	11%

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From a payment system perspective, it would appear that the fee-for-service model may no longer be sustainable. The implications of this change are significant. Articles about how fee for service incentivizes utilization of services, while doing little to emphasize quality, value, and outcomes, proliferate in the press and professional literature.

Impact of the Economic Crisis

As a result of the economic crisis, hospitals and other providers are currently facing challenges that could make it difficult for many to absorb the financial impact of a transition to a different business model. The crisis, which has been well-documented, led to the worst stock market "crash" in 80 years, followed by the worst recession since the Great Depression. The combination of these events has had a direct and powerful impact on the financial stability and equilibrium of many not-for-profit hospitals and health systems.

The list of miseries creating pressures on hospital operations, credit quality, and capital is a long one, which includes softening volumes, deteriorating payor mix, increasing bad debt, falling operating and EBIDA margins, reduced liquidity associated with considerable investment losses, reduced access to capital, more expensive capital when it is available, and accelerating capital needs related to physicians, facilities, and information technology.

Annual rating medians published by Moody's Investors Service already reflect the extent of financial deterioration among not-for-profit hospitals and health systems in all rating categories.[2] The median operating margin dropped 40 percent to 1.5 percent in 2008 from 2.1 percent in 2007; days cash on hand fell 14 percent, to 140 days in 2008 from 160 days in 2007; and other ratios moved in the wrong direction (Table 1). As a result of such deterioration, in the four quarters after Lehman Brothers declared bankruptcy (Q4 2008 to Q3 2009), the number of downgrades of healthcare credits—71—exceeded that in the previous 7 quarters combined—69.

Impact of Healthcare Reform

Healthcare reform may place significant additional pressures on the existing hospital business model. The goals of reform, which include expansion of the total population that is insured, cost reductions of $1.12 trillion over 10 years, improved value, and increased provider accountability for outcomes, indicate the high degree of change that would be required of hospitals. Mechanisms under consideration to achieve the stated goals include payment based on best-practice levels of value, bundled payments, quality-incentive payments, reductions in readmission rates, and competitive bidding for Medicare Advantage plans.

To achieve the goal of highest value for lowest cost, patients will need to receive services in the right place. This will push hospitals and physicians to coordinate patient care along the continuum in more cost-effective and appropriate ways. Payment incentives or penalties would accelerate the change. For example, Medicare may simply stop paying providers for hospital readmissions within 30 to 60 days of discharge. Because 18 percent of hospitalized Medicare patients are readmitted for care related to their original admission,[3] the financial impact on hospitals could be significant. All of the concepts mentioned here represent fundamental, not incremental, change to the hospital payment system.

The Administration is citing certain organizations as models of the desired future state of healthcare delivery. These organizations have in common the employment of most, if not all, of the physicians who practice in the organization. During many decades of operations, Geisinger Health System, Intermountain Healthcare, Kaiser Permanente, Group Health of Puget Sound, and Mayo Clinic have aligned organizational and physician interests both clinically and financially. The current assumption in the reform debate is that such alignment has given these organizations greater control of patient care costs, quality, and outcomes.

Many of the model organizations also are cited as having extensive care and disease management capabilities, achieved through the use of evidence-based protocols, and sophisticated IT systems.

There's much talk about the "replicability" of the systems and cultures in place at these organizations, but it is clear that the Administration wants to push hospitals toward closer economic alignment with physicians and tighter control of both services provided and related costs. This trend is likely to alter thinking about who needs care in hospitals, what physicians are allowed/not allowed to do in hospitals, and how hospitals define their markets or patient communities.

Healthcare as a "Social Good"

The fee-for-service environment, which was reinforced by Medicare in 1966, offered a more predictable volume-based revenue stream to hospitals, physicians, and other providers. As such, it changed healthcare, from what had been a social good, to an economic good. Business or *economic goods* respond to supply and demand curves; *social*

goods do not. The move *away* from fee-for-service reimbursement mechanisms in the reform-accelerated new hospital model could change healthcare back to a social good. This by itself will have important implications for the organization and provision of care and who provides such care and in what setting.

To reduce utilization and costs, payment mechanisms in the new business model will need to create incentives to provide care, *as necessary*, not *on demand*. There are only two ways to reduce total costs or slow the rate of cost increases, namely reducing price or reducing the number of care units provided.

Since 1970, total healthcare spending has grown at an average annual rate of 9.6 percent, or about 2.4 percentage points faster than nominal GDP.[4] The Administration's goal is to reduce the rate of increase of total healthcare spending by 1.5 percentage points, thereby "bending the cost curve."[5] It is likely that such cost deceleration cannot be achieved without a reduction both in service units and the price of such units. Hospitals should anticipate a slowing in the growth of services provided and should be testing various utilization scenarios as part of their ongoing planning process.

Operating, or Not, into the New Era

As described in previous newsletter articles,[6] the combined challenge of the economic crisis and healthcare reform is leading to tremendous consolidation pressures in the healthcare industry, especially among not-for-profit hospitals. At this point in history, there appear to be three distinct types of hospitals and health systems on the consolidator-consolidated spectrum.

The first type is organizations that have been doing well during the last 10 to 15 years and may have the opportunity to do even better under the new business model. They have a high degree of readiness in the area of hospital-physician integration and financial strength to move aggressively within their markets.

The second type is organizations that have been struggling under the old model and are likely to struggle more under the new model. They have a low degree of hospital-physician integration and little financial strength to invest into strategies required by the new business model.

The third type is organizations that have newly challenged financial and market positions and, given new models and standards, have complex strategic decisions immediately ahead of them. Continued independence as a stand-alone hospital or small hospital system may no longer be viable. The moves these organizations make toward partnerships with stronger health systems may determine, in great measure, how fast, and how radically, different markets react to consolidation.

Hospital boards and management teams need to be analyzing their organizations' current strategic-financial condition and how they might be positioned competitively under a new business model. Asking and answering the following five questions can help to clarify their status.

Question 1. Does our *governance structure* support the strategic decision making that may be needed imminently for dramatic service delivery changes? Discussions around board committee structure, size, composition, meeting frequency, functioning, and culture would be appropriate. Will these characteristics and practices work to the organization's advantage in a rapidly changing care management and payment environment?

Question 2. Does our *management and administrative structure and skill set* support the rapid changes that may be required for the new business model? A 1960s hospital administration structure and style are probably not going to be appropriate; the new model would require hospital executives with significantly different skill sets. Because hospitals will be employing physicians, physician management capabilities—including the ability to integrate, organize, and retain physician groups—would be critical. Care management capabilities and a thorough understanding of quality, performance, and outcome evaluation would also be required, as would expertise in the development of sophisticated hospital communication systems.

Question 3. Is our existing *portfolio of hospitals and other lines of business* the right portfolio for changing competitive conditions? Businesses accumulated by hospitals and health systems during the past decades, such as long-term care facilities, home health agencies, managed care plans, joint-ventured ambulatory surgery centers, and so forth, may no longer be affordable or core to the organization. The portfolio of services should be carefully "scrubbed" and businesses that are not core to the mission should be considered for divestiture.

Question 4. Without assuming a level of *risk* that is unacceptable to the board and management team, can our *financial plan* be managed to create the capital capacity and working capital needed to grow and change our business model? The board must understand the total level of enterprise risk assumed as the organization changes its strategic direction under the new business model.[7] It's very likely that the organization will have to take on more risk. Financial leaders should ensure thorough and timely financial forecasting and scenario analysis to determine where the organization stands with each opportunity and how quickly opportunities can be pursued. In some situations, it may be appropriate for the organization to move more quickly; in other situations, the organization will need to slow down.

Question 5. What is the proper *level of scale* for our organization, given a certain market? All hospitals are currently asking questions related to size and scale. How big is big enough and/or how small is too small under these rapidly changing conditions?

Marketplace competitive pressures going forward under a new business model will challenge hospital boards and management teams to a much greater extent than in the past. Market share would be determined not by the number of procedures or services performed, but by the number of patients under care and the quality of outcomes across the entire continuum.

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Because the task of reorganizing care delivery is so substantial, hospitals will likely play a unique role. No other provider group has the ability to organize resources and execute strategies on such a broad geographic and comprehensive level.

Concluding Comments

A new business model for the nation's hospitals would fundamentally alter the overall landscape for health services delivery and how hospitals survive and thrive in that landscape. We suspect that successful hospitals and health systems will be those that have moved forward early and aggressively to align with physicians, acquire care and disease management capabilities, implement sophisticated IT and communication systems, and gain sufficient size and scale to control the care delivery process in their markets. First movers will be rewarded.

For more information, please contact Ken Kaufman at 847.441.8780 or kkaufman@kaufmanhall.com.

References

1 Schumpeter, Joseph A: Capitalism, Socialism and Democracy. New York: Harper and Brothers, 1942. 5th Ed. London: George Allen and Unwin, 1976.

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5 Davis, K.: Bending the Health Care Cost Curve: Lessons from the Past. May 26, 2009. www.commonwealthfund.org.

6 Summer and Fall 2009 issues of the *KaufmanHall Report*. Available at kaufmanhall.com.

7 See Kaufman, K.: "Managing Risk in a Challenging Financial Environment." *hfm* Magazine, Aug. 2008.

Staff Notes

Please Join Us in Welcoming...

Patrick Allen is a Vice President in Kaufman Hall's mergers and acquisitions practice. With more than 13 years of experience, Patrick's responsibilities focus on mergers, acquisitions, valuations, divestitures, joint ventures, fairness opinions, and related transaction services. Prior to joining Kaufman Hall, Patrick was an investment banker in the healthcare mergers and acquisitions practice of CIT Group.

Patrick has a B.S. in Political Science from Santa Clara University and an M.B.A. in Finance from Loyola University of Chicago, where he was an Alan C. Greenberg scholar.

Nora Kelly is a Senior Associate in Kaufman Hall's financial planning practice, providing advisory services to West Coast clients from the firm's Los Angeles office. Prior to joining Kaufman Hall, Nora was a Senior Associate at Triton Pacific Capital Partners, where she executed and monitored new investments in the healthcare, software, and business services industries.

Nora has a B.S. in Math/Economics from UCLA and an M.B.A. in Finance from Columbia Business School.

Cathy Moore is Kaufman Hall's Software Support Manager, responsible for managing the daily operations of the support team for the ENUFF Software Suite®. Her focus is to ensure the highest level of customer satisfaction for clients who call for support. Prior to joining Kaufman Hall, Cathy was a Senior Client Support Manager for Avega, Inc.

Cathy has a B.A. in English from Central College and has received professional certification in numerous process and performance improvement areas from Systemation.

David Ratliff is an Assistant Vice President in Kaufman Hall's financial advisory services practice. David's responsibilities include assisting hospital and health system clients with bond issuances, derivative transactions, merger and acquisition activity, and general capital structure management. Prior to joining Kaufman Hall, David was an investment banker for Citigroup's healthcare finance group, where his responsibilities included debt and derivative transactions, strategic advisory engagements, and solutions for capital platform issues.

David has an M.S. in Accountancy from the University of Notre Dame and a B.S. in Finance with a minor in Economics from the University of Florida.

Luke Taylor is a Software Support Analyst who provides technical support and installation assistance to clients for the ENUFF Software Suite®. Prior to joining Kaufman Hall, Luke worked for MedAssets as a technical specialist focused on implementing and supporting decision support software for the healthcare industry.

Luke has a B.S. in Computer Information Systems from DeVry University in Long Beach, CA.

American Hospital Association

Accountable Care Organizations (ACOs)

- ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery across providers and across time. Many hospitals and health care systems – working with physicians – are well-positioned to provide the organizational structure that underlies the functioning of a successful ACO.

- We support the Senate Finance Committee legislation's version of ACOs because it includes a pilot program that allows groups of qualifying providers – individual hospitals, in addition to physician practices, physician group practices, hospital-physician joint ventures and hospitals employing physicians – to form ACOs and share in the cost savings they achieve for Medicare.

- This opportunity to provide leadership in ACOs should not be limited to physician groups and physician organizational models, as it is in the House legislation.

- The legislation permits Medicare to pilot programs in which ACOs are paid to manage the health care of defined populations beginning in January 2012. ACOs:

  - ✓ Have a legal structure that would enable the group to receive payments and distribute incentives;
  - ✓ Have a sufficient number of primary care providers to serve the population for which they are assuming accountability;
  - ✓ Collect and report on quality data and other information specified by the Secretary of Health and Human Services (HHS) to enable the evaluation of the success of the pilot;
  - ✓ Notify the applicable beneficiaries as determined appropriate by the Secretary;
  - ✓ Contribute to a "best practices" Web site specified by the Secretary for sharing of effective strategies for improving care and efficiency;
  - ✓ Use patient-centered care processes; and,
  - ✓ Meet other criteria set by the Secretary.

- ACOs may be paid either on a performance target model or on a partial capitation model. In the performance target model, an ACO that shows acceptable performance on quality metrics and whose per capita expenditures are less than the targeted amount, is eligible to receive an incentive payment equal to part of the savings that results from having expenditures less than the targeted amount. The targeted amount is calculated based on the amounts previously spent under Medicare Parts A and B on similar patients in previous years, adjusted for inflation and other trends in health care costs.

- The partial capitation model puts the ACOs at risk for some of the costs of care for the beneficiaries included in the ACO's defined population, such as all Part B services or only services related to physician services. The House legislation also enables the public plan to experiment with payments to ACOs, and the House Energy & Commerce Committee's bill extended this concept to enable Medicaid programs to pilot programs as well.