Deloitte 2017 Survey of US Health System CEOs:
Moving forward in an uncertain environment

> The margins of the health care delivery system are under fire. And if you looked at them against other businesses that have to survive, they are challenging, and they are not going in the right direction.
>
> *—CEO of a large faith-based health system*

Introduction

As a follow-up to our 2015 Deloitte Survey of US Health System CEOs, we interviewed 20 health system CEOs in May 2017. We found that, of all the issues that may keep hospital CEOs up at night, they are most concerned about:

- The future of Medicaid
- Moving towards population health
- Declining margins
- Finding, recruiting, and retaining forward-thinking and adaptable health care leaders
- Keeping up with new technology
- Adapting to evolving consumer expectations

In chapter three of our series, we explore why pressure on hospital margins is leading some health system CEOs to pursue new revenue streams even as they continue to focus on cost reduction.

About the survey

The Deloitte Center for Health Solutions interviewed 20 hospital and health system CEOs during May 2017. In 2016, their organizations collectively generated $91 billion in annual operating revenue, with all generating more than $1 billion annually.*

**Based on Deloitte analysis of DACBond, Hoovers, and organization websites*

The CEOs represent a wide range of organization types, including:

- Seven nonprofit hospitals/health systems
- Seven academic medical centers (AMCs)
- Three faith-based nonprofit hospitals/health systems
- Three children's hospitals

CHAPTER 3

Margin pressure
and the search for new revenue streams

Improving margins is a top issue for CEOs

Improving financial performance and operating margins continues to be a top issue for many health system CEOs, with several of those surveyed citing it as their chief concern. Many health care systems are experiencing stagnating or declining margins due to costs associated with increased headcount and investments in clinical innovation and population health initiatives. The effect of possible Medicaid changes on hospital margins compounds CEOs' concern, particularly those leading health systems focused on population health and quality improvement.

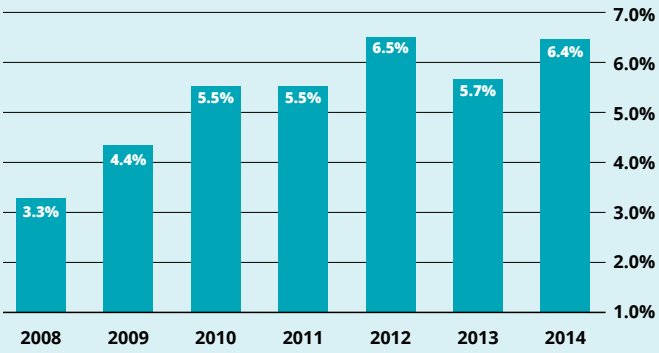
> "Anybody can make a margin look good if you avoid taking care of the problems of the world. I can make my margins [look good], by giving up things like mental health. But if you make the assumption that you should be providing health care services to all people—not avoiding the tough stuff—then you will have a problem with margins. Margin is manageable depending on what it is you want to do."
>
> *—CEO of a large academic medical center*

In the two years since our last CEO survey, improving financial performance and operating margins has climbed up the list of CEO concerns, influenced in part by the health care industry's transition from volume- to value-based provider reimbursement models. Trends that are challenging these hospital leaders to make do, or—in the case of value-based care—do more for less include:

- Medicare per-capita spending growth has been restrained. Between 2010 and 2016, average annual growth increased 1.3 percent[1]—significantly lower than the 7.4 percent annual average between 2000 and 2010.
- Medicaid payments are often low, and Congress continues to debate cuts to the program. Medicaid reimbursement rates are about 45 percent lower than private rates, according to some studies.[2] Additionally, many commercial payers are placing greater emphasis on value-based care. For example, Humana has 63 percent of their membership in value-based care contracts.[3]
- Even as revenues are declining, expenses keep rising—squeezing hospital operating margins (see Figure 1). According to Moody's Investors Service, expenses for nonprofit hospitals grew by 7.5 percent from 2015 to 2016 while revenue grew by 6.6 percent.[4]

> "What has changed is the rapid deterioration... the reimbursements cover just a bit more than 50 percent of our cost...We are operating at near capacity all the time, but that has not translated into margin improvement as it once did."
>
> *—CEO of a large academic medical center*

Figure 1. Average hospital operating margins



Source: American Hospital Association Annual Chartbook, 2016

Although operating margins increased modestly after the Affordable Care Act (ACA) expanded coverage and the economy improved, they remained flat from 2012 to 2014. When the interviewed hospital and health system CEOs compare their organizations to those in other industries—or even other health care industry sectors—they conclude that three-to-six-percent margins are very low. Additionally, they fear that revenue cuts from one payer, or a needed clinical or technology investment could quickly push margins into the red.

Increasing volume may no longer be the answer to improving margins

> "In an industry where our core business is being commoditized and utilization is declining, there has to be ways to grow revenue. So that's becoming an increasingly larger question. We are looking at things like urgent care; we're looking at things like joint ventures for ambulatory surgery...things of that nature that are creating less of a reliance on the inpatient revenue stream and more on the outpatient side. We also are dabbling in a few other things, like simulation, partnering with companies to create opportunities for innovation, and training revenues in simulation environments."
>
> *—CEO of a large nonprofit health system*

Rather than being encouraged to increase inpatient volume to generate revenues, many health systems are being urged and incentivized to treat patients outside hospital walls. To illustrate the impact, the proportion of revenue from inpatient services relative to outpatient services has fallen 18 percentage points since 1994.[5]

Unfortunately, outpatient care revenues, even if the care is provided at a hospital-owned entity, are not as high as those for inpatient stays: Medicare paid, on average $3,002 per inpatient stay and $1,753 per outpatient service in 2015, according to the Medicare Payment Advisory Commission.[6]

Even as hospital admissions have fallen, overall hospital employment has risen—and labor is the largest single component of hospital costs.[7] Deloitte estimates that labor expenses make up roughly 50 percent of total operating costs for most hospitals.[8] In contrast, costs to provide care in outpatient settings are much lower; meaning that hospital operating margins could be improved, even with lower revenues. This notion has propelled many hospitals to acquire physician practices and invest in outpatient services. But even as hospitals have moved to acquire and utilize lower-cost care settings, many payers have adapted their reimbursement practices. For example, to reduce Medicare costs, the Centers for Medicare and Medicaid Services (CMS) has proposed paying lower rates to hospital-owned physician offices which, in turn, would reduce payments for outpatient services.

While reducing costs has long been a focus for health systems CEOs, many are pursuing new cost-cutting measures. Among these are developing new staffing models, shifting patients to outpatient services, and reducing administrative and supply costs.

In addition, many health systems are looking for new revenue sources to offset rising costs. But competing for funding can be rigorous: For example, teaching and research hospitals are seeing less grant support. The National Institutes of Health (NIH) distributes more than 80 percent of its funding through 50,000 grants to roughly 300,000 researchers at 2,500 universities.[9] However, until this year, funding has not generally increased, and inflation has eroded the value of some of these grants.[10] Subsequently, the grants have been harder to win—less than 20 percent of applications are funded.

> Philanthropy: We've got to fill the hole somewhere or another if we're not going to be able to do it with grants from the NIH; if we're not going to be able to do it with operating income, [then] it has to come from somewhere within, and it's likely to be philanthropy.
>
> *—CEO of a large children's hospital*

Some CEOs are investing in clinical and technology innovations with an eye towards generating revenue:

> "One tangible example [of new revenue streams] is how we would share intellectual property that might result from some of the innovations that could be created. It could be a new revenue stream into the organization. We have two that are on the verge of receiving FDA approval and/or patents that could be substantial…they haven't hit yet or realized themselves yet, but it's an example how we have architected a vehicle and a mechanism to benefit from some of the innovations that can occur from within our team and partnerships."
>
> *—CEO of a large children's hospital*

Additionally, many hospitals and health systems are leveraging the revenue potential of developing a physician network:

> "We've created a CIN [clinically integrated network] with our referring pediatricians in our market. We will continue to focus on finding the right strategic partners to leverage innovative technology solutions to adapt our care delivery model into more nimble ways and/or completely new revenue-generating models that are new and not bound by traditional thinking."
>
> *—CEO of a large children's hospital*

Some hospitals are looking to capitalize on their intellectual property (IP). Hospitals and health systems can work with employees to develop any number of innovations—medical devices, training videos, health information technology (HIT) tools, or patient safety solutions. Once the hospital has filed for patent or copyright protections, it can sell or license the IP to other industry stakeholders.

> "We are investing in joint ventures, working with private equity, commercializing a lot of our foreign assets [such as services for international patients traveling to the US for care], and I've already started a number of new companies—all for the purpose of making sure that I could come up with an alternative revenue stream to subsidize the government revenue stream, which is necessary today and would be imperative 5-10 years from now. To continue to expand and grow, you have to have access to capital. If you don't have access to capital, you can't invest. If you can't invest, you can't grow and if you can't grow, you are going to die."
>
> *—CEO of a large academic medical center*

Many health systems are continuing to pursue growth through mergers and acquisitions (M&A). They are working to increase their physician networks, expand their geographic reach, and diversify their specialized offerings and talent. Such growth can assist with building clinically integrated networks and provide the scale needed to reduce costs. Health care organizations with larger patient populations might have increased access to capital, which could mean more money to invest in the transition to value-based care.

> "[W]e are looking at [if] we need to focus on partnering, merging, aligning, acquiring other health assets in the state to be able to get to more scale, drive down overall operating costs, and also have more access points and attractiveness for the consumer and—to be honest—a little more leverage with the insurers."
>
> *—CEO of a large nonprofit health system*

How do value-based payments intersect with margin concerns?

The adoption of value-based payments models is increasing due to policies such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), initiatives from CMS' Center for Medicare and Medicaid Innovation, state Medicaid programs, and, to some extent, private-sector health plans. Value-based payments reward health systems that improve quality and other outcomes, and reduce total costs of care; achieving these goals has the potential to help health systems improve margins.

Many surveyed CEOs agree that population health management is the key to success under value-based payment models *(see Chapter 2: Population health and value-based care)*. CEOs also should consider the following approaches to improve margins:

- **Increase system efficiencies beyond what is needed to be profitable.** Many hospitals and health systems have reduced costs and increased efficiencies at the margins of their organizations, but long-term sustainability may require organizational restructuring.
- **Operate as a consolidated system.** Many health systems have grown through acquisition, and have not fully realized new efficiencies and synergies system-wide. Consolidating where appropriate and looking for synergies across the system can improve efficiency.
- **Pursue or expand new revenue streams.** Many forward-looking CEOs are pursuing revenues from new payers, selling IP, and launching philanthropic organizations.
- **Diversify beyond the core hospital.** As inpatient revenues decline, many CEOs are partnering or integrating physician practices, investing in outpatient services, step-down care, urgent care, etc.
- **Improve revenue cycle systems.** Despite upgrades to revenue cycle systems in recent years, many health systems are still leaving money on the table. They may be able to leverage scale and improve efficiency by reducing the number of supply chain vendors and non-critical employees.

Endnotes

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