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New research and expert opinions in the area of hospital and health system governance.

E-Briefings

What if Trader Joe's Ran Hospitals?

By Rex Burgdorfer, Managing Partner and Jordan Shields, Managing Partner, Juniper Advisory

In 2018, *Freakonomics* coauthor Stephen Dubner posed the question: "Should America be run by Trader Joe's?" He suggested that "the quirky little grocery chain with California roots and German ownership has a lot to teach all of us about choice architecture, efficiency, frugality, collaboration, and team spirit."[1]

Mention efficiency in the context of a health system and one's mind immediately jumps to cost savings. For years, people have espoused the benefits of scale to lower supply costs, bolster liquidity, improve access to capital, raise credit ratings, and the like. While all true, those miss the point. Hospitals rarely enter partnerships based on raw efficiency and the ability to cut costs. Instead, the priorities are most often improving the consumer experience, serving more of the community, positioning the organization as a community cornerstone, and prioritizing quality—the same values for which Trader Joe's is known.

When we talk to our investment banking colleagues in other industries, they express surprise that only about a third of our clients select partners with the richest financial offers. Hospital partnerships are unusual in the world of corporate mergers and acquisitions for the prominence of non-financial terms in partnership negotiations. The identity of the buyer, their perceived culture, and the buyer's proven ability to improve quality and expand local service offerings nearly always trump superior financial offers.

Trader Joe's: The Successful Exception

With that background, we wanted to explore Dubner's premise—that an alternative approach and attention to detail can lead organizations to outperform larger, but lumbering, competitors. We particularly appreciate Trader Joe's for its eccentricities—this folksy, funky culture where each store is unique. Yet, the company has achieved exceptional operational rigor and produced Germany's richest person, owner Theo Albrecht. Products reflect regional quirks and cuisine preferences. The company's mission statement, according to its crew handbook, is to deliver service "with a sense of warmth, friendliness, fun, individual pride, and company

1 Stephen J. Dubner, "Should America Be Run by…Trader Joe's?" (podcast), *Freakonomics*, November 28, 2018.

What's Inside

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Key Board Takeaways

Trader Joe's has found great success while eschewing many traditional grocery store practices. Applying their values can also help a hospital stand out as a leader in care delivery.

- **You can't—and likely shouldn't—be all things for all people.** Focus on in-demand services and superior customer experience to differentiate your hospital and earn patient loyalty.
- **Be deliberate in creating culture.** Trader Joe's has a reputation as a top employer, offering above-market compensation, career opportunities, and a non-traditional environment. A positive culture begins and ends with employees.
- **Get creative.** Scale is important, but it should not be the sole objective. Investment in patient and employee initiatives can pay dividends in meaningful ways. Encourage frontline leaders to reimagine workflows and patient interfaces. Be open to new partnerships and new programs.

spirit."[2] Instead of the short-sleeved button down, khakis, and white apron uniform that America's grocery chains have followed for 100 years, Trader Joe's has it's "crew" wear gaudy Hawaiian shirts and they are free to come to work in shorts.

Knowing Customers Better Than They Know Themselves

Trader Joe's is contrarian. It does not advertise and is not active on social media. The company does not run sales, there are no coupons or loyalty programs. There's no self-checkout; the aisles are narrow and parking lots small. With 80 percent of their products under private label, they do not carry the brands and other household supplies that Americans love so dearly and demand of most other grocers. Each store also dedicates space and staff to hand out free samples. This is not a Saturday morning sample or two, but near-ubiquitous assortment of freshly-prepared, ever-rotating Trader Joe's branded products.

Efficient Operations Does Not Always Mean Cost Cutting

The typical Trader Joe's stocks approximately 3,000 product SKUs, versus a typical grocery store's 30,000. On the other hand, Trader Joe's staffs three to four times the number of employees per shift compared to competitors based on a belief that customer service and shopping experience more than offset that cost. Those extra employees are also all paid above market wages with robust healthcare and retirement benefits, which makes it unsurprising that the chain consistently ranks as one of Forbes top 100 places to work and most admired companies.

At the same time, the chain remains nimble. Management is known for radical experimentation and regularly rotating products based on local demand. Local managers are empowered to make swift operational decisions on site. As a closely held company, Albrecht has demonstrated a willingness to allow for experimentation and patiently wait for results. Where his publicly traded competitors face investor pressure to cut losses and pursue consistent corporate strategies.

Outsized Financial Performance

Besides, or more accurately because of, cult-like allegiance from its customers and a happy, loyal workforce, Trader Joe's is known for its exceptional performance. The average store footprint is one-third the size of competitors and yet still outperforms competitors in terms of total revenue and margin. Amazon-backed Whole Foods is known for its high prices and similarly loyal customers. Its revenues are strong for the industry, bringing in about $1,200 per square foot of retail space. Trader Joe's blows Whole Foods out of the water with $2,000 per square foot.

Applications to the Hospital Industry

What can the hospital industry learn from a German company whose hipster employees don Hawaiian shirts to hawk off-brand bagels? Quite a lot, actually.

Customers Are Key

As the industry moves ever more rapidly towards population health and treatment at the lowest-cost site of care, consumer choice is evolving. National price transparency initiatives are becoming a reality. Albrecht did not ask his future customers what they wanted. If he had, Trader Joe's

As hospital systems consider their identities and how they can best meet the needs of their communities, they should look to industry disruptors like Trader Joe's for ideas.

2 Mary Pilon, "Trader Joe's Employees Say Virus Response Was Haphazard and Chaotic," *Bloomberg Business Week*, April 8, 2020.

would have aisles of comfort brands like Pepsi and Fritos. Instead, Albrecht identified what customers desired: an exceptional shopping experience and food they liked at an affordable price. Very few shoppers would seek out Hawaiian shirt-wearing staff, but they immediately recognize what those shirts signify: happy employees ready to help.

Hospitals can learn from the Trader Joe's approach and culture. Whether in their grocery stores or healthcare providers, consumers are increasingly valuing convenience and innovation over brand loyalty. Look for opportunities to simplify consumers' interactions with the hospital. Invest in patient experience training for all staff, from environmental services to the C-suite. Pay wages that attract and retain employees who provide exceptional service. Be bold in exploring new consumer-centric initiatives. Facilities should be efficient for staff, but in a customer-focused business, that will come second to patient comfort.

All Things for All People Is a Race to the Bottom

Trader Joe's loses customers because they do not sell Tide laundry detergent and Fruit Loops. There are potential customers living right next door to a Trader Joe's who drive across town to the big supermarket to buy high margin staples. But Trader Joe's makes up for that revenue by staying within the lines it drew for itself and executing perfectly. Being able to provide a service and make a positive margin does not necessarily mean that a facility should provide the service. The organization should ask itself a range of questions when deciding which services to add or forgo. These include very basic questions, like is the quality provided here at least as good or better than what patients can get across town? If not, invest to make it better, possibly no longer making it profitable, or cut the service outright. This can be for high end services where a community hospital can't attract enough volume to meet quality thresholds, but it can also be for big medical centers where patients may find worse outcomes for low acuity pneumonia care than they can get at a community health center. Providing care close to home is a worthy goal, but if that care is lower quality, higher cost, or at the expense of the patient experience, organizations should reevaluate their priorities.

Culture Beats Scale

Standalone hospitals that seek the benefits of scale and care coordination have options in choosing system partners. Identifying the best partner and optimal structure requires a carefully designed process. Basing the choice solely on scale, relative cost savings or near-term financial investment often leads to disappointment. While these are all factors, organizations should focus on finding partners that share their vision for patient care. Like Trader Joe's, that might mean investing in above-market nursing salaries or adding physicians to eliminate wait times. The process needs to focus on revealing the partner's identity as a system, not whether they have the most scale, highest financial offer, best payer contracts, or even the most highly-regarded reputation. The processes that Juniper Advisory designs for our clients take organizations right to the sample counter to experience the partner's culture firsthand.

Final Thoughts

Trader Joe's has disrupted the historically conservative grocery business that has trended towards greater and greater homogeneity. As hospital systems consider their identities and how they can best meet the needs of their communities, they should look to industry disruptors like Trader Joe's for ideas. While scale brings a variety of clinical and financial benefits, mission, vision, and culture are ultimately more important in driving the results that matter most—a happy and healthy community.

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What Has COVID-19 Meant for Affiliations and Partnerships?

By Jeff Sommer, Managing Director, and Clare Kelley, Consultant, Stroudwater Associates

Huge operating losses, ongoing operational challenges, and a "new normal" have called into question the rationale of some planned mergers. What can the healthcare industry learn from cancelled mergers, renegotiated affiliations, and partnerships that have been consummated during the pandemic? How can health system leaders utilize these events to gain a fresh perspective on existing and potential partnerships and ensure that organizational objectives are being met?

Pre-COVID-19

In late 2019, the credit rating agencies predicted a positive outlook for the hospital sector in 2020. Per Moody's, NFP hospitals' operating cash flow was expected to improve between 2–3 percent in 2020.[1] The projected growth in operating cash flow was due in part to the highest Medicare reimbursement rate increases in many years, an expected delay in payment cuts to Disproportionate Share Hospitals until late 2020, increases in commercial health plan rates in the low single digits, and tighter expense controls. While Stroudwater felt that these short-term trends were valid, the longer-term outlook was concerning as many "headwinds" for the industry are structural and recurring. Without COVID-19 on the radar screen, partnership activity continued along trends that had been at work for several years including selective buyers and rural hospital closures and bankruptcies.

Post-COVID-19

In March 2020, with the effects of COVID-19 ramping up, S&P and Moody's voiced concern that the coronavirus outbreak was "accentuating cash flow constraints." Primary drivers of cash flow hit by the pandemic were the cancellation of profitable elective procedures, material reductions in service volumes, and higher operating costs associated with new COVID-19 operating protocols. The duration, location, and severity of COVID-19 disruptions will determine the extent of the impact on health systems over the next several months to years. On March 25th, Moody's changed its 2020 outlook for the industry to negative.[2]

Key Board Takeaways: Lessons from the Last Three Years

- **Know your strategic value.** If you want to attract a quality partner and a quality set of contractual terms, you must have a compelling strategic value proposition. Key drivers of value included in the proposition are cash flow, covered lives, clinical quality, referral patterns, and geographic coherence.
- **Strategic alignment is critical.** Enduring strategic value to partners is essential to weather the storm and create an enduring partnership.
- **Know the unique rural value proposition.** If you are a rural health system or a system exploring rural affiliation options, make sure your advisor can vet and model the value proposition of rural operations and unique revenue opportunities so you get the fullest benefit of the unique designations available in the rural sphere. Rural healthcare may be the most misunderstood and undervalued portion of our healthcare delivery system today.
- **Know the strengths and weakness of your partner.** The strength of your partner matters. Does your partner have the liquidity, operational excellence, and clinical resources to deliver? Do their strengths offset your constraints and needs? Does the partnership agreement speak to those opportunities?

The duration, location, and severity of COVID-19 disruptions will determine the extent of the impact on health systems over the next several months to years.

1 Deirdre Fulton, "Moody's Upgrades 2020 Outlook for Non-Profit Healthcare Sector to Stable," *Healthcare Finance News*, December 16, 2019.

2 Suzie R. Desai and Kenneth T. Gacka, "Not-For-Profit Acute Care Sector Outlook Revised to Negative Reflecting Possible Prolonged COVID-19 Impact," *S&P Global*, March 25, 2020.

The uncertainty and very serious short-term impacts on health systems made selective buyers pump the breaks and in some cases, re-think planned mergers and partnerships. As of October, *Becker's Hospital Review* highlighted five mergers that have been called off:[3]

- Michigan: Advocate Aurora and Beaumont Health
- California: Ventura County Medical Center and Dignity Health
- Ohio: Beaumont and Summa Health
- Illinois: Advocate Trinity Hospital, Mercy Hospital and Medical Center, South Shore Hospital, and Bernard Hospital
- New Jersey: Geisinger and AtlantiCare

Affiliation and Partnering Fundamentals

Stroudwater has advised several clients on pending affiliations over the last 12 months, none of which have been cancelled. In one instance, a buyer sought to renegotiate terms and won some limited concessions, but in every instance the planned affiliations are proceeding. Forging a durable partnership requires that each prospective partner have a compelling value proposition for the partnership. Simply focusing on getting the highest purchase price does not ensure that the strategic, operational, and financial rationale is sound and durable. Carefully vetting prospective partners, evaluating potential deal structures, and crafting enforceable deal terms are essential.

A strategically sound partnership will do the following for participants:

- Address critical operating and strategic risks
- Mitigate partner risk
- Address gaps in capabilities
- Enhance both participants' strategic and market position

If one of the parties to a prospective partnership does not understand the strategic value of its affiliate, it is too easy for the partnership to be abandoned or unwound when circumstances change. For example, many of our affiliation clients are small or mid-size hospitals and health systems serving rural communities and regions. Many organizations view rural hospitals as "the juice not being worth the squeeze." These larger organizations often do not appreciate the unique value that rural operations can bring to a larger health system, including:

- System overhead cost-allocation to rural affiliates receiving cost-based reimbursement
- Rural affiliates having access to 340B-associated funding
- Unique clinic designation opportunities, including uncapped cost-based reimbursement, that can be replicated system-wide with the rural affiliate as the sponsor

Stroudwater advised a rural health system in its search for a partner in the months leading up to the pandemic. The initial frontrunner had many of the attributes our client sought in a partner, including high- quality clinical and operating resources, scale, and financial strength. During the process, we communicated our clients' rural value proposition, including the opportunities described above, to prospective partners. Several understood how they could leverage these attributes within their systems and made proposals that reflected this value proposition. Unfortunately, our client's pre-affiliation frontrunner would not, or could not, grasp the value that the prospective affiliate would have brought to their system. Our client selected a competing proposal from a different system. Despite the impacts of COVID-19 on our client and its preferred partner, the affiliation remains on track without a pandemic-related hiccup.

Applying What We Have Learned to Existing Affiliations and Partnerships

For existing partnerships, now is an excellent time to evaluate these assets as a portfolio. Some key considerations include:

- **Renewal risk**
  - Be aware of pending renewal options.
  - How is the partnership performing and how might it be improved?
  - Does your partner intend to renew?
  - Do you want to renew?
  - What other options exist?
- **Be proactive! Ensure you have time to evaluate your options and the performance of your existing partner.**
  - Understand notice provisions and plan accordingly.
  - Evaluate your partner's performance.
  - Evaluate your options—do you have a credible alternative if necessary?
  - What strategic, operational, and clinical considerations should inform your decision-making?

Forging a durable partnership requires that each prospective partner have a compelling value proposition for the partnership.

3 A. Ellison, "5 Hospital Mergers Called Off This Year," *Becker's Hospital Review*, October 13, 2020.

- **Do you have the leverage to renegotiate?**
  - Leverage often begins and ends with credible alternatives.
- **What capabilities and vulnerabilities have COVID-19 revealed about your partner and the partnership? How has COVID-19:**
  - Changed your needs, opportunities, and constraints?
  - Changed your risk profile?
  - Revealed the strengths and weaknesses of your partner?
  - Revealed the pros and cons of the partnership?

Applying What We Have Learned to Prospective Partnerships

- How has COVID-19 changed your needs, opportunities, and constraints?
  - What vulnerabilities and opportunities have been revealed?
- How has COVID-19 changed your risk profile?
  - What new priorities should inform your partnering decisions?
- Has COVID-19 revealed previously hidden strengths and weaknesses of your partner?
  - How did prospective partners respond to COVID-19?
- What was their approach to working with affiliates during COVID-19 and how does that match your needs?
  - What is their track record at their affiliates?
- Does your prospective partner understand your value proposition?
  - Can you effectively describe your value proposition to potential partners?
  - What can you do to enhance your value proposition?

Warren Buffet said it well: "Only when the tide goes out do you discover who has been swimming naked." This advice applies to partnerships as well. Doing the homework up front is the best way to make sure that neither your partner nor your organization are caught in a compromising position when the tide goes out.

The Governance Institute thanks Jeff Sommer, Managing Director, and Clare Kelley, Consultant, Stroudwater Associates for contributing this article. Jeff can be reached at jsommer@stroudwater.com and Clare can be reached at ckelley@stroudwater.com.

Strategic Benefits of ACOs: Assessing Essential Elements that Determine True Value

By Richard Doane, M.H.A, Director, Seth Edwards, M.H.A., Vice President, Bryan Smith, M.H.A., Principal, and Guy M. Masters, M.P.A., Principal, Premier Inc.

The Affordable Care Act (ACA) has not only transformed the way healthcare coverage is purchased, but also how healthcare is delivered. Introduced into Medicare as part of the ACA, Accountable Care Organizations (ACOs) or, in the non-Medicare area, clinically integrated networks (CIN), are a vehicle by which health systems, hospitals, and providers accept shared responsibility for the quality, cost, and experience of an attributed population in an integrated manner across the continuum. CMS has tested multiple ACO models over 10 years, which is leading many to evaluate and quantify their efficacy. However, often these analyses exclude the benefits of ACOs outside of savings to Medicare. For hospitals and health systems, an ACO is a key strategic necessity, particularly with the fiscal pressures on the Medicare Trust Fund catalyzing CMS to move towards finding participants of any willing taker in the fee-for-service (FFS) alternative payment models (such as ACOs) to accept two-sided risk.

Key Board Takeaways

Participation in an ACO has strategic benefits for health systems beyond financial results. Governing boards should consider questions such as the following:

- If we are not currently participating in a Medicare ACO model, do any of these strategic benefits impact the participation decision?
- If we are currently participating in a Medicare ACO model, how has our participation impacted our market position relative to competitors' efforts among the Medicare patient population?
- How can we promote greater alignment and integration among employed and independent providers, as well as with our health system?
- What additional tools, technology, and decision support capabilities should be considered to further reduce total costs of care, and improve quality and patient experience?
- Should our health system/hospital consider becoming more aggressive regarding Medicare Advantage contracts?

Common Goals, Aligned Incentives, Support Independent Clinicians

ACOs/CINs are an excellent way to formally organize both employed and independent providers around the common goal of providing integrated, cost-effective, and high-quality care. This type of integration and alignment of incentives between employed and independent providers can allow traditional competitors to work together to improve the care they provide to their beneficiaries. Health systems, especially those that do not employ large numbers of providers, who delay in implementing or participating in an ACO-like structure put themselves at risk of being able to formally integrate with their independent providers.

Medicare ACO Experience Can Translate to Commercial Value-Based Payment Arrangements

One of the strongest correlations to success in Medicare ACO models is time in these types of programs. Participation in Medicare ACO models provides for the opportunity to learn how to deliver care in an integrated fashion. The lessons learned and resources developed from participation in Medicare ACO models can then be leveraged in other value-based agreements to improve performance across a contract portfolio. There are many opportunities across payers to contract using an integrated ACO/CIN model, including: Medicare FFS, Medicare Advantage, Medicaid, commercial, and direct-to-employers. Over the past five years, there has been an increasing trend of these types of payers contracting with integrated networks rather

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than individual hospitals or practices for risk-based models. The transformation from volume-based to value-based care is one that takes time and commitment. Many organizations across the country have leveraged this "halo effect" of Medicare ACO model participation into success in value-based care and payment agreements with other payers.

Benefits beyond Shared Savings: Stark, Anti-Kickback, and Civil Monetary Penalty (CMP) Waivers

The currently available Medicare models for network (ACO/CIN) entities provide several benefits to participation outside of just the potential to share in savings. One of those key benefits is access to various legal and payment waivers that simplify the process of providing integrated care across the care continuum. Access to these fraud and abuse rule waivers, specifically the Stark, Anti-Kickback, and CMP waivers that are available in all Medicare ACO models, remove the impediments in place under traditional FFS rule to value-based care. While reforms to the Stark, Anti-Kickback, and CMP regulations have been proposed, they have not been finalized as of this article. Today, Medicare ACOs are deemed to be clinically integrated and the participants have access to flexibilities that uniquely position greater opportunities for innovation to deliver integrated care over non-ACO participants.

Market Share Growth and Reputation

Not only are there benefits for the healthcare professional/provider participants of Medicare ACO models, but also for beneficiaries. When participants can deliver care in a truly integrated manner it allows for better management of beneficiaries which leads to higher quality care. Medicare ACOs encourage cross continuum communication which has shown to greatly improve patient satisfaction. Additionally, ACOs who utilize care managers have seen increased patient satisfaction due to their hands-on support with management of chronic conditions, navigation of the ACO's various sites of care, and identification/closure of gaps in care. This increase in patient satisfaction results in enhancing the reputation of the organization.

Participation in the Medicare ACO programs provides the ACO with access to robust Medicare claims data for their assigned population. ACOs can leverage this data to support other value-based models from CMS, like the Hospital Value-Based Purchasing Program or the Hospital Readmissions Reduction Program. Moreover, this data provides great insights into utilization patterns and can be an input to identify growth opportunities, as well as to better understand out-of-network utilization patterns. Access to claims data can support market share growth.

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Competitor Threats to Revenue and Market Position

One of the primary strategic benefits that leads to model participation is the threat from competitors. These threats can manifest themselves in a variety of ways, from for-profit/venture fund-backed physician aggregators, to insurance companies and other risk-bearing entities, to other local health systems using population health as a method to expand market share. Due to the participation rules for the current Medicare ACO models, practices can only participate in one Medicare ACO at a time. This allows health systems and physician groups to utilize the creation of their ACO as both an offensive and/or a defensive tactic relative to the competition. Maintaining alignment with both employed and independent providers allows ACOs to mitigate potential financial impacts from direct market competition and provider aggregation such as loss of patient revenue and out-of-network referrals.

Pursuing the Triple Aim

The driving principle behind the Medicare ACO models has been the Triple Aim: lowering total cost of care, improving the health of populations, and improving the patient experience of care. The first item is often challenging for hospitals considering participation in Medicare ACO models whose primary source of revenue is based on fee-for-service contracts. However, if hospitals and health systems are slow to build their own ACOs they may be at risk of being directly impacted by the total cost of care reduction efforts of their outside competitors, without having the ability to control the pacing of this demand destruction. If this occurs the hospital/health system cedes control of the rate and severity in the

reduction of utilization, essentially becoming a commodity to the ACO. This can lead to significant drops in inpatient revenue without the opportunity to share in any of the savings achieved to Medicare by the outside ACO.

Do Strategic Benefits Equal (or Out-weigh) Financial Outcomes?

Since the inception of the first Medicare ACO program there have been financial benefits available to model participants, such as the ability to earn shared savings. In addition to financial benefits, participation in Medicare ACOs allows for protection from outside competition and commoditization of the hospital, access to waivers to simplify the delivery of integrated care, insights from the access to the Medicare Part A, B, and D claims data, the ability to develop population health capabilities to leverage in other value-based payment programs, and the communication channels to improve beneficiary's care experience and management. In today's rapidly changing landscape, these strategic benefits of Medicare ACO participation are becoming just as important as the financial ones.

The Governance Institute thanks Richard Doane, M.H.A, Director, Seth Edwards, M.H.A., Vice President, Bryan Smith, M.H.A., Principal, and Guy M. Masters, M.P.A., Principal at Premier Inc. and Governance Institute Advisor, for contributing this article. They provide analytics and strategic advisory on ACOs, CINs, and value-based payment models, as well as keynote presentations on trends and governance issues at board retreats and conferences nationwide. They can be reached at Richard_Doane@premierinc.com, Seth_Edwards@premierinc.com, Bryan_Smith@premierinc.com, and Guy_Masters@premierinc.com.