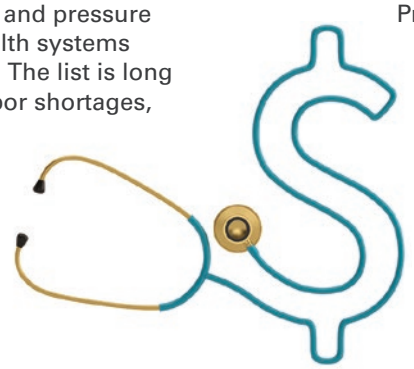
Where Is this Turmoil Leading? It's Heading Toward Value at Scale

By Dave Morlock, Cain Brothers

As a board member of a not-for-profit hospital or health system, you are tasked with multiple important responsibilities. But in the midst of monitoring the performance of your organization, overseeing the CEO, staying connected to the community and their healthcare needs, and thinking about your organization's strategic and budget plans, it can be hard to stay on top of overarching trends happening in the industry.

That said, American healthcare is experiencing changes the likes of which we have not seen in at least a half of a century. Board members must be well versed on those trends and issues. This is especially true when wrestling with trends and issues that impact the core of your organization's traditional business model. Your role is not to do the CEO's and management team's jobs for them. But you certainly need to be attuned to strategic and business model changes and be able to provide guidance and oversight as appropriate.

Entering the third year of the pandemic, the strain and pressure on hospitals and health systems remains unrelenting. The list is long (and depressing): labor shortages, expense inflation, legacy building fixed costs, vaccines, increasing regulatory and compliance burden, reimbursement pressure, physician consolidation, disruptive private equity and public equity investment in patient care, payer consolidation, price transparency, consumer demands, Medicare Advantage (MA) growth and the attendant administrative burdens related to MA, the continuing slow march to value-based care, expensive IT investment, and on and on.



In addition, some health systems are in markets where local socio-economic conditions, payer mix, stagnant population growth, and an over-bedded market exacerbate the already scary overarching industry trends.

Healthcare is a tough business right now. Because of mission dictates, community needs, and the fact that we have the health and well-being of human beings in our hands (literally), it is a business with a soul and a heart. But it is a business nonetheless. Whatever trite phrase you choose to use ("no margin, no mission," etc.), you must be aware of the strategic implications of underlaying business model shifts.

And immediate financial pressures are taking a toll. The first quarter of 2022 has created some exceptionally large losses across the industry, both in terms of the number of hospitals losing money, as well as the size of many of those losses (for example, Kaiser Permanente lost $961 million, CommonSpirit Health posted a $591 million operating loss, and Providence Health recorded an operating loss of $510 million in Q1 2022).

It is no wonder that health system CEO turnover is at some of the highest levels that we have ever seen. According to Challenger, Gray & Christmas, Inc., a healthcare executive placement firm, 29 hospital CEOs exited their roles in Q1 2022, nearly double the amount in the same period of 2021.[1] It certainly begs the question: Where is all this turmoil heading in the future? Because the status quo simply cannot continue.

A Shifting Business Model

We at Cain Brothers believe that future health system survival is all about scale—but not scale in the traditional sense. It's about value-based care at scale. That means scale in attributed lives. Health systems must be the nexus of care for attributed lives in their markets, and those markets must be large enough to be relevant and influential.

Ask yourself: Why are insurance companies acquiring physician practices, management services organizations (MSOs), ambulatory surgery centers, and home care companies? Why does private equity invest so heavily in physicians and physician enablement companies? And why are CVS, Walgreens, and Walmart investing so heavily in the actual delivery of care? They are doing so to become the nexus of care because there is profit in managing care of attributed lives at scale. That's "value at scale."

This competitive pressure is based on Medicare Advantage and value-based care reducing utilization and driving care into the lowest-cost settings. And the key phrase is "at scale."

Key Board Takeaways

Today's health system boards must no longer delay the process to reimagine their organizations in order to create a truly integrated value-based care delivery model that reduces utilization, moves as much care into the lowest-cost settings, and in which the care and payment models work together rather than against each other. The following are some questions for boards to discuss with their senior leadership teams to help move faster towards value at scale:

- How can we expand (further, faster) into full capitation and two-sided risk models?
- What do we need to do in our marketplace to compete for covered lives rather than patient care volumes?
- If we are considering consolidation, how can we ensure that it does not result in a larger, stronger, higher-priced FFS engine?
- What are we doing to increase the size and scale of non-hospital-based care?
- Can we break even at Medicare FFS rates?
- How can we become a platform for potential partners who can bring attributed lives, capital, and know-how to succeed in an MA model?

1 Challenger, Gray & Christmas, Inc., "CEO Exits Hit 119 in March; Q1 Exits up 29% over the Same Period Last Year" (press release), April 21, 2022.

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Public equity investment markets provide an interesting view of where they think the healthcare world is heading. The largest publicly traded hospital company in the country is HCA Healthcare. They have a market value of $80 billion as of the end of 2021, and their 2021 annual revenue was $58 billion, making their revenue multiple 1.37x (see **Exhibit 1**). Contrast that with value-based care companies such as Iora Health and Agilon Health. Exhibit 1 shows their market value, annual revenue, and revenue multiple compared to HCA.

So why does the stock market place a much higher value on the revenues of value-based care companies than the leading publicly traded hospital company? It is because the stock market is forward-looking by nature. They believe the future of American healthcare is value-based care. It is similar to the way the investment markets place a higher value on Tesla than on General Motors, Ford, and Toyota, even though the legacy car companies all sell many more cars than Tesla.

The future of cars is moving from gasoline combustion engines toward electric vehicles. And the future of American healthcare is moving from fee-for-service care toward value-based care. As a board member, you must understand this and have a point of view on what your organization needs to do in order to strategically deal with this shift in the fundamental business model.

An element of value-based care is the integration of insurance risk (i.e., the financing of care) with the actual operations of delivering care. Many health systems have struggled with that integration, because providing healthcare and providing health insurance are diametrically opposed business models. That's why many health systems that have tried to tackle value-based care by owning insurance companies have struggled to actually integrate the insurance and care models. One could

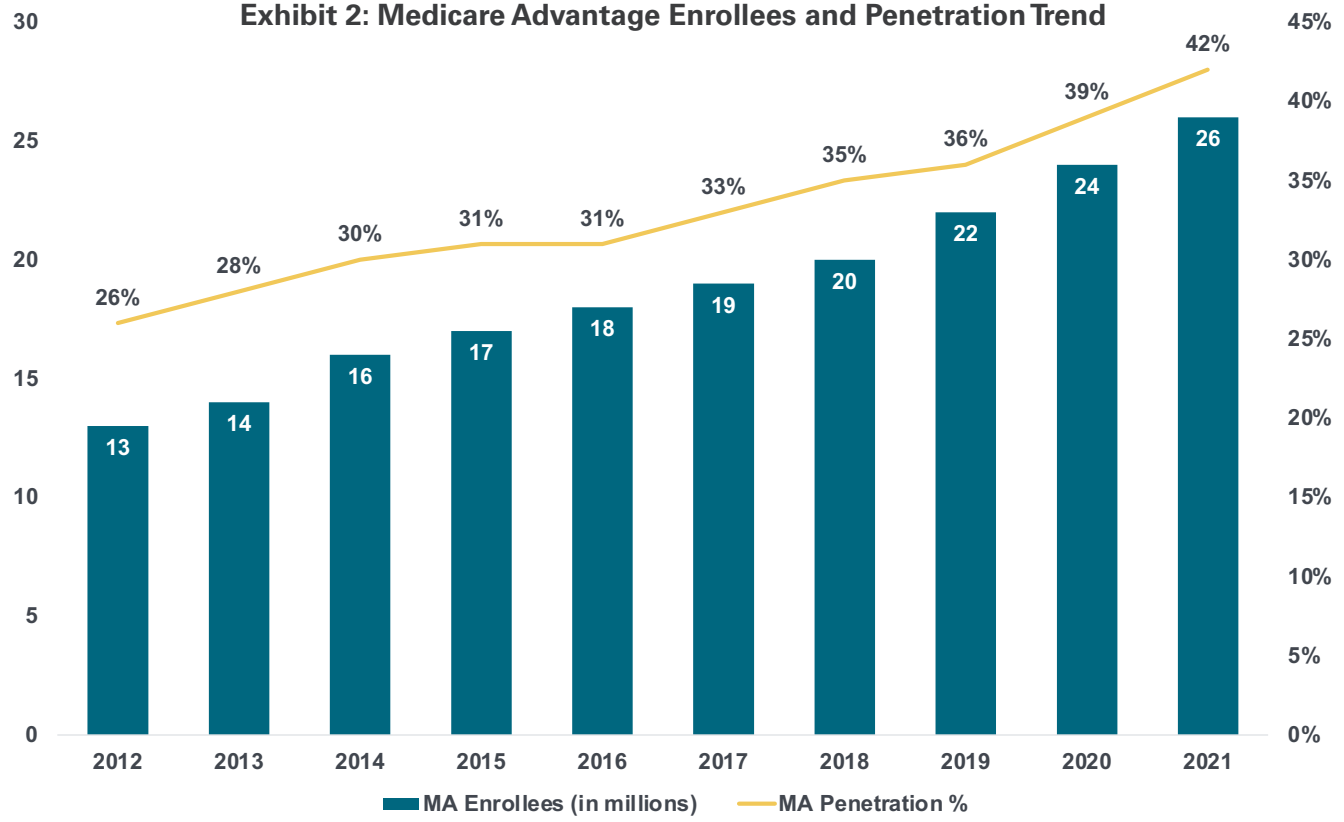
Exhibit 1: Key Financial Information for Publicly Traded Value-Based Care Companies

	Market Cap	Annual Revenue	Revenue Multiple
Iora Health (ONEM)*	$3.4 billion	$623 million	5.46x
Agilon Health (AGL)	$10.6 billion	$653 million	16.23x
HCA Healthcare (HCA)	$80.0 billion	$58 billion	1.37x

*Iora Health was acquired by One Medical on September 1, 2021.

Source: Google Finance, as of December 31, 2021.

Exhibit 2: Medicare Advantage Enrollees and Penetration Trend



Source: Kaiser Family Foundation

argue that Kaiser has managed to pull off this integration. But Kaiser may be a unicorn, providing the one-off exception that proves the rule that diametrically opposed business models can't readily be integrated. Even Kaiser has struggled to successfully export that integrated model outside of the West Coast.

Medicare Advantage has been on a slow and inexorable march toward being a dominant force in American healthcare for many years now. It has broad support across the political aisle. It is actually the privatization of traditional Medicare, though politicians wishing to remain electable generally shy away from that characterization. In the end, Medicare Advantage will have a similar effect on American healthcare that the move from defined benefit pension plans to 401k plans had on American retirement. It provides the vehicle to cap unsustainable growth in costs. While Medicare Advantage growth rates and penetration rates vary by state, the trend is clear (see **Exhibit 2 and 3**).

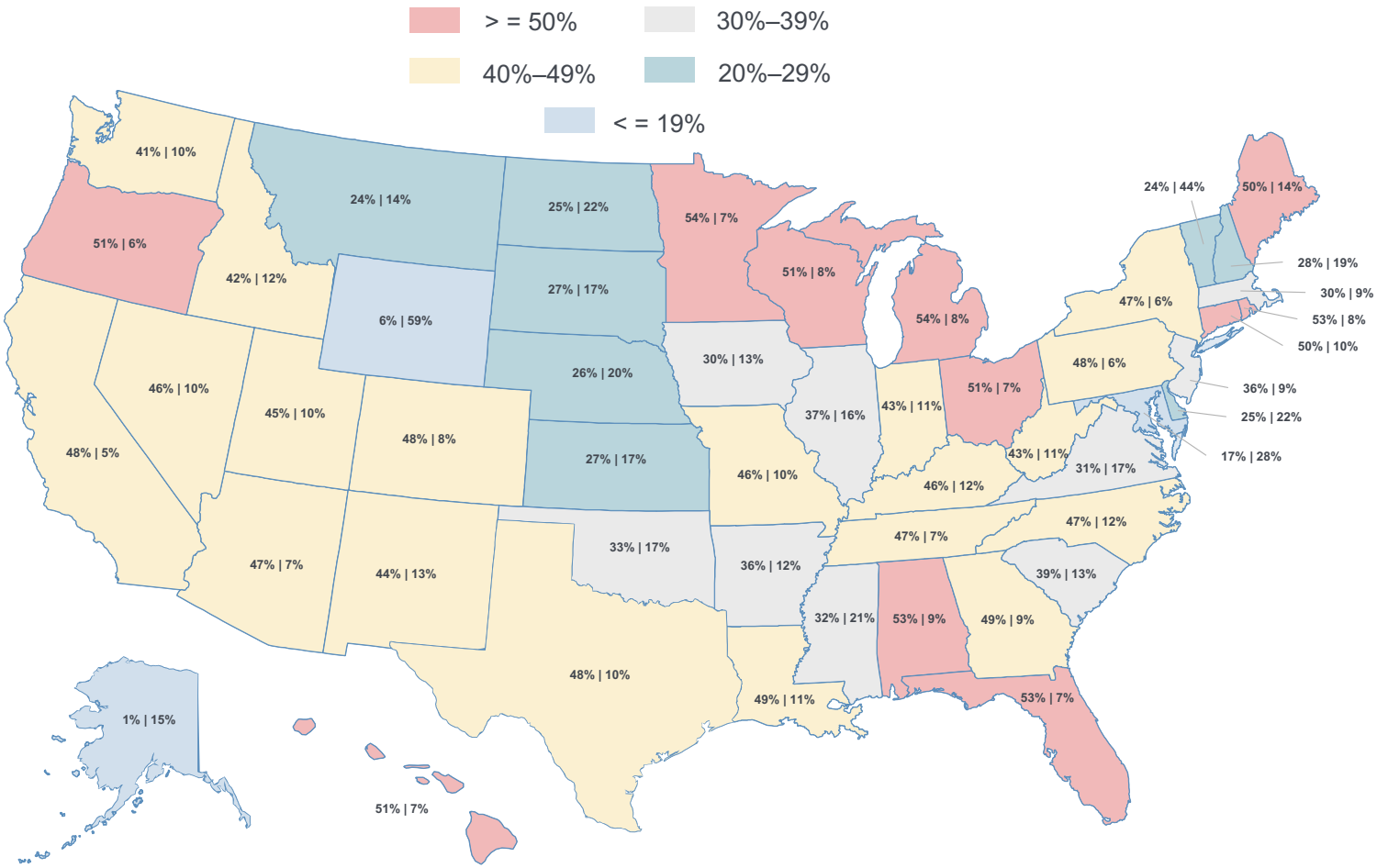
Medicare Advantage will continue to grow. And it will be the main factor that leads to the tipping point where value-based care will supplant fragmented, highly variable fee-for-service care.

The Slow March to Value-Based Care

It has been over a decade since we started the push toward payment mechanisms at the federal level to create value-based care. Organizations have invested significant amounts of money and management bandwidth on the effort. But the march has been very slow. By the end of 2020, less than 10 percent of health system payments were related to either full capitation or two-sided ACO risk. And few markets can be characterized as having true competition between multiple fully integrated health systems competing for covered lives, rather than competing for patient care volumes. What we have experienced instead is markets where consolidation has created large and strong fee-for-service engines, which actually makes healthcare more expensive to people, employers, and payers. And it does so without the element of integration necessarily driving improved quality of care.

An unfortunate outcome of this consolidation without the corresponding connection to competition in large-scale value-based care is the renewed federal push against health system scale. This is a misguided concern. The scale of health systems is not the issue. The real issue is that the

Exhibit 3: Medicare Advantage 2021–2022 Enrollment Growth Rate and Penetration by State



Source: Kaiser Family Foundation, CMS, The Chartis Group

fee-for-service payment mechanism is flawed. What American healthcare needs is more integrated health systems at scale competing with each other for covered lives, under a risk-based reimbursement model. We will never transform healthcare in America until we transform the way we pay for healthcare in America.

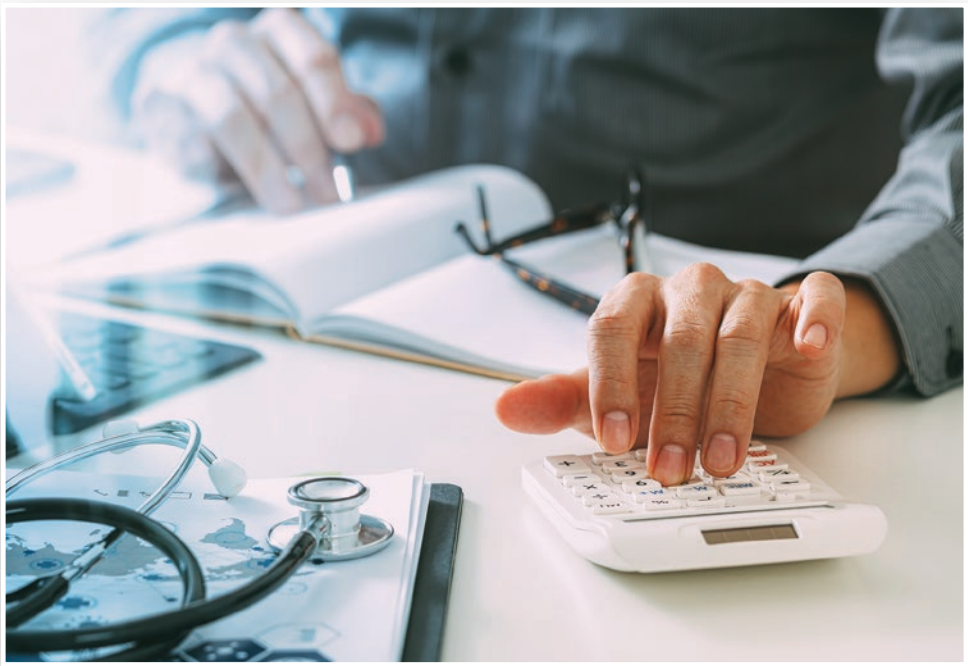
It should be noted that a key reason for the slow march toward value-based care is the significant portion of the healthcare industry's reliance on political lobbying as part of their business model. Almost every congressional district in America has at least one hospital in it. And in virtually all cases, those hospitals and health systems are one of the largest employers in the community. When a disruptive change to their business model is on the table (such as the shift from fee-for-service to value-based care), there is significant political lobbying pushback. A lack of desire, or lack of ability, to compete for covered lives in a value-based care environment could mean financial strain for health systems. At the hint of financial strain, cries of job reductions and reduced access to care for the vulnerable can be heard. And no politician seeks to be seen as a jobs-killer or someone who lacks compassion for the vulnerable (including the vulnerable citizens who vote). Political lobbying is a key tenet of the American healthcare business model. You have to wonder whether lobbying is ultimately a long-term sustainable pillar of an industry business model.

What does this all portend for hospitals and health systems?

Exacerbating this competitive dynamic for health systems is the increasing size and scale of non-health-system-based care giving activities. Large insurance companies are significantly increasing their positions in the provision of care through investment in ambulatory care activities (physician practices, ASCs, ancillaries, and home care). Private equity and public equity also continues to be invested in ambulatory care and physician services at significant levels. And these non-health-system players are doing this at scale. The two largest market participants in this area are United Health Group and CVS-Aetna. Their combined annual revenue is more than a half-trillion dollars (that's "trillion" with a "t").

Achieving Scale in Attributed Lives

Health systems need a Medicare Advantage model that works in both a value-based-care world and a fee-for-service world. In the fee-for-service context, the model means that you can be break-even at Medicare fee-for-service rates. If you continue to rely on the plan of losing money on government-paid business but making up for it with profits on commercial payers, then your strategy will fall apart over time. This fee-for-service context also means that you need to make money in your ambulatory environment, including the employed physician group. In a value-based-care context, the Medicare Advantage model means that you are taking top-line insurance risk, and you are on the hook for population health, quality of care, and economic outcomes for an entire population of attributed lives.



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Health systems have multiple ways to achieve scale in attributed lives. Some of these options include:

- Acquire and employ many primary care providers and gate-keeping specialists, in an attempt to control attributed lives. Are you positioned to outcompete major insurance companies, private

equity, and major pharmacy chains in this physician acquisition space?
- Own and operate a Medicare Advantage health plan, at scale. Scale in this context is measured in hundreds of thousands of lives. And the MA health plan business is a retail business. Are you positioned to outcompete major insurers in this space? Currently, nearly 75 percent of the Medicare Advantage lives in this country are controlled by six insurance companies, and they each have covered lives measured in millions. Can you compete with that scale? The number of small health system MA plans with 10,000 to 20,000 covered lives is astounding. The idea that those plans think that they can compete with large-scale health plans in a retail business like MA is even more astounding.
- Sign a large full-risk capitation agreement with a payer, covering a large number of attributed lives. Are there payers in your market signing those deals?
- Merge with another health system, such that the combined entity has sufficient scale and access to attributed lives to permit your system to survive in the future.
- Access attributed lives via partnerships. You could be a convener of partnerships by being a platform, similar to the way an iPhone is a platform for all of those apps. There are many partners to choose from. This would involve running a crisp, controlled process to identify the right partner who can bring not only attributed lives, but capital and know-how, in order to be successful in the Medicare Advantage model.

Partnerships can be used to successfully participate in the value-based care model by delivering high-quality care in lower-cost settings. For a couple of decades, that has often meant the delivery of care in an ambulatory care setting, rather than in the acute inpatient setting. More recently, an important key for the future is the ability to deliver care in more distant settings. This means care delivered in the home.

In this home-based approach to value-based care delivery, we will see the continuing emergence of a new "shadow continuum of care." The traditional continuum of care has been patients seen in a doctor's office, an ambulatory care clinic, an urgent care, or in the emergency department of the local hospital. Then a patient is admitted to the acute hospital setting. Then after discharge, care is often delivered in a post-acute setting such as a skilled nursing facility, long-term acute care hospital, or an inpatient rehab setting. In the "shadow continuum," care is delivered in the home setting via telehealth visits with providers, visits by home health providers, urgent care at home, acute care in the home setting, skilled nursing facility care in the home setting, palliative care, and then home hospice care.

Certainly, patients will move back and forth between these two continuums. But over time, as monitoring infrastructure gets even better, more and more care will be delivered in the virtual continuum of care. This is a lower-cost setting and will contribute to better health outcomes, better cost outcomes, and greater consumer satisfaction.

Very certainly, there will be continued private and public equity money invested in this space. As an example, UnitedHealth Group's Optum recently acquired home care provider LHC for $5.4 billion. As a health system, are you putting your precious capital into the virtual continuum of care, or in the brick-and-mortar continuum? This is a competition between the new healthcare economy vs. the old healthcare economy.

In moving from the old healthcare economy to the new healthcare economy, scale matters. But not from the traditional sense of leverage against payers or suppliers. Scale in attributed lives matters because of actuarial soundness, access to capital, shared operational services, and deploying technology and innovation on a scale where a reasonable return can be achieved.

A new world is emerging for health systems. They can shift paradigms, make partnerships, gain scale, and survive. Or they can hunker down, hope, and then wither away. What will you do?

The Governance Institute thanks Dave Morlock, Managing Director, Head of Health Systems Group, Cain Brothers, for contributing this article. He can be reached at dmorlock@cainbrothers.com. Cain Brothers, a division of KeyBanc Capital Markets, is a trade name of KeyBanc Capital Markets Inc. Member FINRA/SIPC. This article is for general information purposes only and does not consider the specific investment objectives, financial situation, and particular needs of any individual person or entity.