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In the Race for Digital Transformation, Health Systems Are Trailing Disruptors

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The competitive bar for digital transformation in healthcare has been raised high as major tech players and virtual health companies have become considerable rivals to hospitals and health systems. These new market entrants now represent as much of a competitive threat to hospitals and health systems as their traditional competitive peer provider organizations, according to a recent survey from The Chartis Group.[1]

This survey indicated that while providers' top competitors still include peer provider organizations, market disruptors are shifting the paradigm of competition. In fact, a high percentage of health system executives ranked their top three rivals posing high levels of competition as follows:

- Other hospitals and health systems (39 percent)
- Virtual health companies, such as Teladoc, MDLIVE, and Amwell (39 percent)
- Large tech companies, such as Apple, Google, and Microsoft (35 percent)

In addition, the survey found that only 13 percent of hospitals and health systems consider themselves ahead of the pace of change these new market rivals are setting. These non-traditional competitors are hyper-focused on consumer needs, utilizing an outside-in approach—that is, one that is driven by consumer insights and a consumer orientation—to create differentiated digital care experiences and services.[2] Most healthcare organizations, on the other hand, have an inside-out approach driven by

1 Tom Kiesau and Bret Anderson, "The Race Toward Digital Transformation: 2022 Health System Survey," The Chartis Group, March 15, 2022.

2 "How to Advance Digital Health Programs by Focusing on Consumer Needs and Outcomes," The Chartis Group, 2022.

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what they believe they need internally and with an orientation toward the internal stakeholder.

Healthcare boards play a critical role in ensuring their organizations stay competitive. Accelerating effective digital transformation can only happen when the board supports change at an enterprise-wide level.

Advance Plans Quickly and Strategically

Although health systems report that their primary impediments to digital transformation are financial, 99 percent agree that digital transformation is crucial. Health systems recognize that digital transformation will help them meet their strategic objectives, including improving health outcomes, reducing costs of care, attracting new customers, and retaining existing customers.

However, most (79 percent) are still in the planning stages of their digital transformation journeys. More than 70 percent of survey respondents named remote patient monitoring, a digitally enabled service center, digital specialty care, and digital-first primary care as top priorities for digital transformation. These initiatives, along with digital front door (69 percent) and hospital-at-home (60 percent), require significant investments. Getting unstuck from planning and shifting to executing on the plan requires CEO- and board-level commitment to enterprise-wide governance

→ Key Board Takeaways

- Understand the changing paradigm of competition for health systems as non-traditional players have become considerable rivals.
- Break the governance siloes to empower those who oversee digital transformation with the ability to drive change across the entire system at the enterprise level.
- Elevate digital transformation to an enterprise strategic priority, with those responsible for transformation reporting directly to the CEO and supported across the organization.
- Commit to the financial resources necessary across digital transformation use cases that are becoming a standard requirement to remain competitive.
- Transform digital care experiences based on meaningful data that enables greater personalization.

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and resourcing—not simply assigning digital transformation as a task to siloed departments.

Focus Your Digital Transformation Journey on the Consumer

With necessary backing in place, differentiated digital offerings must start with what consumers are demanding from their care experiences. Health systems often fall down when they start with what healthcare providers are looking for and simply hope it matches what consumers are looking for as well.

Digital rivals are out in front because they excel at providing personalization. Personalized care transcends the medicine or clinical treatment and must include a positive and captivating experience for it to be compelling to patient consumers.

→ The Lasting Impact of the Telehealth Boom on Healthcare Consumers

Prior to the pandemic, only a small cadre of consumers reported a previous telehealth experience, 15 percent nationally according to NRC Health's Market Insights survey. During the first wave of COVID, telehealth usage surged and 35 percent of U.S. consumers turned to virtual care.

As traditional patient care has resumed, the lasting effects of the telehealth boom remain. Nearly half of consumers (46 percent) now have a "virtual or e-visit with a doctor" under their belt. This experience has been mostly positive. In 2020, 74 percent of consumers reported being "satisfied or very satisfied" with their virtual visit. Top remarks centered on convenience and efficiency, two areas where hospitals and health systems struggle with in-person experiences.

Now consumers are wanting more personalized encounters with their care ecosystems—digital services that extend beyond telehealth. More consumers than ever are expecting communications and access to connected tools and online resources to give them the information they want, when they want it.

This sidebar was contributed by The Governance Institute. The data included is from NRC Health's Market Insights survey from 2019–2022 and Real-time data from Q4 of 2021.

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This personalization accounts for patient preferences about how they want to be communicated with and which digital options they want in relation to in-person care. It also accounts for demographic-driven needs and desires.

Health systems' digital rivals have mastered the ability to aggregate and analyze consumer behavior and preferences across demographics and cohorts to quickly generate insights and refine their digital offerings to meet those specific needs. Successful digital transformation must tailor products, services, and offerings to accommodate these nuances of personalization.

Expand the Scope of Consumer Insights Now to Create Real Value

Gaining greater insight into consumer behavior is a prerequisite for developing personalized digital care experiences. By tracking *how* patients are accessing care—not just *why* they are—and consolidating touch points like portal usage, phone calls, and Web traffic, health systems can be informed by more insightful data. Aggregating these insights and matching digital offerings to pertinent patient interaction needs and preferences will allow digitally enabled experiences that attract new patient consumers, retain existing ones, build stronger physician networks, and extend into new markets.

Hospitals and health systems recognize the importance of acquiring an aggregated view of consumer data to better tailor the care and experience they deliver. However, most organizations have not yet established the means to gather and apply these critical insights.

Given the potential for personalized digital care experiences to impact key strategic priorities like attracting and retaining patients, provider organizations can't put their business objectives on hold while they build more capabilities. More health systems are expecting to partner with digital entities that offer deployable and scalable solutions to help meet the patient consumer demand for personalization. Whether through building, buying, or partnering, getting to market with customizable digital offerings is the means for health systems to achieve their key strategic priorities and business objectives.

The New Digital Care Landscape Needs Enterprise-Wide Leadership Support

Digital transformation is no longer an opt-in priority for hospitals and health systems. It is a necessary journey to not only plan but implement—and time is of the essence.

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The milestones of digital transformation—streamlining care, improving the experience, and personalizing it for the end user—are increasingly met by non-traditional rivals that share similar business objectives of attracting and retaining patients to achieve a positive return on investment (ROI). Health systems need to act now to meet this new competitive imperative and should ensure that each digital transformation initiative has a clear business case to demonstrate value generated for the health system and its consumers.

Making that happen requires an enterprise-wide approach driven by health system boards and their CEOs. By hardwiring a high degree of strategic prioritization, boards can play an instrumental role in driving digital transformation success and sustainability for their organizations.

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Structuring Post-Closing Governance in Today's Merger Environment

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As the non-profit healthcare merger market changes dramatically, so also must the merger parties' approach to post-closing governance matters. This is especially as it relates to board culture, decisions concerning corporate purpose, board size and composition, board authority and reserved powers, and committee structures.

There are at least four factors driving this change. This article highlights each of those factors and provides proactive solutions for each.

1. Antitrust Enforcement

First, and perhaps most obvious, is the Biden Administration's concentration on enhancing competition in the marketplace, and its implications for Federal Trade Commission (FTC) oversight of corporate mergers, especially in the healthcare industry. As is widely recognized, the FTC has aggressively challenged horizontal mergers of healthcare providers across the country over the last several years. It has prevailed in certain key federal court litigation filed to block other mergers. All this has significantly clouded the climate for mergers of health systems operating in similar or complementary markets.

As a result, health systems are giving greater consideration to merger options involving health systems from geographically disparate regions, in the hope that they will not trigger traditional FTC concerns with concentrated markets. Yet these types of mergers can create unique—but resolvable—governance challenges that must be addressed during the negotiation phase, including:

- Overcoming the cultural and informational barriers associated with widely disparate geographic backgrounds
- Lack of familiarity with the operating history and competitive environment of the respective merger parties
- Possible differences in the parties' respective social, economic, and political environments

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These and similar issues raised by disparate geographic markets could render more difficult the post-merger board's oversight and decision-making processes.

The solution lies in part to a more significant commitment to addressing post-merger governance culture in the transaction timetable. In years gone by, merger party boards often became acquainted in abbreviated ways through cocktail parties, dinners, and short retreats—often hamstrung by antitrust protocols that prevented much substantive discussion.

That is unlikely to be sufficient in the new environment—especially where the parties represent disparate geographies. The potential for successful post-merger governance will benefit from much greater emphasis on socialization, cultural alignment, and vigorous joint onboarding activities (still within antitrust protocols). Engagement of a consultant with an industrial psychology background will enhance such efforts.

> Issues raised by disparate geographic markets could render more difficult the post-merger board's oversight and decision-making processes.

→ Key Board Takeaways

- Commit to addressing the post-merger governance culture. Ensure that there are opportunities for socialization, cultural alignment, and joint onboarding activities (within antitrust protocols).
- Educate and train the post-merger board during the transaction process so that directors are prepared to thoughtfully execute their fiduciary duties right away.
- Ensure that, post-closing, the board agenda is committed to exercising oversight of how the organization's activities support the commitments made in the regulatory process regarding the rationale and goals for the transaction.
- Keep the board informed about organizational risks and challenges so that it can effectively work with management to lead the merged company through the initial stages of operation.

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2. Transaction Magnitude

Second is the sheer size of many of the transactions in the current merger market. Oftentimes they involve one or both parties of significant economic and operational size (e.g., large regional or statewide health systems). In other situations, they can involve a party with a complex portfolio of subsidiaries and related healthcare investments.

Under either circumstance, the duties of the post-merger governing board will be substantial. It will be assuming fiduciary responsibility for a combined organization with a large operational and financial footprint. This board will be expected to be in a position to thoughtfully exercise those responsibilities on "day one"; for organizations of such size and scope, corporate governance law does not provide any grace period for director preparation.

The solution will be greater focus on the education and training of the post-merger board during the transaction process. This would cover a range of information, from basic organizational structure, to publicly available operational and financial information, to a description of current healthcare delivery challenges in the parties' respective markets, and other important preparatory information. While any such education and training must proceed within strictly defined antitrust protocols, it should nevertheless be treated as a pre-closing priority and supported (and staffed) by the parties' respective senior management team members and external advisors.

3. State Regulatory Oversight

Third is the increasing tendency of state charity officials to inquire about the fundamental purposes and goals of mergers involving non-profit healthcare organizations. This inquiry may often extend to questions regarding the rationale of the boards of the respective merger parties for authorizing the transaction.

The public policy behind this tendency is the state's need to assure that charitable assets are being applied appropriately and that a non-profit health system's governing board is acting as a good and faithful steward of those charitable assets in authorizing a merger with another non-profit. This state need becomes acute when the merger partner is located in another state and where the post-closing headquarters of the combined organization will be located out-of-state. Of particular, but not the sole, interest of these regulators is how the interests of the healthcare consumers in their state will be impacted by the merger.

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The solution will be to ensure that, post-closing, the board agenda is committed to exercising oversight of the ways in which the activities of the merged organization support the commitments made in the regulatory process regarding the rationale for the transaction and the efforts made to achieve its goals. Working with the legal advisors of the merged organization, this oversight activity would become an important post-closing task of the board.

4. Enhanced Oversight Obligations

Fourth is general governance development that, while not directly related to the merger process, will have a substantial impact on post-merger governance.

One of the most significant, yet discreet, governance developments of the pandemic era has been the expansion of corporate directors' oversight obligations—i.e., the expectation that the risks and challenges of corporate operations require a greater governance commitment to oversight.

This expansion is essentially the byproduct of evolving third-party expectations that directors be attentive to a larger universe of issues than before. The pandemic and the extraordinary business and operational risks it exposed heightened third-party attention to the importance of the board's oversight and decision-making duties.

This shift could affect how directors perform their duty of care in the post-merger environment, which has historically been known for the complexity of its integration issues and challenges.

The solution will be, in part, for the board to "lean in" more fully in this regard, becoming more informed about, and more committed to monitoring the resolution of, these issues and challenges. Rather than being deferential to senior management during the integration phase, the board will be expected to be more of a resource and reference point to management as it leads the merged company through its early stages of operation.

The solution may also include creating a post-merger board that will reflect greater consideration for how board size relates to board effectiveness. The goal would be to create a board that is large enough to address its oversight and decision-making responsibilities, yet small enough to make decisions on a timely basis and hold meetings when necessary without quorum or notice problems.

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Other Considerations

This new merger environment, and its focus on fiduciary involvement, is likely to prompt the merger parties to consider a variety of other governance measures and duties related to the post-closing board of the combined organization. These include, but are not limited to, the following:

- **Commitment to non-profit purposes:** Post-closing, the board should ensure that the combined organization remains committed to non-profit ownership and to operation consistent with the principles of non-profit corporations, serving the healthcare consumers, the communities in its service areas, its suppliers, and its employees.
- **Mission preservation:** All board members should share a consistent interpretation of the purposes and mission of the combined organization, and the focus of the fiduciary responsibilities they owe.
- **Focus on the combined organization's purpose:** The combined board will be expected to exercise its duties on behalf of the stated purposes of the organization, not the interests, goals, and initiatives of any of the organization's predecessor or legacy organizations.
- **Role of the board:** Post-closing, governance will proceed more smoothly when all board members agree that the board's role is to oversee the combined organization's management and business strategies to ensure long-term sustainability of its mission.
- **Board/management dynamic:** Leadership efforts will be enhanced by an understanding as to the ultimate responsibility of the governing board for the operations of the combined organization, and for the authority it retains with respect to this responsibility.

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Summary

Structuring effective post-closing governance has always been a major feature of the non-profit merger process. However, a variety of recent developments combine to attribute increased importance to this transaction task. While there is no one-size-fits-all or "must have" approach to designing effective post-closing governance, there are a variety of measures available to support efforts toward such a goal.

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Don't Let Overhead Overwhelm Your Organization

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Today's hospital and health system leaders face an interesting and challenging operational balance. Healthcare organizations must continue to provide high-quality patient care while at the same time fitting the expenditures needed for such care quality efforts within payments that in many cases may not keep up with inflation. A recent PwC report noted that hospital revenues are expected to increase by an average of 6.5 percent in the coming year.[1] At the same time, operating expenses—especially in view of the costs of caring for patients during the COVID-19 pandemic—are increasing at a much higher rate, approximating three times the expected increase in revenues.[2] In the January issue of E-Briefings, Steve Valentine and Guy Masters highlighted top trends for 2022 and pointed at the need for emphasis on cost management.[3] Managing operating expenses will be a high priority for industry leaders in the coming years. The question for boards and senior leaders is which expenses require the most attention?

Fixed Expenses: A Threat and Opportunity

Because hospitals and health systems operate around the clock every day, there is a minimum expense level necessary to ensure patient services are available when needed by the community. Further, there is a great deal of expense investment required to bill and collect fees from multiple insurers with different payment requirements. Also, the infrastructure for compliance, credentialing, and other administrative functions are a normal part of the hospital operating expense. The costs associated with buildings and equipment in the facility can be substantial as well. However, these types of expenses do not vary when patient volumes decline

1 PwC, "Medical Cost Trend: Behind the Numbers 2022."
2 Anastassia Gliadkovskaya, "Rocky Road ahead for Hospitals in 2022 with Rising Labor Costs, Tougher Negotiations with Payers," Fierce Healthcare, November 15, 2021.
3 Steven Valentine and Guy Masters, "Healthcare Forecast 2022: 10 Trends for Board Members and Senior Leaders," E-Briefings, The Governance Institute, January 2022.

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and must be paid regardless of revenue collections. This could create financial solvency risk for a hospital or health system with a high level of overhead cost during times when volumes—or high-paying elective procedure volumes—decline, as happened during the height of the COVID-19 outbreak in 2020. While it is easy to set prices based on the direct costs of care (incremental cost pricing) to compete for volumes, some organizations may be forgetting about the need to have these fixed costs considered using full-cost pricing. These fixed expenses pose a threat to financial solvency and an opportunity for improvement for healthcare leadership teams.

→ Key Board Takeaways:

- From 2017–2019, non-profit hospitals on average incurred a 3 percent loss from patient care services. Non-operating income generates an offset to those losses and yields an overall net profit averaging 7 percent during the same timeframe.
- Included in operating losses are overhead costs for administrative functions and capital expenditures, which do not usually vary downward when patient volumes decline. Administrative overhead costs can average 20 percent of net revenues for voluntary hospitals.
- Capital expenses (depreciation, interest, and leases) comprise 5 percent of net revenues and may be tied to revenue-producing investments. However, boards should critically evaluate capital investment portfolios for potential divestiture and also evaluate future investments to limit sunk costs that cannot be varied with patient volumes.
- Board finance committees may find value in a routine assessment of revenue contracts to validate the extent to which payment rates generate a contribution margin usable to defray fixed overhead expenses.
- Boards and senior leadership must critically review expenses for non-patient care purposes on a routine basis to verify that those expenses further the organization's mission while not creating an unsustainable drag on operating margins.
- Current investment market downturns may limit the availability of non-operating income sources used to subsidize operating losses, thus increasing the value in a critical assessment of administrative and capital costs.

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Analyzing Fixed Costs

The CMS Medicare cost report database[4] can be used to estimate fixed administrative expenses for a hospital or health system. The administrative expense department on the cost report includes expenditures for all functions mentioned above, as well as tax payments and information technology resources. In addition, many organizations are part of multi-hospital systems and may have fixed corporate office expenses that are charged to member facilities and are captured as "home office" expenses on the cost report. The cost of capital equipment and buildings is another fixed expense captured in the cost report including straight-line depreciation, interest on capital debt, and capital lease costs.[5] For purposes of this analysis, these three departments (administrative, corporate office, and capital equipment and buildings) in the cost report are considered fixed "overhead" and any other expenses are considered able to vary to at least some degree with patient volumes. While patient care areas such as ancillary departments or nursing units have some fixed element of cost, this analysis assumes that units or functions could be consolidated in those areas as volumes reduce.

This article uses analysis of data from 4,188 U.S. acute care hospitals that had no ownership change during the years 2017–2019. The assumption underlying this data selection is that hospitals facing a change in ownership or closure may have unusual transactional items such as write-offs or divisional consolidations that could skew analysis of ongoing operations. The goal in this analysis is to critically assess fixed overhead expenses in a steady state.

Across the three years in this analysis, local government and non-profit voluntary hospitals averaged a 3 percent loss from patient care operations[6] while fixed overhead costs[7] averaged 25 percent of net revenues. Overhead appears an opportunity for executives and boards to address financial solvency through a critical view of these expenses, since any reduction in administrative or capital costs go straight to the "bottom line." On average, voluntary hospitals generated a 22 percent "contribution margin" during this time,[8] when overhead costs were excluded from total operating expenses.

4 CMS, "Cost Reports."
5 CMS, *Provider Reimbursement Manual*, Part 2, Chapter 40.
6 Calculated on Worksheet G-3 of the CMS Cost Report Form 2552-10, row 3, column 1.
7 Obtained from Worksheet A of the CMS Cost Report Form 2552-10, rows 1, 2, 3, and 5, column 7.
8 Calculated as patient care income from Worksheet G-3 of the CMS Cost Report Form 2552-10, row 3, column 1, adding overhead costs from Worksheet A, of the CMS Cost Report Form 2552-10, rows 1, 2, 3, and 5, column 7.

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The common approach to maintaining solvency in these non-profit facilities is through subsidizing operating losses with non-operating income sources like investments, philanthropy, or local tax district subsidies.[9] Recent growth in direct patient care expenses attributable to COVID-19 care and prevention further increase pressure on hospital financial stability as those expenses consume more of hospital revenues. Further, recent slowing of the U.S. economy could be a precursor to reduced investment returns and contraction of philanthropic activity, thereby reducing the "safety net" available to voluntary hospital organizations in the coming years.

Expenses that fall in this overhead area are not entirely avoidable, but merit scrutiny for opportunities to improve. During the three years in this analysis, voluntary hospitals averaged:

- 20 percent of net revenues in administrative costs
- 6 percent in capital costs
- Less than 0.25 percent in home office expenses

Once implemented, capital investments are sunk costs and options for reduction are limited. Also, equipment investments may generate revenues that sustain the organization and cannot be shed without potentially reducing revenues and exacerbating a difficult financial situation. Core administrative functions such as credentialing, revenue cycle, and IT support services also represent some degree of required expense to provide patient care services. Expenses going into the administrative cost center likely merit greatest attention as they represent the largest item not directly associated with revenue-generating patient care services. Not all such costs can be eliminated due to regulatory or accreditation/licensure requirements. But expenses in non-patient care departments merit scrutiny for items not adding value to patient care or sustainability of the organization.

To that same end, a retrospective critical evaluation of capital expenditures may likely identify investments that are not generating positive returns. While capital costs make up a minority of overhead costs, some reductions could yield benefit to the organization's bottom line. Even in a voluntary setting, capital investments should be considered for potential to generate returns and non-revenue-generating expenditures should be critically assessed to limit any impact on financial sustainability.

While boards usually do not get involved in operational decisions such as which position to hire or what investment to make, management can benefit from some

9 Kaufman Hall, *National Hospital Flash Report*, June 2020.

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board oversight and support. The finance committee can negotiate a position control roster as part of the annual budget review process, at which time, the value of a fixed salary can be critically evaluated alongside management. Similar oversight of annual budgets for administrative cost centers can assist management in providing a valuable "sounding board" on this operating expense element. Finally, the capital expenditure review process is a common tool by which the board and finance committee can ensure a proper review by management of these long-term fixed commitments. Capital investments can impact the organization's financial position through added fixed depreciation expenses over multiple years and a pro forma budget in addition to the typical cash flow analysis will help stakeholders see the profitability impact of these decisions.

Non-profit hospitals and health systems have patient care missions that must be sustained; however, this requires adequate resources that may be limited in today's hospital market with increasing patient care expenses and limited revenues for services. Boards and senior leaders should look for opportunities to improve on operational performance through a critical assessment of expenses charged to administrative functions in the organization, potentially turning an average loss from patient care services into a profit—without impacting patient care.

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