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Moving from a Holding Company to an Operating Company:

The Next Level of Challenge for Regional and Multi-State Health Systems in the U.S.

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A large number of hospitals and health systems in the U.S. were formed by way of asset mergers—especially most non-profit systems. Many non-profit community hospitals were aggregated and consolidated for scalability of operating costs, more efficient access to capital markets, expected third-party payer contracting leverage, and market-based pricing power (price leverage within defined geographic regions).

Over time, smaller, regional health systems grew in size to become national in scope with operating assets distributed across multiple states and geographic regions in the U.S. under the theory that "bigger is always better."

Many of these growth strategies were underpinned by a philosophy of governance and management characterized and conveyed to new members as a promise:

> "While you are joining the system, we recognize your rights to local autonomy pertaining to governance and management. After all, healthcare is local and you know what is best for your community."

With this philosophy came certain implied local prerogatives:

- Self-determination regarding board composition and function
- Local hiring and oversight of the CEO
- Local control of strategy
- Self-stylized physician affiliation strategies
- Local control of services, pricing, and third-party contracting strategies
- Local control of clinical service model design, operations, outcome evaluations, and standards, and the policies and guidelines governing local quality of care and patient safety management
- Local control of mission design and execution
- Local control of medical staff management (including quality)

But, with a true merger (or a genuine acquisition), isn't the acquired entity subject to controls dictated by the reserved powers lodged with the governing board of the parent organization? The answer is typically yes, but implied latitude has often been granted; related, local operating site freedoms and governing prerogatives can vary.

Markets, Market Behaviors, Health Policy Change, and the Law Challenges the Old Model

Experienced health system leaders often characterize the initial operating model applied as a "holding company approach"—one where centralized governance and management control are implied, but rarely exerted. The "affiliates" are permitted to operate with wide latitude so long as expected performance outcomes are produced; these outcomes are often weighted toward the financial.

Facing almost constant state and federal policy, legal, and regulatory change, coupled with intense economic pressure, leaders of a number of large U.S. health systems have determined the need for a seismic shift in governance and managerial philosophy—a shift from a "holding company" to an "operating company" model.

Such a shift is characterized by notable changes requiring local or regional affiliates to modify standard operating procedures initiating higher levels of system-wide uniformity. These changes include:[1]

- Design and management of clinical service lines centralized to a corporate strategy (e.g., cardiovascular, cancer care, preventive medicine, and chronic disease management)
- Methods and models for the employment and compensation of physicians and other licensed providers
- Standardizations of electronic health records systems
- Dissemination and rapid adoption and adaptation of accepted, evidence-based clinical best practices
- Applications of common plan for governance, leadership, and strategies
- Standardizations of patient safety policies and procedures
- Standardizations of policies and procedures for hospital-based, medical staff management
- Standardizations of performance analytics and reporting
- Standardizations of capital structures and capital management
- Standardization of insurance-related coverages and institutional risk-related management methods and models

1 D.K. Zismer and D.C. Wegmiller, "Clinical Service Lines: Mapping the Future of Community Health," C-Suite Resources, July 2012.

The Psychology of the Shift

The shift to an operating company model necessitates more centralization of control, which can meet with resistance from the local governing bodies and management of controlled facilities. The psychology of the response is often predictable and palpable:

- From local boards: "This wasn't the deal. We expected to maintain local control. You always said that we knew best, as all healthcare is local."
- Similarly, local CEOs can be heard to say: "I'm not in charge anymore—I'm just a hotel manager. How can I be held accountable if I no longer make key decisions?"

In short, community healthcare organizations that joined larger health systems frequently feel that "the shift" violates many of the promises and covenants that were integral to the original deal. Some will turn a blind eye to the realities of the obvious, including declining financial performance at a time when strengthening the collective balance sheet of the health system is required.

Case Example

Community Hospital and Health System (CHHS), a 250-bed hospital with 100 employed physicians, joined National Health Services (NHS) toward the end of 2010. Reasons for joining NHS included these factors:

- Declining balance sheet liquidity due to physician practice acquisitions
- Insufficient debt capacity to fund required inpatient facility upgrades
- Inability to acquire an electronic health record due to cost
- A lack of organizational competencies for the emerging world of "accountable care organizations"

A full asset merger was pursued. The existing local governing board and management team remained in place. Capital access commitments were made. One member of the senior leadership team of NHS was assigned to the board. NHS governance reserved powers were made known and willingly accepted by CHHS.

The messages from NHS to CHHS were:

- "You own your balance sheet."
- "All healthcare is local."
- "You govern and operate your health system."
- "How you develop and operate partnerships with local physicians is your call."
- "We (NHS) are here to help."

From the end of 2010 to the end of 2013, the following occurred:

- Both NHS and CHHS experienced declining free cash flow performance.[2]
- Aggregate capital requests from all system affiliates far exceeded the balance sheet capacity of the consolidated NHS balance sheet.
- National purchaser accounts (employers) identified excessive price variation across NHS affiliates serving their employees.
- CHHS regional competitors moved aggressively and successfully on high-value payer contracting strategies causing CHHS to lose market share for key strategic clinical service lines.

NHS senior leaders concluded that it was time to move from a holding company model to an operating company model. The reaction of CHHS (and other health system affiliates) was simple: "This is not what you promised."

The realities of the structure and documentation of the underlying "affiliation transaction" clearly demonstrated that NHS possessed the absolute right to execute on the new plan, with CHHS possessing the right to "buy itself back" if it had the financial wherewithal. Lacking that financial strength, a painful yet inevitable state of transition ensues.

The Big Questions

Health system leadership, faced with the challenge of moving from a holding company structure to operating models of community healthcare design, strategy, operations, and capital structure management, face "big questions" related to this challenging shift:

1. What role do local boards now play (if any)?
2. Is there a useful framework of operating principles from which health system leadership can guide required change?
3. What are the best models and methods for centralization of key policies, procedures, and support services?
4. What role does "brand development" and "brand management" play in the health system's corporate strategy?[3]
5. How can leaders of regional affiliates maintain and exercise reasonable levels of local operating autonomy?
6. Must the professional autonomy of affiliated (including employed physicians) clinicians be compromised?
7. Can the potential for enhanced financial performance of the whole really be enhanced?
8. Should owned assets be trimmed (e.g., sold or traded) and, if so, based upon what broader strategic vision and plan?
9. What is a functional model for an effective health system senior leadership team and how shall it operate?
10. How should an operating model positively and productively affect patient care and public health at the community level?[4]

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2 D.K. Zismer and C. Beith, "Free Cash Flow Productivity and Its Connections to U.S. Health System Financial Performance and Strategy in Current and Future Markets: A 'Macro View' of a Potentially Systemic Problem," The Governance Institute, February 2014.

3 D.K. Zismer, "The Promise of the Brand: How Health System Leaders Are Guiding the Transition to Health Services Integration," *Journal of Healthcare Management,* Vol. 58, Number 1, January/February 2013, pp. 12–14.

4 D.K. Zismer, "An Argument for the Integration of Healthcare Management with Public Health Practice," *Journal of Healthcare Management,* Vol. 58, Number 4, July/August 2013, pp. 253–257.

Perspectives from the Field: Catholic Health Initiatives, Denver, Colorado

Catholic Health Initiatives (CHI) is a national health system formed in 1996 as a consolidation of four Catholic health systems for reasons that closely mirror those listed in this article. Since that time, it has grown to be one of the largest not-for-profit health systems in the country, with more than 90 hospitals in 18 states, over $20 billion in assets, and nearly $14 billion in annual revenue. The system also has aggressively acquired physician practices and now employs over 3,400 providers. CHI has also grown into other non-hospital-based components of the care system, including more than 90 home health agencies, 12 long-term care facilities, three assisted-living facilities, and 24 residential facilities.

Although CHI was never formally structured as a pure "holding company," its culture and management practices originally reflected a great deal of local autonomy at both the operations and governance levels. This local independence resulted in disparate information systems, financial systems, human resource policies, etc. Local market CEOs essentially "captained their own ships" and the corporate office was relatively small. Outside of pooled capital resources/allocations, realizing some level of scaled economies through participation in group purchasing operations, and very broad financial targets, there was never a great deal of involvement and direction provided from the national office to the local "markets."

Like most healthcare organizations, over the last 15 years, CHI has struggled to maintain sufficient operating margins and required free cash flow performance in the face of declining reimbursement. Halfway through fiscal year 2009, CHI found itself dealing with a potential break-even operating margin (if not a loss). A number of decisions were made in response. First, a stewardship task force was formed that included both market CEOs and selected national leaders to develop a turnaround plan. Second, the organization was restructured to "blur the lines" between the national office and the markets by creating several dual senior executive positions where individuals served both as regional CEOs and as national senior vice presidents of operations. That group formed the senior operations team for the system as a whole and was made into a permanent senior management structure.

Though the turnaround in 2009 was successful, the struggle to reach required financial performance continued in the years that followed due to changes in the industry and increasingly constrained governmental reimbursement changes. As the Affordable Care Act was conceived, and as it became apparent that it would succeed, CHI realized that the struggle would increase significantly if operations continued in a "business as usual" mode.

During these years, senior leadership decided to shift to a method of managing operations that involved stronger national influence. For example:

- Support services were centralized.
- Policies were established.
- Information systems, including human resources and accounting systems, were put on a common platform.
- A multi-billion dollar clinical informatics build was initiated from the national level with required participation by all markets.
- A national physician enterprise was established to manage the growing number of employed providers at the national level.
- Equity partnerships were formed in key areas of operational management (e.g., revenue cycle, physician practice management, etc.) with required participation by all markets.
- Outsourcing occurred in certain areas of IT technical and service management with required participation by all markets.
- National clinical service lines were established for cardiovascular, oncology, orthopedics, and hospitalist service lines.
- Payer strategies and operations were pulled to the national level, and CHI decided to enter the health insurance business at the national level as a way of responding to the changing healthcare landscape.
- Future rationalization of system assets is driven by a focus on the creation of fewer, larger, more integrated and collaborative "super-regional health systems"—a design that emphasized driving need to ensure that size produces scaled economics.

In other words, CHI senior leadership decided to begin building what would become a stronger national operating model, moving away from a management style that was more akin to the holding company model utilized on an informal basis in the past.

As this increasing standardization and national direction took hold at CHI, this represented a major cultural shift for the organization and its leadership at both the national and market (local) levels. Leaders often struggled to understand how their roles were changing as a result of this transformation. Accordingly, the existing governance structure is now being reexamined in light of these changes. At a recent annual leadership retreat, a full day was spent fleshing out what this strengthened "operating model" meant for the role of senior leadership. At that meeting, it was decided that work would be done at a senior level to define a set of system-level operating principles to guide senior leaders and assist in understanding their changing roles.

These changes in CHI's approach to managing its business were deemed to be necessary in order to respond to healthcare reform and to strengthen the organization, thereby ensuring its long-term viability in what is certain to be a very different and less predictable national healthcare system in the future.

The Framework

CHI recently conducted meetings at the board and senior leadership level to more accurately and specifically define what it means to move to a stronger operating company model. There was a realization that this vision had implications for both the governance model and the operating model. A conceptual framework was used that identified three potential future organizational designs:

- Level 1: "the vital few": At this level, an enterprise function is staffed in only a skeletal manner at the national level. There may be common analytics and

tools present, but there will be few, if any, national subject matter experts or consulting available to the markets. Full accountability for results rests at the market level, and there is little to no standardization of process for attaining the goals sought.
- Level 2: At this level, there are more resources staffed at the national level, with more internal consulting available. Targets are largely set at the enterprise level in a standardized way. There may be a few select methods and models for reaching prescribed targets, which are standardized at the enterprise level by national leadership. However, accountability for meeting performance targets rests primarily at the market (local) level.
- Level 3: This is essentially a centralized national service. Targets, analytics, and processes for reaching those targets are typically standardized across the enterprise, and resources throughout the enterprise report up to an enterprise-wide functional senior leader.

To put a final model into practice, CHI is currently in the midst of a major system-wide initiative called the Support Services Transformation. As part of this, there are approximately 30 enterprise-wide work streams led by national leaders that are redesigning their functional services to be both more effective and more efficient. The template process for this redesign includes materials that help leaders think through this model and make a business case for the appropriate level at which to operate each identified function within the enterprise. CHI leadership has decided that, as a default, functional services at the enterprise level will operate at level 2, according to the framework detailed above. If leaders of the various functional areas feel that a level 1 or a level 3 mechanism is more appropriate, they make that case as a part of their suggested redesign, and present it to an executive review team for consideration.

CHI leadership is also working with its Board of Stewardship Trustees to evaluate the governance model throughout the organization, and clarify the role of each board at various levels, as well as the local board's relationship to the CHI Board of Stewardship Trustees. This is resulting in new operational matrices defining roles, committees, reserved powers, and decision rights for all levels.

Measurement

In order to monitor results throughout this process, CHI is using its balanced scorecard at the operating site level. System leadership has also decided to create a new scorecard at the governance level called the "Living Our Mission" scorecard. The concept is to identify a small set of metrics that have implications at governance levels throughout the organization concerning whether or not a particular entity is accomplishing what is needed to make progress in mission-critical areas. Obviously, such a model will also have ramifications for the operational balanced scorecard. Although still a work in progress, the areas being measured in the "Living Our Mission" scorecard include:

- **Service to the poor and vulnerable:** charity care, self-pay, and Medicaid as a percentage of gross revenue
- **Leadership effectiveness:** the percentage of ratings of four or five on a five-point Likert scale
- **Physician satisfaction:** an aggregate of four key components driving overall satisfaction: communication, involvement in decision making, quality consistency, and likelihood to recommend
- **Quality:** aggregate of seven nationally recognized key indicators for the quality of care a patient receives during their hospital stay
- **Patient experience:** aggregate of eight nationally recognized key indicators of a patient's experience
- **Safety:** aggregate of eight nationally recognized key indicators for patient safety during a patient's hospital stay, referred to as a PSI-90 score
- **Organic growth:** new patient visits, primary care and specialty care
- **Transformation to value-based healthcare:** number of attributed, or "covered," lives
- **Operating EBIDA**

CHI leadership will also work to determine the appropriate impact on operational metrics reviewed regularly as part of the balanced scorecard noted above. These metrics cover factors such as quality/safety, stewardship/financial performance, growth, and people.

Are There Real Risks in Not Moving to Operating Company Models?

An obvious question asks to identify the risks of retaining the "holding company" model in governance and operations. While a number of potential difficulties can be cited, the following are major concerns of continuing the use of a perhaps outmoded governance structure:

- **Health system financial sustainability:** Credit agency reports and evidence in professional literature solidly point to risks to non-profit operating performance and balance sheet liquidity; with specific concern focused upon the ability to produce sufficient free cash flow from existing operating models.[5,6]
- **Medical staff functions:** Hospitals controlled by health systems operate, by state law, with formal medical staff structures that, in turn, see the medical staff operating as an agent of a local hospital governing board. Medical staff leadership is typically composed of a mixture of independent physicians and those employed by the local hospital or health system. The principal role of the hospital medical staff is advisory to the local board relating to the credentialing and privileging of individual physicians, the clinical practice patterns and quality of individual licensed practitioners, the recommendation of medical staff bylaws for adoption by the local board, and oversight and advice on hospital safety and clinical programs risk management. As noted below, recent precedent should cause senior boards of non-profit health systems to take note of the derivative risk exposure accruing as a result of placing this kind of control in the hands of the

5 D.K. Zismer, "How Might a Reforming U.S. Healthcare Marketplace Threaten Balance Sheet Liquidity for Community Health Systems?" *Journal of Healthcare Management,* Vol. 58, Number 3, May/June 2013, pp. 168–172.

6 D.K. Zismer, J. Fox, and P. Torgerson, "Financing Strategic Healthcare Facilities: The Growing Attraction of Alternative Capital," *hfm,* Healthcare Financial Management Association, May 2013.

local board of a controlled hospital in a large system.

- **Adoption of clinical best practices for service line strategies:** Most health systems in the U.S. report being in the business of clinical service lines as a principal strategy to deliver clinical care of uniformly high quality according to known, evidence-based standards. Unacceptable variations in clinical standards and practices can be minimized by internal panels of clinical experts overseeing service line management at the system level.
- **Development of unifying brand strategies:** Markets (patients, families, purchases) should be shown that, for critical clinical service lines, there is one standard of practice applying known clinical best practices. Risks exist in the health system's ability to defend variation in clinical practice (and related incidents and outcomes) across controlled sites.

Growing Evidence for a Fresh Look at the Attendant Legal Risk

As discussed, holding company models of governance often empower local hospital boards to make key decisions. Whether this delegation of authority from a controlling parent to a legally subservient local entity was made as a part of the negotiation process needed to close a transaction or because of other factors, the reality is that local empowerment has long been a tradition with many national health systems—especially not-for-profits.

The courts conclude time and time again that hospitals and their boards must exercise reasonable, due care to provide quality care, permitting only qualified and competent physicians to practice at a hospital facility. How to best assume and exercise this obligation in the large healthcare system becomes the important risk-related question.

From the legal and regulatory perspective, the world continues to change and the empowerment of local hospitals to make key decisions is increasingly risky. Most agree that the granting of local control (and related accountabilities) can contribute positively to operational success, at least in the short term. However, formal or informal delegation of control to a local hospital board does not absolve the parent board from governance accountabilities. As we presented earlier, in many traditionally structured health systems, critical elements of control often continue to reside with the local hospital and its board, despite the presence of an almost-standardized set of sweeping reserved powers theoretically transferred to the parent entity from the local hospital at the time of closing of an integrating transaction (a merger, for example). Given a changing legal and regulatory framework, the time has come to seriously consider whether the accordance of certain and specific local decision-making power is worth the risk. Put another way, are there points of decision prerogatives that are simply too important and risky to be delegated formally or informally by senior, health system boards to the local hospital?

Since the 1960s, courts throughout the nation have progressed steadily toward a clear recognition of the concept of corporate negligence in the healthcare governance setting. Starting with the case of *Darling v. Charleston Community Memorial Hospital*, the nation's courts have come to recognize the existence of an independent duty of the local hospital and its board to assure quality patient care.[7] The recognition of this obligation by the nation's courts thus placed a very real financial burden on another entity besides the physician directly involved in patient care; it is a risk which needs to be carefully managed.[8] The courts conclude time and time again that hospitals and their boards must exercise reasonable, due care to provide quality care, permitting only qualified and competent physicians to practice at a hospital facility. How to best assume and exercise this obligation in the large healthcare system becomes the important risk-related question.

Before the advent of the multi-hospital system, this risk was managed with decisions made exclusively by local hospital boards. As noted above, the power to credential and privilege physicians has, rather curiously, remained at the local hospital level, despite reserved powers often held by the parent at the system level. The problem with the retention and exercise of this critical authority by a local hospital board in an integrated system is that the liability risk ultimately accrues to the system, even though that system has not played a role in the problematic choice. Further, credentialing choices made locally seem often not to be managed well; one wonders if system control over these choices with more careful management would not be more effective. Put simply, these local decisions expose the larger system (and its board) to unnecessary legal and financial risk for reasons that are best explained only by past history and a negotiation that lead to an integrating event (e.g., a decision for a hospital to merge with a larger system).

7 Darling v. Charleston Community Memorial Hospital, 33 Ill.2d 326, 211 N.E.2d 253 (1965).

8 See also Johnson v. Misericordia Community Hospital, 97 Wis.2d 521, 301 N.W.2d 156 (Wis. 1981).

The regulatory and legal threats inherent in the continuing operation of a holding company model in today's environment expose both local hospitals and their parents at the system level to increasing risk. Boards should carefully consider a change in corporate culture and procedure, pointing more toward the implementation of a system-wide governance and operating model.

More recently, the case of *Medical Staff of Avera Marshall Regional Medical Center et al. v. Avera Marshall Regional Medical Center* illustrated well the increasing importance of medical staff and related decisions that become problematic when placed in the hands of a local hospital functioning within a holding company model.[9] In this case, the Minnesota Supreme Court, again joining a growing national trend, concluded both that the independent medical staff at Avera could sue and be sued and, more importantly, concluded that the medical staff bylaws of the hospital were contractual in nature, thereby binding Avera to a set of unexpected conditions and promises with its medical staff. Again, this precedent serves as evidence that local choices regarding a matter such as the terms of medical staff bylaws can indeed have an unfavorable impact system-wide. The risks that local decision making poses in a holding company model are increasingly significant as measured against promises of "local control." Also illustrating risk accruing to local hospitals is the case of *In re Otero County Hospital Association, Inc.*[10] In a lengthy and well-reasoned opinion, this court noted well the credentialing and medical staff risks accruing to both a small rural hospital and its management company when complex medical staff and credentialing decisions were poorly questioned. For our purposes, this case notes, once again, that significant risk accrues when a local hospital board exercises control over medical staff matters and physician contracting issues absent a more centralized and presumably more carefully crafted and thorough process of managing the corporate risks derived from the behaviors of affiliated physicians.

Finally, and perhaps more significant from a dollars and cents perspective, local control of business structures with physicians, payers, and the like make it challenging to be compliant with ever-changing federal obligations. For example, under the current obligations of the Affordable Care Act, it is often desirable to develop accountable care organizations (ACOs). The obligations that must be met in order to develop and successfully operate an ACO are myriad and are very challenging for a local hospital to successfully develop and manage. Presumably, the sophistication of an operating company would be of greater help in developing compliant structures to accomplish business objectives.

In sum, the regulatory and legal threats inherent in the continuing operation of a holding company model in today's environment expose both local hospitals and their parents at the system level to increasing risk. All of the factors noted above should direct hospital and health system boards to carefully consider a change in corporate culture and procedure, pointing more toward the implementation of a system-wide governance and operating model. Health system boards should carefully consider (or perhaps, reconsider) the wisdom of allowing local control, at least in the areas of:

- Board responsibilities for the oversight of clinical quality
- The credentialing and privileging of licensed medical staff
- Management of a medical staff's roles and responsibilities to a local hospital board
- The requirements and expectations of "due care" of a local system CEO as it relates to the effective management of local governing boards; especially the interaction with local medical staffs and their responsibilities for quality of care and licensed provider behaviors in the hospital

Perhaps remaining for clarification in this arena is a matter relating to state licensure. Most state regulatory schemes require that hospitals "have a governing body…to manage and maintain the provision of quality

9 Medical Staff of Avera Marshall Regional Medical Center et al. v. Avera Marshall Regional Medical Center, 857 N.W.2d 695 (Minn. 2014), 836 N.W.2d 549 (MN. Ct. App. 2013).

10 In re Otero County Hospital Association, Inc., Case No. 11-11-13686JL, U.S. Bankruptcy Court, District of New Mexico (2015).

services." The question remaining for resolution at a later date is whether that board must be local, regional, or national; stay tuned as the courts delve into this issue in the years ahead.

Having the Right Conversation at the System Board Level

Based upon the perspectives and evidence presented here, it is prudent for U.S. health system boards to address at least the following questions with system senior leadership:

1. What are powers reserved to the system board and how are these presented, implemented, and managed with our controlled entities?
2. How and to what extent are local chief executives working with local hospital boards and affiliated medical staffs to ensure that system reserved powers are properly managed at the local level, including the management of the duties of the local hospital medical staff?
3. To what extent does "our" approach to interactions by physicians employed by the system (or locally controlled entities) with independent physicians on the hospital medical staffs present the potential for enhanced legal and regulatory risk?
4. To what extent is the system promulgating a program of ongoing board education in areas of related risk and shared risk (risk shared by local members and the health system overall)?

Speed Required

The process begins first with education and discussion—of system board members, local affiliated boards, and senior leadership at both the system and local levels and at all clinical levels. The focus of the education must be simple and direct, and the discussion must be transparent. Given the pace of change in our industry, the speed of the shift presented here cannot be slow.

Consequently, leaders pursuing the strategy of moving from holding companies to operating companies must be mindful of the likely cultural shocks to their systems.[11, 12] It needs to be carefully planned, and thoroughly socialized with all key stakeholders, using the best principles of successful change management.

Given the rapidly changing healthcare landscape, anything less has the potential to represent significant risk. In these times, survival dictates the need for significant operational and governance change.

The need to connect governance from the system level to that of local members is not merely a good idea, it's a mandate. Governing boards and senior leaders of U.S. non-profit health systems may need to own up to the fact that the "going-in promise" to those who joined the health system in good faith is not sustainable due to a number of legitimate, but unforeseen, reasons. Regardless of good intentions going in, the game has changed.

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11 D.K. Zismer and J. Thompson, "The Gundersen Health System 15 Years in the Making: A Retrospective on a Path to Success," The Governance Institute, *BoardRoom Press,* April 2012.

12 D.K. Zismer, "The Psychology of Organizational Structure in Integrated Health Systems," *PEJ,* May/June 2011.