Transforming Not-for-Profit Healthcare in the Era of Reform
Ratings Driven Increasingly By Management Effectiveness in Executing New Strategies

Summary

The passage of healthcare reform will bring large scale changes in operating and capital strategies employed by not-for-profits hospitals to deliver healthcare services. These changes will require healthcare leaders to focus even more on multi-year strategies to assure long-term financial sustainability in an era of reform and newly constrained economic reality. The implications of healthcare reform, which may not be fully felt for several years, are intertwined and inseparable from other structural challenges facing the hospital industry. These challenges, which will test existing business models, include growing revenue pressures, greater emphasis on quality, and an imperative to lower unit costs and achieve greater efficiencies through economies of scale.

The impact of healthcare reform, even with the benefits from reductions in uncompensated care, will ultimately be negative for the industry in the sense that existing operating practices and strategies may be insufficient to maintain credit quality. Those hospitals that can effectively change their business models and position their organizations for payment reform will be most prepared and best able to adapt. A well-versed management team with forward-looking governance will guide the hospital or health system during these changes.

The strategies to best prepare the organization will require operating changes and capital investments and have varying financial and credit implications for a hospital’s bond rating. This report discusses the credit implications of four of the key strategies that leading hospitals will likely pursue in an era of reform and structural change in the industry:

» Growth strategies to drive revenues and achieve critical mass
» Physician alignment to prepare for global reimbursement
» Investment in more information technology to further cost and quality initiatives
» Effective management and governance, driving long-term financial sustainability
Revenue Pressures Will Necessitate More Aggressive Growth Strategies to Achieve Critical Mass

Even before the full effect of the reform legislation takes effect, hospitals will see tighter reimbursement from all payers. In the short-term, Medicare rate increases may be minimal for the upcoming federal fiscal year starting October 1, 2010, and over the longer-term, Medicare rates are likely to be cut as the federal budget pressure continues and the insolvency of Medicare looms. For Medicaid, many states have already reduced Medicaid rates following unprecedented drops in state tax revenues. On the commercial side, most hospitals and health systems report that annual commercial rate increases continue to decline with tougher negotiations ahead as the insurance industry continues to consolidate and gain leverage over hospitals. Finally, the lingering effects of the recession has resulted in greater volatility in volume and elevated levels of uncompensated care, further pressuring revenue. While some hospitals are aggressively cutting costs to compensate for lower revenue growth, the new harsher economic reality is necessitating a greater focus on top line revenue and sustainable long-term growth strategies.

Many of the larger regional systems and multi-state systems weathered the credit crisis and recession better than smaller hospitals because they benefited from size and geographic diversity. They were able to leverage their market positions and utilize the benefits of operating economies of scale. Most of the rating downgrades in 2009 were for smaller hospitals (see figure 1). While not immune from the impact of reform, larger health systems will likely be better positioned to adapt to the changes that are coming because of their critical mass.

FIGURE 1
Rating activity during the credit crisis: Q4 2008 Through Q1 2010

<table>
<thead>
<tr>
<th>Rating Upgrades by Total Revenues</th>
<th>Rating Downgrades by Total Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large &gt;$750M 38%</td>
<td>Medium $251-$749M 28%</td>
</tr>
<tr>
<td>Medium $251-$749M 42%</td>
<td>Large &gt;$750M 29%</td>
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<tr>
<td>Small &lt;$250M 20%</td>
<td>Medium $251-$749M 29%</td>
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<tr>
<td></td>
<td>Small &lt;$250M 43%</td>
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Source: Moody’s

Strategies:

This new economic reality will mean that the leading hospitals and health systems will more actively engage in revenue growth strategies. These include mergers with or acquisitions of other hospitals; acquisitions of or joint ventures with physician-owned surgery or imaging centers; and organic revenue growth strategies (adding new or expanding existing inpatient and outpatient services such as outpatient centers with imaging capabilities or same-day surgeries, cardiovascular services or
orthopedic services). As discussed in more detail below, some hospitals are employing physicians to solidify volumes and increase revenues.

Finally, many hospitals are looking internally for ways to increase revenues by restructuring central business office functions, including revenue-cycle and front-end registration processes. The focus on greater internal growth will be especially critical for hospitals or systems that are precluded from acquisitions or mergers because of anti-trust challenges.

Credit Implications:

Positive credit factors include:

» Gains in market share and scale that lead to greater pricing leverage, moving the hospital toward the goal of being a “price-setter” rather than a “price-taker”

» Greater revenue recognition from strategies that focus on central business office functions

» Potential for substantial expense savings for larger systems through consolidation and centralization of support services

» Elimination or reduction of competition through acquisition

» Increase in outpatient revenues through outpatient growth strategies, which may have higher returns and margins

Negative factors include:

» Integration risk when merging different cultures or medical staffs

» Time lag between investment costs and revenue realization

» Costs associated with more investment in information systems to improve revenue cycle management

» Difficulty in sustaining revenue growth once the easier gains from internal processes are achieved

Quality Initiatives and Potential for Global Reimbursement Will Drive Need for Greater and More Effective Physician Alignment

Over the past couple of years, many hospitals have pursued new or renewed strategies to more closely align with their physicians. Alignment has allowed many hospitals to secure referrals, increase market share and negotiate better rates with commercial payers. Hospitals are also able to drive quality initiatives through evidence-based medicine developed by physician leaders through alignment.

Under reform, these hospital-physician alignment strategies will be particularly important given the possibility of “bundled payment” methodologies and emphasis on Accountable Care Organizations (ACO). An ACO is a multi-dimensional provider of healthcare services that includes primary care physicians, specialists and hospitals; the ACO’s members will coordinate care for the patients with the goal of meeting and improving on quality benchmarks and sharing in any costs savings. Even before ACOs were developed, hospital-physician alignment has become becoming increasingly critical for hospitals to recruit and retain physicians and improve clinical outcomes.
We expect the leaders in this new era will be successful at creating more effective alignments with physicians that go beyond contractual arrangements. Many hospitals have aligned with physicians through employment or joint ventures, but such economic arrangements do not necessarily translate into the desired benefits of true alignment. Under effective alignment, physicians are highly engaged in hospital strategies for improving quality, creating operating efficiencies, and ensuring financial viability. For many health systems, employment is only a first step in a multi-year migration to true physician integration.

**Strategies:**

Many hospitals are employing physicians as a first step toward integration. In some cases, hospitals are revisiting this strategy much more carefully after suffering though previous failed attempts in the 1990s that only saddled them with high cost of employed physicians and little additional revenue growth (see figure 2).

**FIGURE 2:**

What’s Changed in Physician Alignment Strategies: Then (1990s) and Now

**Then:**

» Rampant employment, practice acquisition  
» Rapid decision-making, little financial planning  
» Limited technology to track productivity  
» Minimal incentive and productivity standards in the employment contracts  
» Strategy driven by hospitals  
» Physicians could afford to hold out for high price

**Now:**

» Menu of alignment strategies including employment and other economic models  
» More sophisticated financial modeling and monitoring of performance  
» Judicious and methodical approach to employment as a key, long-term strategy  
» Cultivation of physicians as leaders and greater participation on board committees  
» Strategies driven by both physicians and hospitals  
» Physicians eager to leave pressure of smaller practices for support of larger hospital

Today hospitals appear to be more methodical in their negotiations with physicians, utilizing more in-depth financial analysis and integrating strategic, capital and financial planning. Most hospitals are offering employment contracts with productivity measures clearly articulated up front. Unlike the 1990s, when physician acquisition prices typically included goodwill as a sign of market power of leading physician groups, most systems can now be more selective and prudent in acquiring physician practices for a more affordable price that reflects the increased operating pressures on independent practices. Also different today, many physicians are actively seeking hospital employment to avoid the burdens of managing a practice and strive for a work-life balance.
Hospitals that have achieved true physician alignment have been integrating with their physicians for many years. In these cases, the physician division is usually managed by a physician leader. Aligned physicians are heavily involved in clinical quality initiatives and participate on the board committee on quality. Physicians are also involved in driving operating efficiencies such as length of stay management and materials management.

Credit Implications:

Positive credit factors include:

» Greater efficiencies and potential for improved financial performance through aligned incentives to increase standardization and control costs
» Creation of a more cohesive culture and greater buy-in of hospital strategies
» Greater leverage with payers
» Better preparation for and management of bundled payments
» Potential for greater advances in quality initiatives and improved outcomes

Negative factors include:

» Ongoing costs associated with physician employment or the loss of income to physician joint ventures
» Risks of start-up losses with creation of new practices
» Challenges integrating employed and independent physicians and creating unified culture and strategy

Heavy Investment in Information Technology Required to Achieve Quality and Cost Goals

Leaders in this new era will advance the use of information technology to measure and achieve goals for improved quality and greater operating efficiencies. Both of these goals will be critical to maximize reimbursement and income as well as provide greater transparency for consumers, payers and regulators. Healthcare reform will effectively change hospital reimbursement from episode-based care to a methodology based on clinical outcomes and cost. Clinical outcomes and cost will become much more transparent, allowing patients to select where they want their hospital treatments based on these two measures.

The establishment of the Center for Medicare and Medicaid Innovation will be the governing body that will oversee the clinical outcomes and determine what measures and standards will be required by the hospitals. This additional regulatory oversight and increased reporting requirements will add a new layer of expense for most hospitals, as well as require additional investments in information technology.

During the credit crisis and recession, many hospitals and health systems effectively slowed the rate of expense growth -- in some cases absolute expenses actually declined. Typical expense reduction strategies focused on labor productivity, materials management and greater patient-registration processes to reduce bad debt expense. For some health systems, these expense measures compensated
for flat or low revenue growth and resulted in profitable operating performance that exceeded prior income levels.

Hospitals are now challenged to achieve further cost reductions which will likely be harder to accomplish now that the “low-hanging fruit” has been removed. The next level of cost reduction will require a deeper and more difficult strategy to re-engineer entire processes from patient throughput to billing. The ability to restrict growth in expenses to levels below revenue growth and increase cash flow will be integral to funding capital needs, especially for hospitals with limited access to capital.

**Strategies:**

Many of the larger regional and national systems are targeting greater efficiency from their organizations with a unified information technology platform to ensure that all hospitals, clinics and physician offices are electronically connected. This drive for management improvement is often an acceleration and formalization of performance improvement plans established at many organizations during the recent recession.

Systemic information management improvement is a costly, multi-year strategy that requires a large upfront investment. Ironically, many larger regional and multi-state organizations have an untapped resource in their failure to achieve standardization of basic processes that are dependent on information technology—such as finance, human resources and other shared services. Successful adoption of organization-wide standardization, based on a unified information technology platform, will both add to the bottom line and make future mergers and acquisitions easier to implement.

The leaders within the industry are simultaneously investing in more sophisticated planning and reporting tools enabled by information technology, and which can facilitate better productivity, supply management, regulatory compliance and timely reimbursement under commercial contracts. Improved planning tools that integrate capital, strategic and financial strategies also allow management to improve its ability to forecast and adjust plans to changing market conditions.

**Credit Implications:**

Positive credit factors include:

- Improved financial performance through systemic and sustainable cost control processes and ability to respond more quickly to unexpected revenue shortfalls
- Standardization of all goals and measurements, providing more consistent and effective management of multiple business lines or locations
- Ability to measure and report clinical outcomes and costs, resulting in greater transparency and possibly a competitive advantage
- Higher patient satisfaction with more consistent care processes and easier access to care
- More reliable ability to forecast financial performance, comply with regulatory mandates and alter plans as conditions change
Negative factors include:

» Costs for information technology and software systems, including capital costs as well as ongoing expenses

» Labor force disruptions, including management or physician turnover, caused by difficulties reaching goals of unified systems and processes

**Improved Management and Governance Needed to Successfully Implement Strategies**

Changing business models and adapting to new payment methodologies will significantly test hospital management and governance. Many hospitals had extreme difficulty in the mid 1980s when Medicare changed to a DRG payment scheme from cost based reimbursement. The degree of change facing hospitals under healthcare reform and other industry structural shifts is even more fundamental, touching all aspects of hospital operations and capital strategies.

To stabilize or improve credit quality of their organizations in coming years, many hospital leaders and board members will lead cultural change. This will be necessary to position the hospital strategically and financially to meet the challenges of a new economic environment. Boards are likely to become thoroughly educated in the changes that healthcare reform will bring, and their guidance will be paramount in the hospital’s success.

Leaders can be expected to emphasize strong relationships and partnerships with physicians that go beyond traditional alignment models and seek to include physicians in all areas of decision-making. Likewise, physicians can be expected to more openly embrace a hospital’s goal to change wholesale the delivery of care from episodic to a continuum of healthcare delivery where cost and quality are constantly measured and benchmarked. While many hospitals reduced training expenses over the past two years, a resumption of these efforts is likely in order to train middle management and physicians to assume leadership positions integral to the long-term future of the hospital.

The most effective management and boards are those that recognize and clearly define their future challenges and implement strategies to address these challenges. Even highly rated hospitals and health systems are expected to reassess their fundamental preparedness for industry change and adopt revised plans and strategies. Data and benchmarking are used throughout these leading organizations to monitor progress against these strategies. Mid-course changes and revisiting strategies occur when needed.

In addition to the core strategies discussed above, successful hospitals and boards are assessing the following management improvement tactics and strategies that are expected to achieve lasting long-term benefits:

» Greater training of middle management and future leaders

» Increased benchmarking of best practices

» Increased board education on reform

» Greater participation on boards and board committees by individuals with finance, technology, legal and investment expertise
Reconsideration and removal of “no term-limit” policies for those hospitals that have term limits

More judicious use and oversight of external consultants

Greater scrutiny of debt structure, bank agreements and derivative products

More contingency planning, including development of several cost reduction strategies that can be implemented quickly if certain triggers occur

Consideration of a capital or merger partner, even if current financial performance is stable

Assessment of growing scrutiny over tax-exemption

Increased staffing in the finance and IT department

Movement of physicians into leadership positions

Conclusion

The delivery of healthcare services will undergo much transformation in the era of healthcare reform. Those hospitals and health systems who can plan multi-year strategies and effectively change their business models and culture should be most able to adapt. Growth strategies, physician alignment and greater efficiencies, along with effective management and governance, will be integral in positioning the organization for payment reform.

Moody’s Related Research

Special Comments:

- Long-term Credit Challenges of Healthcare Reform Outweigh Benefits for Not-for-Profit Hospitals, April 2010 (124233)

- Annual Sector Outlook for Not-For-Profit Healthcare for 2010, January 2010 (122650)

- Preliminary Medians for Not-for-Profit Hospitals Show Stabilization In Operating Ratios, But Continued Weakening of Balance Sheet Metrics, April 2010 (124111)

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