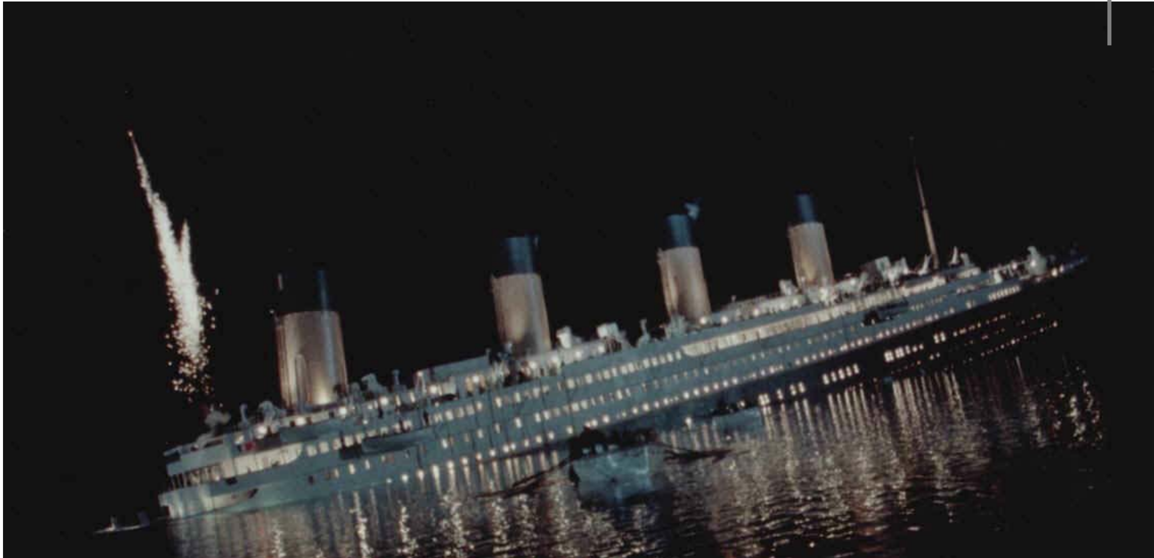
Spring 09



The End of the Third Bubble

Neal C. Hogan, PhD

Table of Contents

Introduction: Of Black Swans and Bubbles **3**

A Short History of Bubbles **4**
The Paradigmatic Bubble: The South Sea Bubble of 1720 *5*
The First Bubble: The Dot Com Bubble of 2000 *7*
The Second Bubble: The Housing Bubble of 2008 *8*
The Third Bubble: The Health Care Bubble of 2010 *10*

The End of the Third Bubble **14**

New Insights Lead to New Opportunities **18**
Market Acquisitions Assessment *18*
Asset Maximization Analysis *18*
Zero Capital Capacity Increase *19*
Resetting the Outpatient Margin Standard *20*
Re-Assessing Physician Readiness *20*
Building a Physician Asset Discipline *21*
Doctor Managed Disease Management *21*
Bundled Payment Readiness Assessment *21*

Closing Thoughts **21**

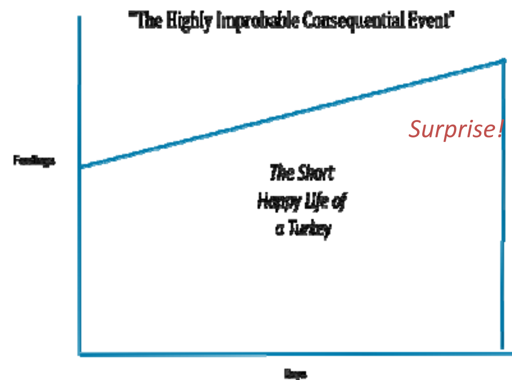
In all my experience, I have never been in any accident … of any sort worth speaking about. I have seen but one vessel in distress in all my years at sea. I never saw a wreck, nor was I ever in any predicament that threatened to end in disaster of any sort.

Captain E J Smith, 1907[1]

Introduction: Of Black Swans and Bubbles

One of the few investment councilors to make money for his clients in 2008 was Nicolas Taleb, author of *The Black Swan.* Taleb moved his clients into cash positions during 2006 and 2007 because he believed that the massive complexity inherent in derivatives and credit default swaps on bundled mortgages turned into securities had created the likelihood of a "highly improbable consequential event." The devastating effects of such an event have been Taleb's primary study since his early career. His basic premise is that we fool ourselves into believing that our mathematical analyses of the past give us trend lines that will explain the future. The book's title comes from a 16th Century English expression "When I see a black swan" that would be similar to our "if pigs could fly." The expression had to be dropped after the discovery of Australia – and its quite common black swans.

In his book Taleb uses a simple story to explain what he means by "the highly improbable consequential event." Suppose you are a turkey. Every day a man comes to feed you, and each day it seems that he feeds you even more food. You, and your financial analysts, planning department, economics team, and strategists, collect the data that you have concerning the man, the food, and relevant historical patterns. You do an in depth and rigorous analysis of all of that data and determine that the trend line is very good.



And then one day the man arrives and chops off your head.

It takes a complicated series of events to create a bubble, so perhaps it is no surprise that we miss all of the signs telling us to be prepared for that bubble to burst. Taleb argues that surprise catches us because we discount the likelihood of the "improbable consequential event."

No one wants to see a bubble.

Taleb's analysis should lead health care executives to ask three questions:

- How likely is it that we are seeing a bubble in health care?
- Are we missing any "Black Swans"?
- What can we do to prepare for the end of the bubble?

---

[1] Smith was the Captain of the *Titanic* when it sank during its maiden voyage in 1912.

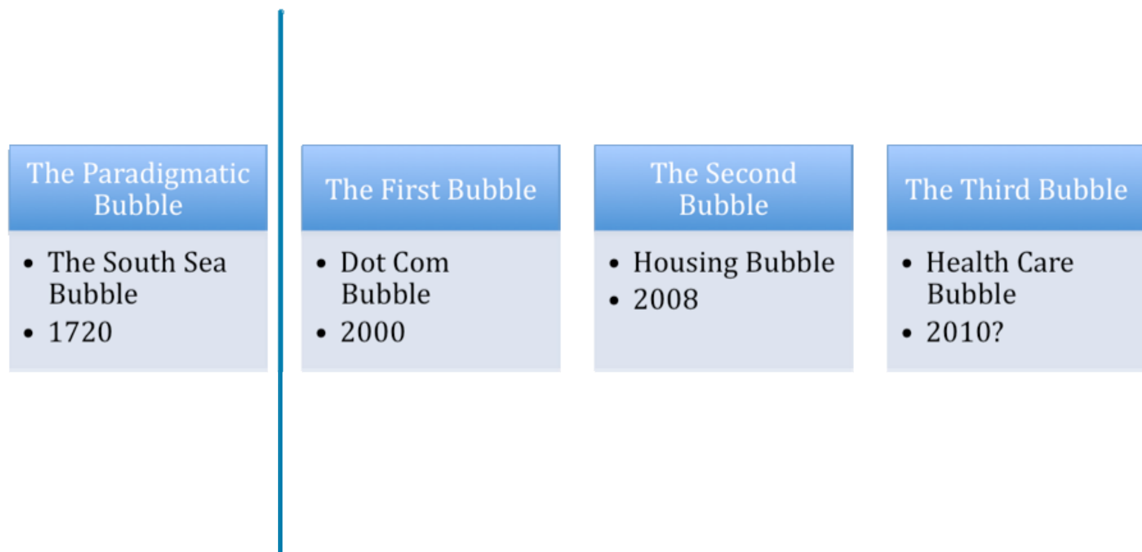
A Short History of Bubbles

No one ever wants to admit that they are currently working in a bubble sector.[2] It takes a great deal of convincing to move people into the belief that a bubble event is in place. The best approach to the problem is to look at bubbles from the past and determine what are the necessary underpinnings of a bubble event. There is no better place to begin than with the first bubble, the South Sea Bubble of 1720. That analysis will lead to a bubble "model" - the *Four Cornerstones.*

We will then test that model on the two bubbles that have occurred in the last decade: The first bubble: The Dot Com Bubble of 2000, and the second bubble: The Housing Bubble of 2008.

Finally, we will examine the current state in health care and ask:

- Are the *Four Cornerstones* in place for a bubble in health care?
- What events will predicate the end of the third bubble?
- How do health systems discover opportunities as the third bubble ends?



[2] Robert Shiller published his warning about the housing bubble in 2000, in his book *Irrational Exuberance.* Few listened to his argument at the time.

The Paradigmatic Bubble: The South Sea Bubble of 1720

The first use of the word bubble in reference to an economic event occurred in 1720 as the result of a market crisis created by a single firm.[3] The bubble began in 1711 when the Lord Treasurer, Robert Harley, created the South Sea Company. Nominally a trading company, its primary activity was the funding of government debt incurred during the war of Spanish succession. The company convinced holders of short-term government debt to exchange it for stock in South Sea. The stock was in essence a perpetual annuity. In 1719, the company again sold shares of government debt, gaining a 5% dividend. By the end of that year, the South Sea Company held over 20% of converted British national debt.

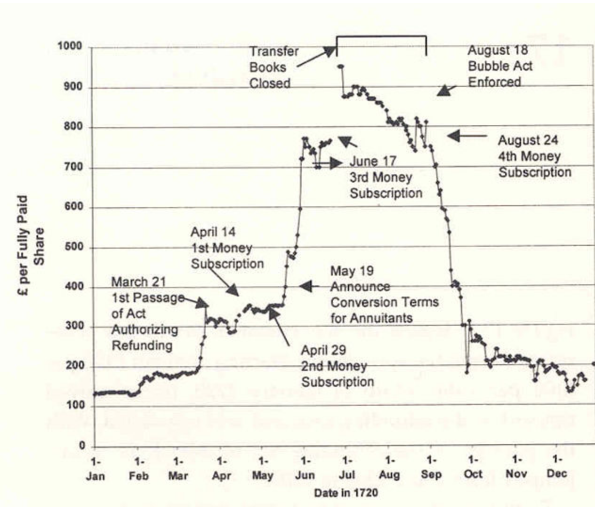


Figure 17.1
Daily South Sea Share Prices, 1720. Data courtesy of Larry Neal.

In 1720, South Sea directors began rumors that the firm's shares were enormously undervalued because the market was not taking into account the company's exclusive rights to trade in the New World. It argued that the vast New Economy of the New World created security for shareholders. Share prices rose from 128 pounds in January to over 1,000 pounds by the end of the year. Other stock companies capitalized on the frenzy and developed bizarre foreign ventures and schemes that traded on the "security" of the New World's economy. These offshoots of the South Sea model became known as bubbles, as they bubbled forth from the original.

Suddenly (and abruptly) in August of the following year, the party came to an end. Investors realized that the colonies for which the South Sea Company held a charter providing exclusive access were now under the control of the Spanish, making South Sea's "exclusive" charter moot. In addition, the main business of South Sea was the transportation of slaves to the New World and those transports had been limited to one ship per year. The company had no revenues and was essentially a Ponzi Scheme. Finally, the tag along firms – or "bubbles" - all began to collapse.

We bring up South Sea because it defines the four cornerstones of a bubble:

First, the **necessary fallacy**. In the case of the South Sea Bubble, everyone involved - the government, the directors, and the customers - believed that initial investment was "just a recapitalization of debt." Investors believed that the South Sea Company was behaving like a bank. They had invested in securitized debt, and that security would pay a nominal rate of

[3] South Sea Bubble chart found at http://people.few.eur.nl/smant/m-economics/southsea.htm

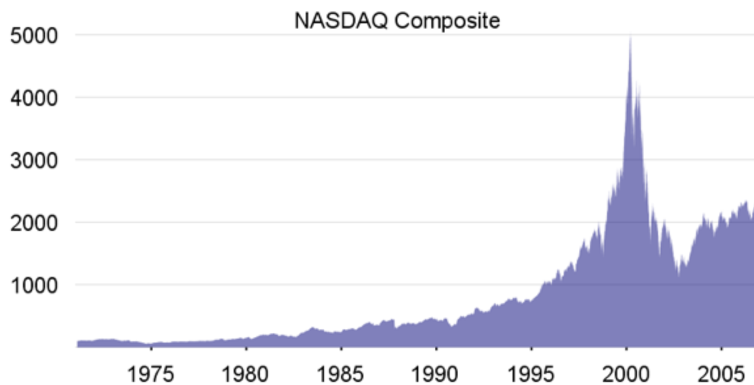
interest for many years. In fact, the interest rate was too high to be maintained, and rumors of the worth of the company's charter led the firm to be overvalued.

Second, the **consumer blind spot**. Customers who purchased shares in the South Sea Company ignored the fact that there was really no company producing revenue. It made no sense that returns on the secured debt could exceed the real interest rate paid by the government.

Third, **government complicity** exacerbates the problem. With the creation of the South Sea Company's equity, the government had successfully offloaded 1/5 of its debt. One of its largest gambles - the cost of the Spanish war - had been paid for. No one in the government wanted to question the efficacy of the South Sea solution.

Finally, the industry in which the bubble occurs develops a **security rationalization**. Executives come to believe that there are certain "rules of the game" that will protect them. In 1720, the New World seemed to be a font of all riches and had created a new security for all investors.

The First Bubble: The Dot Com Bubble of 2000



Will the analysis and the use of the *Four Cornerstones* hold up in our more recent bubbles? [4] The first large bubble of the last decade was the Dot Com Bubble. The rapid rise of the World Wide Web created enormous opportunities to innovate and develop new businesses. Every conceivable business was attempted – from flooz.com which sold "internet currency" to Kozmo.com, which would deliver virtually anything (a single donut, or a video tape) to your door within one hour.[5]

The strategy was to capture market share and "get big fast." The bubble burst in March of 2000 – wiping out $5 trillion dollars in market value.

The **necessary fallacy** of the Dot Com Bubble was the concept of the "dawn of a new economy" in which the old rules of business – for example, that companies need revenues – no longer applied.

The consumer in this case was the purchaser of internet stocks. The **consumer blind spot** was the absurdity of the P/E ratios of the new internet companies. Because they had no earnings, they often had no P/E ratios. People spoke of valuing companies based on the number of "eyeballs" attracted.

Government complicity was driven by the belief that these new companies, and the new wealth they were creating, would create vast new revenues for the treasury.

The **security rationalization** embraced by investors and company executives was quite similar to the one used in the South Sea Bubble – the New Economy would create an enormous new

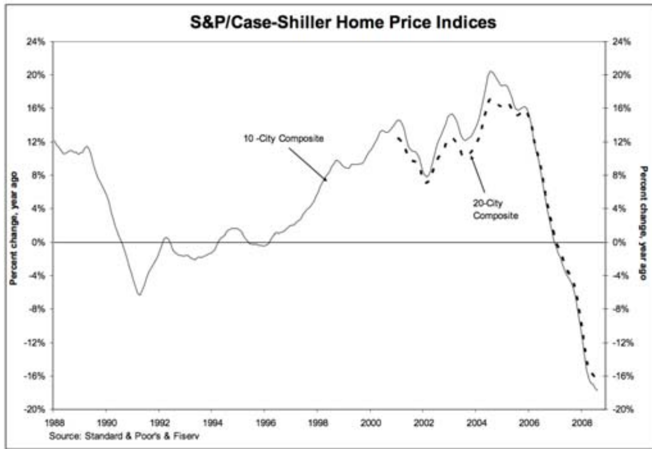
---

[4] NASDAQ Composite Graph from http://www.justsearching.co.uk/JustBlog/why-did-the-dotcom-bubble-burst.html

[5] For a wonderful top ten list of the biggest internet flops, see *CNET's* "Top 10 Dot Com Flops" at http://www.cnet.com/1990-11136_1-6278387-1.html.

market, and there would be room for a whole host of new players, from people selling dog food to "internet incubators" that would simply exist by virtue of creating new start up companies. Everyone could get rich.[6]

The Second Bubble: The Housing Bubble of 2008



The Housing Bubble is a far more recent (and thus more painful) example. There are a host of factors that go into an economic downturn of such proportions.[7] We will not review the story of the bubble here – except to examine how it might fit our *Four Cornerstones* model.

[6] One of the most notorious internet companies was CMGI an "internet incubator" whose stock price went up 10 fold in a few months. CMGI purchased the naming rights to the New England Patriots stadium for $10M, only to go out of business a few weeks after the name was put up.

[7] The *New York Times* has run an exceptional series of articles called "The Reckoning" on the roots of the housing bubble and the current collapse of markets. Go to the website at www.nytimes.com and search "The Reckoning" to see the complete series.

Four Cornerstones of a Bubble	*South Sea*	*Dot Com*	*Housing*
Necessary Fallacy	Only recapitalizing debt with equity	The New Economy	House prices never fall
Consumer Blind Spot	There is no "business"	P/E Ratios	No Hurdle Mortgages
Government Complicity	Success in downsizing national debt	Dot Coms = new treasury revenues	Housing: our economic engine
Security Rationalization	Enormous new market (The New World) creates security	New Economy (new market) creates security	Hedging creates security

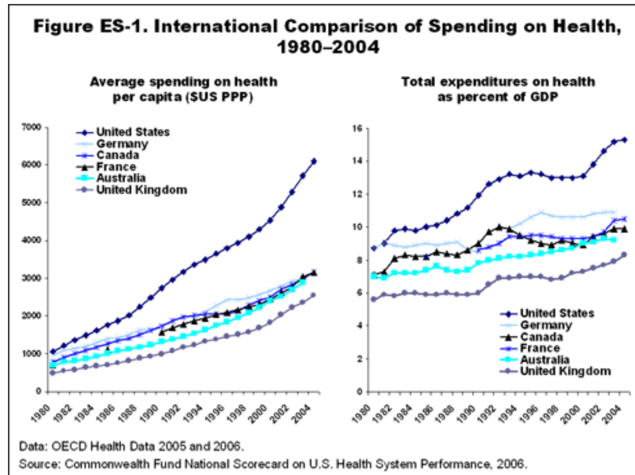
There was a simple and **necessary fallacy** involved in the Housing Bubble: *home prices never fall*. Even as Robert Schiller was predicting a crash in this market back in 2005, he noted that prices tend to rise over time. From the 1940s on, housing prices tended to rise, but as the turkey learned, trend lines do not make for future predictions.

Customers ignored the fact that everyone was getting a mortgage. The most infamous of these were the "NINA" mortgages (No Income, No Assets) that were developed in 2006. No longer was anyone "qualifying" for a mortgage, lenders were giving them out like candy. If anyone could get a mortgage, then the market would become imbalanced with a vast number of buyers chasing a small number of sellers.

The **government complicity** was legion: the Federal Reserve Bank lowered interest rates, Freddie Mac and Fannie Mae were left unfettered, the SEC failed to regulate hedge fund or credit default swaps. The government focused more on how many people were getting to "own" their homes, and how home prices were growing the economy, than on the fundamentals underlying the growth rate.

Finally the **security rationalization**: hedging creates security. Homeowners were hedging in a way, because many had no money down. The investors in the mortgages (and the reason that the popping of the bubble has been so devastating) were hedging their bets on the mortgages. The amount of money in "credit default swaps" and mortgage derivatives is estimated to be 10 times the amount of the actual value of the mortgages. When the bubble popped, the hedging turned out to fail. Because no one had actually "insured" the assets, every bank realized that it owed billions of dollars in credit defaults, and no bank wanted to lend money to any other.

The Third Bubble: The Health Care Bubble of 2010



An argument that there is a bubble (one that is about to burst) in health care is a tough sell. Because we don't hear of people making a "killing" in health care, or see videos of health care investors flying in G3 private jets to their chateaus in the south of France, people remain skeptical. But let's be frank. When Warren Buffet warned in the late 1990s that the asset valuation of internet companies made no sense, and that he would not invest in them, he was literally laughed at by the Wall Street community. When Robert Schiller wrote *Irrational Exuberance* and predicted the crash of the housing market, and the following devastation – no one listened. As Taleb argues, people have a tough time seeing black swans.

What makes it more difficult in health care is that there have been so many Chicken Littles across the last two decades. The "sky is falling" argument goes back at least to the Clinton years. People warned that "Health care consumes 12% of GDP, and if it goes over 14% disaster will strike." And yet, we blew right past 15% of GDP, and as of 2007, the national cost of health care had risen to $2.2 trillion dollars, or $7,421 for every man, woman, and child in the country. It made up an all time high of 16.2% of GDP.

People have argued that "Medicare will soon go broke," and yet somehow, we continue to find ways to fund Medicare. "Health insurance premiums cannot rise 10% every year"– yet they do.

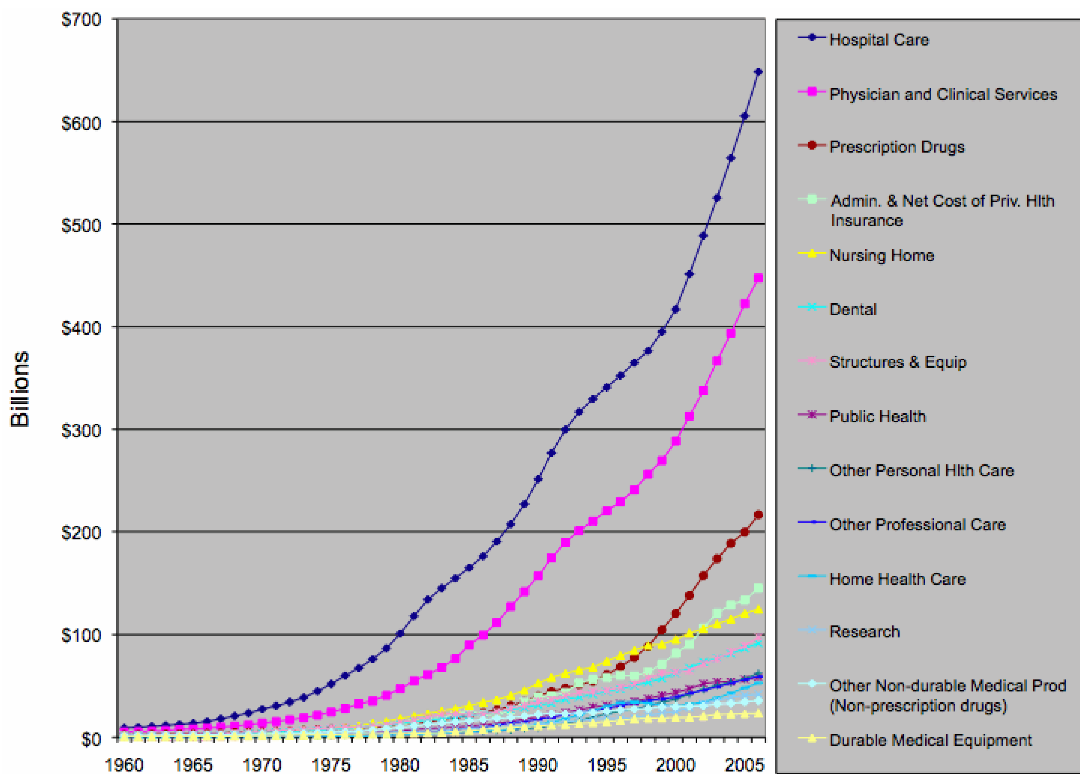
Three things are going on here.

First, perhaps it is more an example of the Boy Who Cried Wolf than of Chicken Little. The sky never fell, but eventually the wolf did come. But by that time no one was willing to listen to the boy.

Second, when people have cried wolf loud enough, action gets taken, pushing back any collapse. The Balanced Budget Act of 1997 slowed growth in Medicare expenditures, and every decade or so, Congress acts to "fix" Medicare in a way that extends its life.

But there is a more important argument to be made: people have been thinking about "health care" in the wrong way. People think of health care as a single "economy." In fact, it is many micro economies: pharmaceutical firms, retail drug stores, hospitals, outpatient centers, specialist offices, specialist procedures, primary care doctors, home health, nursing homes, etc.

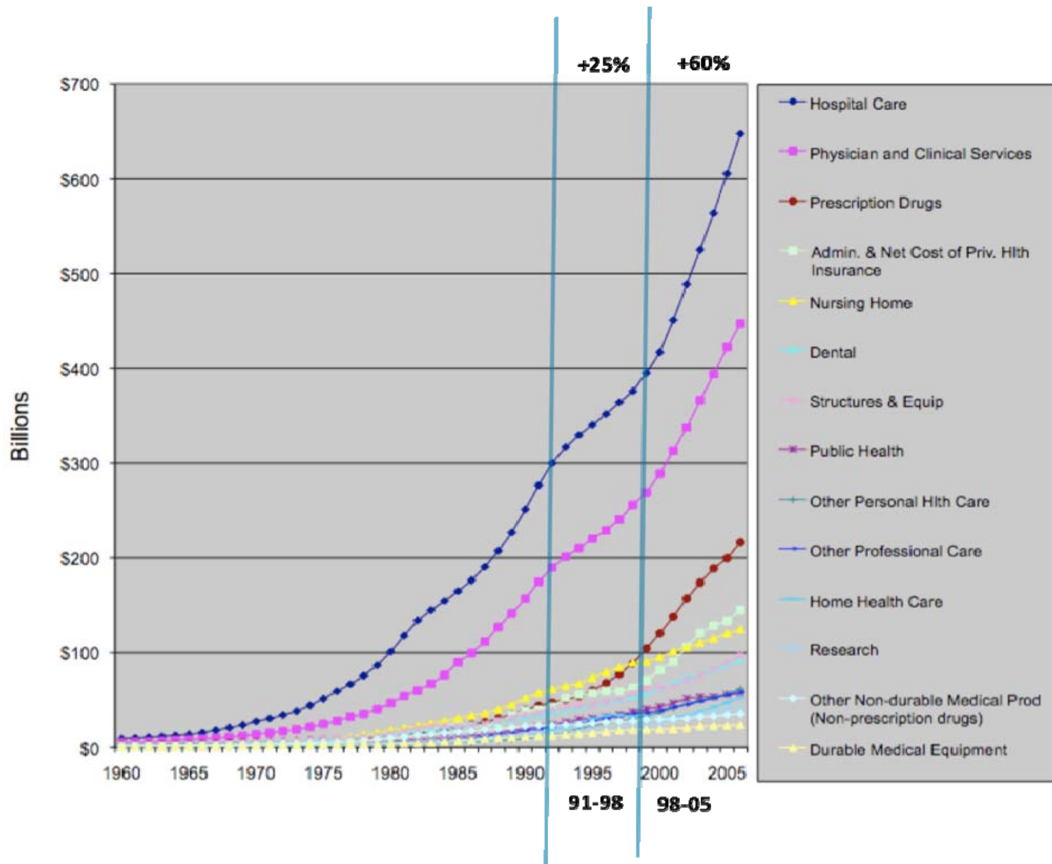
Is it possible that there are clear signs of a bubble in one of these sectors? This is not about whether the GDP can support the costs of care, or the federal government can afford the costs of the Medicare program. This is a question of "Are there any sectors of the health care economy that have come to look like the first half of the graphs of the bubbles we show above?" That should be followed by an examination of the *Four Foundations* we have found in every bubble to see if they are occurring in a sector of health care.



The data above is more informative than others used to depict growth in the financial fortunes of the health care economy for two reasons. First, frequently health care spending data is organized to display annual variations in the rate of increase in spending on health care. At other times it is used to show how much of the GDP health care has captured. This data looks at total, inflation-adjusted dollars that are going into health care through commercial insurance, Medicare, and Medicaid. It is a much clearer way of seeing how much the sector has grown in the last half century.

Second, instead of looking at "health care" as a singular economy, the analysis divides up where these dollars go.[8]

The rate of growth in expenditures on hospital care and physician and clinical services is remarkable. And while that rate of growth has been on a steep upward curve for two decades, the curve becomes nearly vertical in the last five years.



This becomes even clearer when we add two vertical lines to the chart. We have created two "periods" that have occurred in the last 15 years. For the period 1991-1998, provider expenditures increased by about 25% for the two categories. But during the period of 1998-2005 (the most recent data), expenditures rose by about 60%.

Without doubt – looking at the trend line of dollars spent on hospitals and physicians – this looks like the first half of a bubble.

But do our *Four Foundations* fit? Is there a necessary fallacy, a consumer blind spot, government complicity, and a security rationalization?

---

[8] From Samuel Baker, University of South Carolina, Arnold School of Public Health.

We believe so.

Four Cornerstones of a Bubble	*South Sea*	*Dot Com*	*Housing*	*Health care*
Necessary Fallacy	Only recapitalizing debt with equity	The New Economy	Prices Never Fall	Prices Never Fall
Consumer Blind Spot	There is no "business"	P/E Ratios	No Hurdle Mortgages	Triple Cross Subsidy
Government Complicity	Success in downsizing national debt	Dot Coms = new treasury revenues	Housing: our economic engine	"Deficits Don't Matter"
Security Rationalization	Enormous new market (The New World) creates security	New Economy (new market) creates security	Hedging Creates Security	Scale Creates Security

The **necessary fallacy** in health care is very similar to the one found before the Housing Bubble: *prices never fall*. The Balanced Budget Act of 1997 was a radical shock to health systems: after 30 years of annual price increases, Medicare gave no price increase for a single year. That single year of price flattening – not even a decline – raised a furor in the industry. No one believes that prices can fall in health care, and everyone has an argument why not. When it is pointed out that prices fall rapidly in other industries, executives argue, “health care is not manufacturing.” When people argue that (inflation adjusted) prices have fallen even in service industries like hotels and restaurants, executives argue, “our payment structure is different.” No one believes that prices can fall in the health care industry.

The health care consumer is tripartite: the employer, the insurer, and the patient. None of them want to think about the triple cross subsidy in health care. Employees have money taken out of their paychecks each month and sent to Medicare recipients. In addition, the employee tax dollars are used to pay for people on Medicaid. Because that money (in the form of Medicare and Medicaid) does not cover the cost of care for those patients, employees pay more for their health insurance. When that employee has a heart or orthopedic procedure in a hospital, the payment is vastly more than a Medicare, or a Medicaid, patient pays because now the employee is subsidizing the “charitable mission” of the hospital. The **consumer blind spot** is this triple cross subsidy.

The **government’s false belief** is that “deficits don’t matter.” They do matter, and the one time that a few people in government began to believe that is the one time that health care prices flattened.

The **security rationalization** in the industry is one that players cling to: size matters. The greater the scale of the organization, the more likely it is that organization can command higher prices.

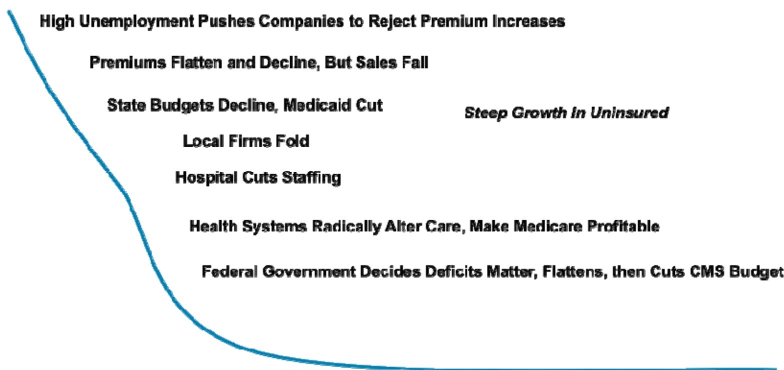
As long as organizations get to "sustainable indispensability" then there may be bumps in the road, but nothing can devastate them.

There is a bubble in health care – which leaves us with two questions:

How will the bubble pop?
How do health systems find opportunities at the end of a bubble?

The End of the Third Bubble

DEFLATING THE BUBBLE
Nightmares are made of this....



For the bubble to pop all *Four Cornerstones* must crumble*:*

- ✓ Prices fall.
- ✓ Consumers refuse to pay premiums that lead to cross subsidies.
- ✓ The government decides that deficits do matter.
- ✓ Scale of systems is no protection from price cuts.

More likely than a popping is a slow dissipation of the bubble taking 2-4 years, but still bringing significant pain to providers. It is easy to construct a likely scenario (black swans not needed):

From 2009-2011 providers will experience a decrease in commercial revenue driven by the following events:

- The continuing recession (and high unemployment) will drive employers to refuse health insurance premium increases. Given that traditionally employers have used health benefits to attract and retain employees, and that unemployment is likely to increase in the near term, we will also see more employers dropping the health insurance benefit.

- Those employers who elect to continue covering their workers (but still refuse premium increases) may further the shift to very high deductible products. We have already seen a 100% increase in the median deductible (from $500 to $1,000) in 2008. Many more employers may choose $1,500 to $2,000 deductible policies. In addition, employers may be willing to sacrifice choice and return to restrictive plans of the kind offered in the early 1990s.

- A shrinking demand for employer sponsored coverage will lead premiums to flatten and even decline. Nevertheless, the sales of policies will continue to fall. This combination of bad events will lead insurers to cut their payments to providers. As noted above, it is possible (though unlikely) that they will become less concerned with access, which would make system "footprint" a less powerful tool in negotiations. At the same time, tightly integrated systems, who can demonstrate high quality and low utilization, may be well positioned for new types of relationships with insurers.

Medicaid and "self-pay" revenue will decline, and bad debt will increase

- Nationwide unemployment will go above 10%, thus increasing the numbers of patients who have no insurance, or who will rely on Medicaid.

- Hospitals (seeing declining revenues) will cut costs – and this (ironically) will worsen the bad debt/Medicaid situation. Hospitals are the largest employers in many markets and these staff reductions will put even more pressure on Medicaid and create more uninsured.

- State budget crises will lead to increasing Medicaid cuts.

- Some type of reform will pass, which may lead to more people being insured, but in a product (or products) that may have rates closer to Medicare than to commercial insurance.

- While increased access to care will be good for the nation, it will not be an unalloyed good for health systems. Bad debt may decrease, but systems will still need to either learn to deliver care at Medicare rates, or figure out how to cost shift the new "reform" product.

Between 2011 and 2013 the Federal Government will cut Medicare spending.

- Medicare spending cannot continue to rise at current rates.

- Vast budget deficits created by stimulus packages will lead the government to finally decide that "deficits matter." New Balanced Budget Act passed.

- The new balanced budget effort will be pushed by lawmakers and this will lead to a renewed interest in cutting the costs of Medicare. Any reform - whether it be bundled payments, or current MS-DRG rate cuts - will lead to a loss of revenue for providers.

- In another irony, as hospitals are driven to make Medicare profitable they make drastic changes to care, and through incredible innovation, succeed. This very success will lead the government to have faith that it can cut the Medicare budget.

A Troubled Outlook

The Star-Ledger — **University Hospital faces crisis**
However, UMDNJ officials insist a shutdown is not a possibility
Sunday, December 14, 2008

AP
Sector Snap: Hospital operators fall
Monday December 1, 1:11 pm ET
Hospital operators slide as analyst warns of greater debt risk during economic slump

TheStreet.com — **Hospitals Face a Baby-Boom Bust**
11/12/08 - 01:48 PM EST

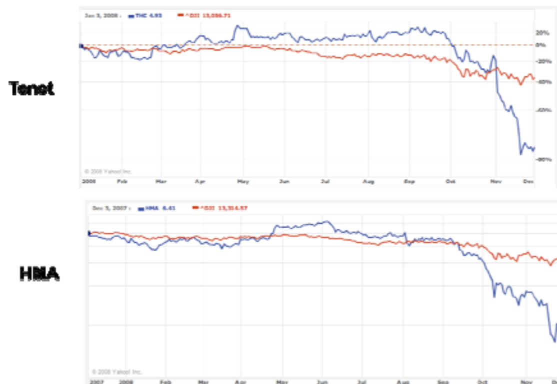
Moody's
November 2008
Not-for-profit Healthcare Sector Outlook Revised to Negative from Stable

Tampa Bay Business Journal
Friday, January 2, 2009
Reports chronicle looming healthcare crisis across Florida

BDC Advisors LLC

Many believe that bubble deflation has already begun. The signal event was the decision by Moody's in November 2008 to downgrade its outlook for not-for-profit hospitals to negative. That even signaled to bond investors that the sector was not a safe haven and that negative changes were likely to occur.

But the not-for-profit sector was not alone in getting bad news from "the street." Stock market analysts covering the for-profit hospital sector also reconsidered their stance on the state of the industry. By the end of the year in 2008, virtually every analyst had determined that commercial hospitals were in trouble, as evidenced by the poor performance of publicly traded hospital companies like Tenet and HMA (even against the terrible performance of the Dow Jones Industrial Average).



Already, the radical increases in the cost of capital have led health care institutions to rethink their capacity expansions. In some cases, projects have already been

abandoned. In November 2008, Summa Health System and its partner the Crystal Clinic stopped work on a JV orthopedic hospital when their accessible loan rates went from 4.5% to over 8%.

In other cases, the capital crisis has pushed poor performing players to the brink, and they are seeking to be acquired by, or to affiliate with, healthier partners. Shortly after the capital crisis began in the fall, BroMenn Hospital in Normal, Illinois, started negotiations to be acquired by Advocate Health System. University of Connecticut Health Center, which has survived only with the aid of $52M of state bailouts since 2002, is seeking to merge with Hartford Hospital.

Does a 300% Increase in capital costs shift desire for new inpatient capacity?

Physicians are looking for deals – but will falling physician reimbursement mean that hospitals once again get burned by buying up physician practices?

Physicians are also witnessing troubled times. In the seemingly natural cycle of boom and bust in the infusion space, suddenly oncologists around the country are seeking to be acquired by hospitals. They are not alone. Many private practitioners, seeing a decline in revenues, are now much more open to the idea of finally coming on board as employed physicians at their local hospital.

Almost every area of the country is already seeing unemployment numbers rising, with some areas already in double digits. The aforementioned doubling of the median co-pay in 2008, coupled with increasing numbers of uninsured as a result of the increases in unemployment, are already leading to downturns in revenue generating volume at physician offices, outpatient centers, and hospitals.

New Insights Lead to New Opportunities

Despite the seeming carnage around us, there are many opportunities for health systems. **We recommend that health systems begin by reassessing their current position.** There are many avenues for insight generation – here we offer brief outlines of eight ideas. Not every one of these practices will be right for every system. Systems should choose which practices are most appropriate for their current state, engage in a quick gathering of the right data, and an analysis of their situation. The results of these "rapid insights" will lead systems to correct decision making in what is a rapidly changing market.

Market Acquisitions Assessment

Enterprises with a strong cash position may want to seize the moment and affiliate or partner with now weakened players to capture market share.

Asset Maximization Analysis

On the other hand, the burning platform of the end of the bubble creates an opportunity for all hospitals and health systems to consider "right-sizing" the number of businesses in which they are engaged. Obviously, during "fat years," organizations easily become bloated. It is typical during times of recession for firms to lay off

What is the right size for the system? Is it time to shed low margin businesses?

workers using a “last in, first out” strategy because many of the more recent hires were a result of lax cost control practices. More important to future strategy, during lean times firms should be using the favorable environment to try different tactical moves: getting into new business, expanding territory, purchasing more real estate, and acquiring more technology. The popping of the bubble may mean that it is time for the organization to shed some of those tactics. The difficulty is to objectively gather the data, analyze business performance against benchmark, match the entity with the strategy, and determine if it is right for a cut. It is also necessary to bring the Board, and the stakeholders involved, along during the process. We would recommend the following:

- A Cross System Margin Review
- Benchmark to Best Analysis
- Necessary Strategic Analysis
- Engage Stakeholders in the Negative Candidate Selection
- Rationalize and Monetize Negative Candidates
- Perform an additional “Strip the Paint” Review of Remaining Business Units

Zero Capital Capacity Increase

Everyone is aware of the building boom that occurred in health care in the last decade. The low cost of capital, combined with a race to control the profitable service lines, and the public demand for private rooms, led to a boom not seen since the days of Hill–Burton. The first effect of the end of the health care bubble has been a sudden increase in the cost of capital (and significant hurdles to obtaining capital). Many hospitals realize that their volume projections are not aligned with their current capacity. This puts systems in a difficult position: needing additional capacity, but seeing pro formas (with an 8-10% cost of capital) that do not work out. What is needed is to go beyond the traditional attempts to improve throughput. While some of the analysis remains the same, a deeper “zero capital capacity increase” requires a rethinking of how health systems manage beds. Hospitals will need to “design to cost” meaning that patients need to be housed in accordance with the price being paid. Analyses of readmission rates and the ability to curb them, along with pulling physicians along down that curve, are a must. New reviews of ED use, treatment of chronic patients, and mix must be undertaken. Systems need to determine ways to care for patients using non-hospital assets (preventing admissions).

More than simply working on “throughput,” insights generated from this work can radically alter hospital operations, how physicians and nurses work together, and care coordination. We would recommend:

- Population Throughput Analysis
- Chronic Care Gap Study
- Re-admission Loss Review
- Quick Return Recommendation
- Long Term Capacity Strategy

Resetting the Outpatient Margin Standard

Beyond insights around global asset performance, there is specific work to be done in the outpatient arena. Increasingly, health system executives are more *outpatient* executives than *hospital* executives. Outpatient is a growing business – and one that is not run particularly aggressively. Though outpatient margins are higher, net contribution margin per patient is substantially lower, and systems have remained focused on the high margin procedural inpatients. It is time for systems to reconsider what business they are in.

The hospital business (as evidenced by Moody's negative outlook) is not a good business to be in. The outpatient business ranks far higher. Systems must dig deep into their outpatient numbers, match their performance to benchmarks, and determine where the operation could be generating more cash. The same inpatient discipline of volume growth, contract performance, and benchmarking performance needs to be brought to outpatient. Finally, this focus must lead systems to exit some outpatient business (lower margin) and dive deeper into others (higher margin). We would recommend:

- Prompt Entity Profit Analysis and Benchmarking
- Geographical and Market Matching Assessment
- Critical Margin Gap Identification
- Tactical Improvement Selection
- Best Practice Implementation

Re-Assessing Physician Readiness

Health system executives are painfully aware of the need for physician cooperation in order for the system to meet its goals, but no market is without angry physicians. The question that system executives need to ask with regard to physicians is – what is possible in your environment *today*? The problem is (and one that is tough to admit): the executives cannot possibly know. Only the physicians know, and it is important that systems bring in a third party to discover what is, and what is not, possible with the medical staff. Once the "real assessment" of physician readiness is complete, it is time to turn to the next effort: working with the physicians to move the entire system toward "the possible." The possible is the strategy that the physicians and the hospital choose together to move forward in the market.

- Rapid Market Diagnostic
- Physician Impact Review
- Physician Readiness Assessment
- Joint Physician/System Foundation Sessions
- Strategic Goals Alignment

Building a Physician Asset Discipline

Health system physician assets span a spectrum from owned physicians, partners, and networks, to private practice doctors who have no real relationship with the system, but who do send patients to system facilities. Though central to the business, few enterprises fully understand the flow, balance, and finances regarding these relationships. We would recommend:

- Physician Subsidy Analysis and Pushback
- Physician Portfolio Review
- Rightsizing Owned, Networked, and Private Practice Physicians
- Building Best Networks
- Maximizing the Physician Asset Base

Doctor Managed Disease Management

We all know the numbers. Elderly patients with one or more chronic illnesses consume over 50% of Medicare spending. Despite this, these patients are poorly managed (typically having 12 physicians), and when they do end up inside hospitals they make a marginal contribution, but hospitals would much prefer a procedural patient. Nothing about this system is good.

- Chronic Disease Revenue/Cost Analysis
- Chronic Disease Admission Reduction Impact Analysis
- DRG To Bundled Payment Bridging Strategies
- Clinical Information System Readiness Assessment
- Decision Support Capabilities Assessment
- Delivery System Design Gap Analysis

Bundled Payment Readiness Assessment

Everyone in health care knows that some form of bundled payment is coming – and we know it is the right answer. That said, for today providers get paid a unit price and for doing more units. The key question is "How do we cross the chasm from unit pricing to bundled pricing?" Systems need to determine how well they are performing today, where performance can be improved (and still yield high margins today), and where to best invest for the near and long term. We would recommend:

- Delivery Gap Analysis
- Payment Change Revenue Analysis
- Care Integration Performance Review
- Best Practice Delivery Techniques

Closing Thoughts

When a bubble comes to an end, companies fail, but industries do not. The painful shakeup that is caused by the end of a bubble exacerbates the competition in the industry, but there are still winners (though more losers). Yahoo, Google, Amazon, Paypal, Travelocity and many other

internet firms made it through the Dot Com Bubble. After the shakeout from the collapse of the Housing Bubble, there will be another list of survivors.

Health care will be no different. The key to success will be predicated on the ability to gain quick insights into the changing environment, developing strategies for delivering in that environment, and executing flawlessly.

To comment on this article, or learn more about the **Rapid Insights Series**, please contact:

Neal C. Hogan, PhD
Director
BDC Advisors
nhogan@bdcadvisors.com
603.865.4641