Not Changing is the Greatest Risk: An Open Letter to Hospital and Health System Leaders

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You've been through a lot. We've battled the first pandemic in a decade and the most significant one in generations. Unfortunately, for many leaders, it won't be the last of your career.

This has been a very challenging time: physicians, nurses and staff infected and even killed by the virus; tremendous financial losses; forced layoffs or furloughs; disaster plans activated; supply chain challenges; endless media requests and demands from state and federal agencies for data.

Many of you, exhausted, sleep-deprived and without a day off in months, are now facing your first lull. You may be able to move from crisis management towards thinking about the big questions, such as: "Now what? How do we recover financially? When do we bring back furloughed employees? What do we do about capital improvement projects tabled due to the pandemic?"

You may also begin thinking about lessons learned and changes to make to prepare for a second wave of SARS-CoV-2 or another crisis.

Ideally, this is also the time to begin a review – and likely substantial revisions or complete overhaul – of your strategic plan. This pandemic is accelerating change, especially in healthcare. And, if you don't anticipate these changes, coronavirus will be the least of your long-term concerns.

Here are a few immediate steps you can – should – start with now. Some aren't "strategic" in the traditional sense but will lay the groundwork across your organization for what comes next:

1. Thank everyone.

Memorialize team members you lost, thank those who were infected for their service. While nurses and doctors have understandably received the highest profile in the media and online, there are many unsung heroes. How many more people would have been infected without the diligent cleaning and disinfecting by the environmental services staff? Consider how the resourcefulness of supply chain staff likely helped prevent additional infections and deaths. Many of your staff may have been fearful about coming to work, yet critical to the operations – registering patients, providing meals, taking calls, filling prescriptions, managing airways, performing imaging and running labs, providing physical therapy, keeping the IT infrastructure and plant ops running, tracking and responding to rapidly changing legal and regulatory guidance... Recognize them. They were all there when we needed them.

2. Acknowledge external support.

Thank public and other external stakeholders – EMS, donors, volunteers, companies that donated PPE, the public that made home-made masks and everyone else who made it a bit easier to manage through this.

3. Share safety measures.

Let the public know you're taking extraordinary steps to ensure their safety when they need your services.

Remind them that the risk of staying home with a stroke or a heart attack is much greater than the possibility of contracting COVID-19 by coming in for care.

4. Conduct a formal debriefing.

Assemble all your organization's leaders involved in managing this first wave while it's still fresh in everyone's minds. Look at what went well and what didn't, what you learned and what should change. Update your plans and prepare for a potential second wave accordingly.

5. Reevaluate your supply chains.

The lack of federal preparation leading up to and during the first wave meant that physician groups, hospitals, health systems, states and the federal government were all competing for limited supplies by bidding against each other and other countries. We now have to plan differently to ensure that we have the supplies we need for the next crisis.

6. Reevaluate your workforce policies.

For example, do you discourage people from staying home when they are sick by requiring a doctor's visit and note or using unpaid time off?

7. Review your IT.

Information systems were lacking when it came time to track and report the flood of data. Leaders should review necessary changes to automate data collection and improve collaboration with outside agencies. This may also be the time for strengthening your commitment to and investments in data analytics.

This is an important time to revisit the environmental and economic landscape of healthcare and our communities, the assumptions we used in prior plans, the cost pressures that will be on healthcare providers and our customers, the lessons we have learned through this pandemic relative to our clinical model and what the new normal is likely to be. These are the issues we'll consider throughout this piece.

PART I

A Dramatically Changing Environment

No doubt that your communities are very proud of your organization and your people. During 2019, the national conversation around hospitals had grown in scope, criticism and intensity. While very few good things have come out of this pandemic, one is the reminder that community, regional and academic hospitals and medical centers are very different from the physician-owned surgical hospitals and ambulatory providers of care and, in fact, essential to the care of our communities and our nation. During this crisis, community and regional full-service hospitals provided emergency and intensive care and saved countless lives. While the federal government lent some limited assistance to hospitals in a few hotspots of the country, the reality is that without our community, regional and academic hospitals, the deaths would have been exponentially greater.

Hospitals and health systems have and will continue to suffer tremendous financial losses during the pandemic. Some will not survive. Some will, but only through a change in ownership. Nevertheless, we will eventually get through this, life will return to a new homeostasis, and memories of the health care heroes will fade.

> **Next year, or whenever the headlines are no longer consumed by coronavirus, we will likely have an economy still in recovery.**

Unemployment will likely remain high, and businesses will feel economic pressure and focus on managing costs (which will revive the discussions about healthcare costs). In addition, state and local government budgets will be stressed and looking for cuts (again bringing healthcare costs into the spotlight).

Additionally, we are approaching a presidential election and a Supreme Court decision on the fate of the Affordable Care Act. Both are of monumental importance to healthcare leaders and may profoundly impact your organization. All of this needs to factor into your review of your strategy.

For a moment, just consider some likely scenarios as providers reopen services under the current administration and with the ACA still in effect.

Record numbers of people have lost their jobs or were furloughed. Many will join the ranks of our uninsured or Medicaid expansion populations. We will see:

- Increases in bad debt, especially for those in high-deductible insurance plans and those who lose their insurance and are not eligible for Medicaid (the gap population).
- Increases in charity care.
- A marked increase in Medicaid.
- A continued shift from commercial insurance to Medicare.
- A shift of commercial coverage with broad access networks to exchange plans with narrow networks, resulting in your now being out-of-network for some of your patients.
- Decreased revenues from ambulatory and outpatient services as people defer care or planned surgeries.
- Decreases in revenues as some patients continue to fear coming to the hospital.
- Patients presenting with more advanced disease having put off screenings and preventive care.
- Patients may present sicker because they deferred coming to the emergency room due to fear of the coronavirus, making their care more costly and less likely to be covered by DRG payments or other reimbursements.
- Decreased operating margins, which will in turn decrease capital spending.
- Decreases in days cash-on-hand due to lower revenues and increased costs from the pandemic.
- Downgrades of bond ratings by rating agencies which will increase borrowing costs.

Not a rosy picture, right?

Let's look at another scenario where the Republicans maintain control of the White House and Senate, and the Supreme Court strikes down the ACA. The issue is that, to date, we have not seen a clear replacement plan. Without a robust replacement, the public exchanges, advance premium tax credits, subsidies and Medicaid expansion all go away. That combination would lead to something along these lines:

- Significant increases in bad debt, especially for those who maintain their insurance with high deductibles and large out-of-pocket expenses, those who develop conditions that are excluded from coverage under their new policies, and those who lose their insurance and will almost certainly not be eligible for Medicaid and don't have the option of a subsidized exchange plan. Bad debt will also increase due to failure of association health plans or religious ministry cost-sharing plans to cover the service after it was provided or as a consequence of their insolvency given their lack of state department of insurance oversight.
- Significant increases in charity care.
- Some increase in Medicaid.
- A continued shift from commercial insurance to Medicare.
- Decreased revenues from ambulatory and outpatient services as people put off care or planned surgeries.
- Decreases in revenues as some patients continue to fear coming to the hospital.
- Patients presenting with more advanced disease as they put off screenings and preventive care (this will increase the number of patients for which the revenues do not cover the costs of providing the care) due both to fears of coronavirus, but also the fact that preventive care and screenings will no longer be covered services and will no longer be provided without out-of-pocket expense.
- Patients may present sicker because they deferred coming to the emergency room due to fear of the coronavirus or limited insurance coverage, making their care more costly and less likely to be covered by DRG payments or other reimbursements.
- Decreased operating margins, which will in turn decrease capital spending.

» Decreases in days cash-on-hand due to lower revenue and increased costs from managing through the pandemic.

» Downgrades of bond ratings by rating agencies, which will increase borrowing costs.

I have written previously about what I think the outcome of the legal challenge to the ACA should be (uphold the lower court's determination that the individual mandate is unconstitutional, but uphold the remainder of the statute and merely sever the individual mandate from the statute). But, predicting the outcome today with the change in the makeup of the Court has become much more difficult.

> **Regardless of where you fall on the political spectrum, all of this must be taken into account for your strategic planning.**

PART II

A Compelling Case for Change

With the tremendous financial pressures of the past few months, you're likely focusing on increasing your revenues by restarting services and cutting expenses at least while revenues ramp back up. Guess what? Almost every company and individual you serve will be doing the same thing. Most companies experienced a significant loss of revenue that will take time to regain, and individuals have lost income and likely incurred more debt. For those who regain work, their hours may be limited, their commissions may be lower, and they, too, will be looking for cuts to their household expenses. And, because the pandemic occurred early in the year, it's fair to assume that most people had not met their deductible before the coronavirus shut things down. Meeting their deductible now may be a significant deterrent to them seeking "elective" services anytime soon.

Given the financial realities the healthcare industry is facing, I would suggest that we can no longer "make it up on volume." We have to think differently. Companies and governments will all be looking for cost reductions, and healthcare costs will be a line item with a target on its back.

> **Healthcare organizations should no longer think of themselves as immune from market forces.**

Today, things are different. Disruption was already coming to healthcare; it's simply been accelerated by the novel coronavirus.

Free-standing imaging centers, ambulatory surgery centers, free-standing cardiac cath labs and physician-owned surgical hospitals have largely come about and expanded over the last three to four decades. More recently have come "micro-hospitals," telemedicine, mobile healthcare services and hospital-at-home services. Each of these (and many others) has been disruptive as new companies with new models look to break into the $3 trillion healthcare industry by making services more convenient, more affordable and a better experience.

But those disruptions have been largely measured out over years. Coronavirus just handed them a big helping hand. Now, patients say they will put off all of those services that make hospitals money under fee-for-service – for months to a year. And what happens if we have a bigger, deadlier second wave this fall? It would be foolish to think that patients are not going to consider the appeal of non-hospital settings to receive care while avoiding patients with COVID – even if their concerns are unfounded.

Moreover, given the economic downturn, the financial pressures on people and organizations they work for

are going to be immense. The appeal of benefit design to drive employees to lower-cost settings will be significant.

> **Also, coronavirus encouraged some to try telehealth services, and all indications are that the experience is positive. People will continue to use it. If hospitals and health systems don't make this offering available, plenty of telehealth companies will step in and fill the gap.**

Finally, the bond and stock markets are not likely to be great investment vehicles for the short-term. There will be a lot of private equity and venture capital looking for places to safely and profitably invest their money. Providers must assume significant dollars will be deployed in healthcare – and some directed at physicians who have had their businesses turned upside down and who will be willing partners in creating new opportunities for financial returns that can take advantage of the new market realities. More on that in the next section.

The intention here is not to simply identify problems facing health systems. There are solutions. But first, it's important to finish exploring these challenges because change is hard, and few are willing to make sufficient changes until forced to do so. And while people naturally tend to believe change is risky, not changing is riskier.

In Part III, let's discuss physician challenges and opportunities.

PART III

Reassessing Strategy and Physician Relationships

The U.S. healthcare delivery system is about to realign. Decisions that hospitals and physicians were already considering are about to accelerate.

Think about the last couple of years. Remember the comments from leaders across the country that fee-for-service was the problem and value was the answer. To be clear, in this formulation, "value" means risk – downside risk. We won't align incentives with pay-for-performance or upside-only arrangements, and shared-savings arrangements haven't worked so far and are unlikely to work in the long-term.

While it seemed that healthcare leaders and federal agencies agreed that the answer was moving to value, agreement was the easy part. Figuring out how to do it remains the hard part. (More on that in the next section).

A key question has been, "How big do you have to be to take on risk?" This leads to discussions around the role of critical-access hospitals, independent community hospitals and even independent physicians in a value-based world.

Before the pandemic, the question of survival as an independent entity for small or independent hospitals was largely a strategic one – a question that revolved around the worldview of the board and CEO. How long would the healthcare world remain the same? Could the hospital ride it out through fee-for-service and maintain its independence for the foreseeable future? Even if change was coming, was there time to hang on to fee-for-service but adjust down the road if necessary? For many of these hospitals, the pandemic added stress to already challenging financials, so the question now may not only be the strategic one, but one of financial survival.

Many independent physicians had never faced an existential financial threat to their practice until recent months. Unlike hospitals, physician practices typically have few reserves for a crisis. Therefore, significant cash flow events will cause physicians to make up for the loss by reducing expenses through cuts to staffing and compensation.

Even before coronavirus, many physicians were considering where healthcare was headed and what their best options would be. While physicians generally value independence, it comes at a cost. Practice expenses increase every year. But aside from large groups or high-demand specialties, physicians often have little leverage with managed care companies and may not see revenues increase enough to cover growing expenses. In addition, regulations continue to grow. Submitting claims and collecting payments have become more challenging given the number of insurers and the differing rules for each. Back-office administration continues to become more complex.

Now, in light of the pandemic, physicians are rethinking their risk tolerance and considering employment for the sake of greater security and ease of practice administration. Others wish to remain independent but may seek other revenue streams to provide greater protection, or at least more control, in the event of further disruption.

So, what does this all mean for health system leaders? First, open your channels of communication. Smaller hospitals may want to explore their options. Even if your health system is not interested in making a particular acquisition, consider the implications if that hospital is acquired by one of your competitors.

> **You also need to begin conversations with your physicians – both employed and independent. You need to know how they are doing, what they are feeling, what concerns they have and whether your relationship is secure.**

One of the first things to ask is whether they felt supported and protected during the pandemic. Too many did not. It's hard to imagine that those physicians will feel any loyalty to their hospitals or leaders.

Even where physicians did feel cared for, they may have concerns about the hospital's finances and their own long-term viability. They may be concerned that the path to financial recovery means cutting physician salaries. Physicians are generally reticent to address these concerns directly with leadership. Instead, they may assume the worst and look for a more secure arrangement. Leaders should therefore have open conversations with physicians about the current situation and plans for the future.

Even where physicians feel respected and cared for, even if they are not concerned about financial viability, others may be meeting with them and offering them attractive terms. As noted above, private equity and venture capital firms will be looking for better returns than they can make in the financial markets, and healthcare will be one of the sectors that could provide it.

All told, you must reassess your physician relationships. Your strategy will do you no good if you do not have engaged physicians to drive it forward.

PART IV

Value

A quick recap of the major issues to consider during a post-pandemic strategic review:

- Financial repositioning
- Financial pressure on individuals, companies and local governments
- Potential impact of the 2020 elections
- Potential impact of the Supreme Court's decision on the constitutionality of the ACA
- Disruption driven by new entrants, private equity and venture capital firms
- Changing consumer expectations and fears about seeking services at hospitals
- Realignment of healthcare delivery, particularly for critical access hospitals, community hospitals and independent physicians
- Stability of relationships between providers and employed physicians

So now what? We have reached the pivotal issue for our industry going forward: fee-for-service vs. value.

Consultants, conference speakers and many CEOs have been telling healthcare boards for years that fee-for-service is the problem and value is the answer. Has anything changed to suddenly suggest that current healthcare spending is sustainable and that the pressures on politicians to address insurance coverage, healthcare costs, the viability of Social Security and Medicare and drug costs will go away (especially during an economic downturn)? Will employers continue to willingly incur ever-rising healthcare costs in the face of economic instability?

Leadership teams still debating whether to keep milking fee-for-service or to change strategic direction and pursue value should consider three- or five-year trends around the following (up to year-end 2019 to avoid disruption caused by the novel coronavirus):

- Inpatient and outpatient episodes provided to Medicare and Medicaid beneficiaries as a percentage of all episodes of care for which there was a payer. (In other words, are patients moving onto Medicare and Medicaid, which will obviously affect revenue per case?)
- Growth in inpatient vs. outpatient services.
- Net revenue per adjusted admission vs. cost per adjusted admission.

Some parts of the country have been largely spared from declining fee-for-service revenues and/or profitability, but the majority of hospitals and health systems have seen:

- Shifts in the payer mix from higher revenue commercial payers to lower revenue governmental payers.
- Movement of inpatient services to lower revenue outpatient settings.
- Rising costs per case that will threaten profitability in the absence of increased revenue per case (which won't come from governmental payers.)

We've been endlessly reminded to never waste a crisis. Now is a perfect time to forecast profitability under fee-for-service given what were likely deteriorating metrics even prior to the pandemic. Then, add in the environmental factors discussed above: economic conditions, cost pressure on customers, new market entrants and disruptors, changing relationships for physicians and a continued movement towards outpatient settings.

With that forecast in place, is fee-for-service still the problem and value the answer? If not, stop saying it. If so, revise your strategic course, because now is the perfect time to shift in that direction.

Here I'll move into a first-person story to explain. Yes, making a move to value is hard. I led a business model transformation, and it was not easy. Preparations began seven years before flipping the switch in 2017 and moving nearly a third of our health system's revenue to global capitation.

We did it when we did because our team and board saw the writing on the wall. We realized that change was coming, and it would be far better to make a move while we were still doing well under the existing business model to help fund early losses associated with a change. Also, we expected (and were later proved to be correct) that there would be a first-to-market advantage. Finally, we had used the preparatory time to gain the alignment of our staff and physicians. Everyone knew this was the right thing to do and people were excited to do it.

Why we did it rested on human nature. Many health systems say the answer is value but only pay it lip service by putting two to four percent of their revenue at risk. That is not enough to change the behavior of leadership teams, physicians or staff. It is difficult to make the investments necessary to manage risk if only a few percent of revenue involved – the organization will not change its behavior. When a financial downturn occurs, the first response will be to increase volumes.

History has shown that many companies failed to transform their business models when they were still doing well, even when they were convinced that change was coming.

Healthcare leaders should work to transform their business model now because almost no hospital or health system is doing well today under their historical model. And, if they look at their three- to five-year trends, most will probably conclude that fee-for-service was on the decline. Add in coronavirus and the environmental factors presented above, and things do look bleak for the foreseeable future.

Still, it's better to make strategic decisions based on opportunity rather than merely responding to threats. Coronavirus has presented tremendous opportunities for success in the move to value – much more than when my health system did back in 2017.

For example:

- People are hesitant to proceed with "elective" procedures.
- The use of telehealth has increased, and satisfaction is high.
- Physicians are now delivering remote care by phone or other methods for consults that would previously have "required" an office visit.

> **The pandemic has forced providers to rethink what is necessary, delivering care through mechanisms that reduce revenue under a fee-for-service arrangement.**

Now, physicians are in a better position to focus on what is necessary and what is not – exactly the right approach under value-based arrangements – rather than insurance companies making those decisions under fee-for-service. Furthermore, most health systems have access problems – an issue that urgent care clinics, retail clinics, telehealth providers and other disruptors have capitalized on. But now, with the pandemic keeping people away from medical offices despite the fee-for-service incentives, patient needs can still be met through lower-cost mechanisms, which is the point of value-based arrangements. Additionally, this model frees time to see patients who do need an in-person visit but might otherwise have skipped care or gone elsewhere.

In short, the current crisis has created opportunities to manage risk, lower costs, promote better access, and provide care in ways patients are likely to prefer. And, it opens the door for opportunities that disruptors were beginning to pursue even before the coronavirus outbreak, such as mobile care and hospital-at-home.

The ultimate win is that health systems are uniquely positioned to manage global risk arrangements. Large employers have already realized that the answer lies not in a lower unit price but in controlling utilization and getting high-quality services when they are needed. Fee-for-service does not incent either of these goals.

Healthcare C-suites know how their organizations fared under fee-for-service during the pandemic. What would that have looked like under full-value

arrangements? To find an answer, just compare the quarterly earnings reports for hospital companies versus those of health insurance companies. And as we've established throughout this piece, things will not go back to normal soon…if ever. Evaluate your strategic plan today, and begin making the hard-but-necessary changes so that whatever happens next – with the election, the Supreme Court, private payers, PE, physician groups, models of care delivery and more – your organization will be able to deliver quality care and fulfil its mission for decades to come.

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About The Art of Change

Launched in 2019, *The Art of Change* is a publication from Jarrard Phillips Cate & Hancock that addresses the relationships and the fundamental human dynamic at the core of healthcare. It is designed to share the best thinking from our firm and among clients and friends about how to master the Art of Change to make healthcare better.

Today, in the wake of COVID-19, the principles within the Art of Change are more relevant than ever: Articulating a vision so compelling it pulls people through an uncomfortable journey to a future that cannot be fully known. Listening and conversing and acknowledging the difficulty of the work with the people who will need to do it.

In Season 2, we will continue to explore these principles in the context of specific issues healthcare leaders must grapple with in this new healthcare era: Patient experience, M&A, workforce engagement, social issues and diversity, and more.

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